LATEST CMS UPDATES & GUIDANCE

MID-ATLANTIC SOCIETY OF POST-ACUTE & LTC MEDICINE

PRESENTERS

Barbara Bates, MSN, DNS-MT, RAC-CT, QCP-MT; Executive Trainer, MDS Consultants

Naveen Maddineni, MD; Psychiatry Director, Maryland, Psychogeriatric Services

Melissa "Missy" Mansfield, BSN, MS, RN; Regional Vice President, Complete Care MidAtlantic

Naudine Mokhtari, PharmD; Clinical/Consultant Pharmacist; CEO, NTM Rx Consultant

Moderator/Panelist: Ziad K. Mirza, MD, CPE, CMD, FACP, MBA, ABIM, ABPM/UHM; Multi-Facility Medical Director, Aligned Med Partners

Co-Moderator: Fatima Ali Naqvi, MD, CMD, MMT, HMDCB, WCC, FAAFP, Ingleside Rock Creek Medical Director, President MMDA (PALTmed local chapter), Editor in Chief (MMDA Newsletter), Assistant Professor George Washington/Medical Faculty Associates

AGENDA

Part I – *Overview of Key Areas: MDS Impact*

Barbara Bates, MSN, DNS-MT, RAC-CT, QCP-MT

Questions and Answers

Moderator: Dr. Ziad K. Mirza

Co-Moderator:

Dr. Fatima Naqvi

TRAINING OBJECTIVES

1. Discuss the 2025 updates to the survey process and how they may impact on the practice and care of the resident
2. Identify strategies to prioritize implement & monitor changes
3. Describe the Minimum Data Set (MDS) assessment tool and the need for accuracy
4. Highlight the MDS sections key to the Medical Team and their supporting documentation

TRAINING OBJECTIVES

5. Discuss provider orders and clarify timing of orders for use in determining active diagnoses
6. Identify common deficiencies that occur due to lack of specific provider documentation
7. Describe what we must know about the Preadmission Screening and Resident Review (PASRR)

CMS REGULATORY CHANGE 2025

F627 & F628 – Transfer, Admission, Discharge and Discharge Documentation

- Assessment for self care or need for caregiver
- Discharge organized, communicated, well thought out
- Policy & Procedure allows resident return following hospitalization and therapeutic leave
- Against Medical Advice (AMA) policy is reviewed, aligns with current guidance
- Staff educated/understand what AMA means

F758 & F605 – UNNECESSARY USE OF PSYCHOTROPICS & CHEMICAL RESTRAINT

Merged with F tags and removed F758 Unnecessary Use of Psychotropics

F757 Revised and reorganized to include guidance for unnecessary medications excluding psychotropics

F605 – UNNECESSARY USE OF PSYCHOTROPICS/CHEMICAL RESTRAINTS

- Not required to treat resident's medical symptoms
- Used as last resort
- Documentation that facility attempted interventions have been deemed clinically contraindicated or unsuccessful
- Residents have right to be informed & participate in their treatment

  -Notification before initiating or increasing, right to participate, right to accept or decline the medication

F605 – UNNECESSARY USE OF PSYCHOTROPICS (CONTINUED)

- Facility must ensure each resident's drug regimen must be free from unnecessary drugs
- Unnecessary medication definition:
  - Excessive doses – including duplicate drug therapy
  - Excessive duration
  - Without adequate monitoring
  - Without adequate indications for use
  - Presence of adverse consequences which indicate should be reduced or discontinued
  - Any combination of reasons noted

F605 – UNNECESSARY USE OF PSYCHOTROPICS(CONTINUED)

- New order or increasing psychotropic medication – must address in medical record non-pharmacological approaches used prior
- Document assessment of relative benefits & risks, preferences and goals for treatment
- Admitted with psychotropic without clearly documented indication
  - Prescribing provider & IDT should determine if med justified by conducting comprehensive medical & psychiatric evaluation

F605 – UNNECESSARY USE OF PSYCHOTROPICS(CONTINUED)

- Psychotropics switched from one type to another – rationale for change should be reflected in medical record
- Documented verbal consent is sufficient, but documentation must cover everything reviewed verbally
- Mental Disorders should be diagnosed, using evidence –based criteria, such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and documented in resident's record.
- Resident/Resident Representative must be informed of benefits, risks & alternatives for medications – including black box warnings in advance to initiation or increase

INSUFFICIENT DOCUMENTATION

- Schizophrenia or other diagnoses only mentions as indication in MD orders – no supporting documentation
- Practitioner's note or transfer summary from previous provider stating hx of Schizophrenia or other diagnosis without supporting documentation confirming the dx with previous practitioner or family – facility failed to provide evidence of comprehensive evaluation after admission by a practitioner
- Note of Schizophrenia or other diagnosis in EMR without supporting documentation which populated throughout EMR
- Note of Schizophrenia or other diagnosis in EMR by a nurse without supporting documentation by a practitioner

F658 & F841 – PROFESSIONAL STANDARDS & MEDICAL DIRECTOR

- Clarification that the medical director is responsible for intervening when medical care is inconsistent with current accepted standards of care
- Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her (F868 – QAA committee)
- Clarification regarding the Medical Director's responsibilities related to implementing resident care policies (specifically about prescribing antipsychotics)
- Action items for F658
  - Educate medical directors and all prescribers

F641 – ACCURACY/COORDINATION/CERTIFICATION

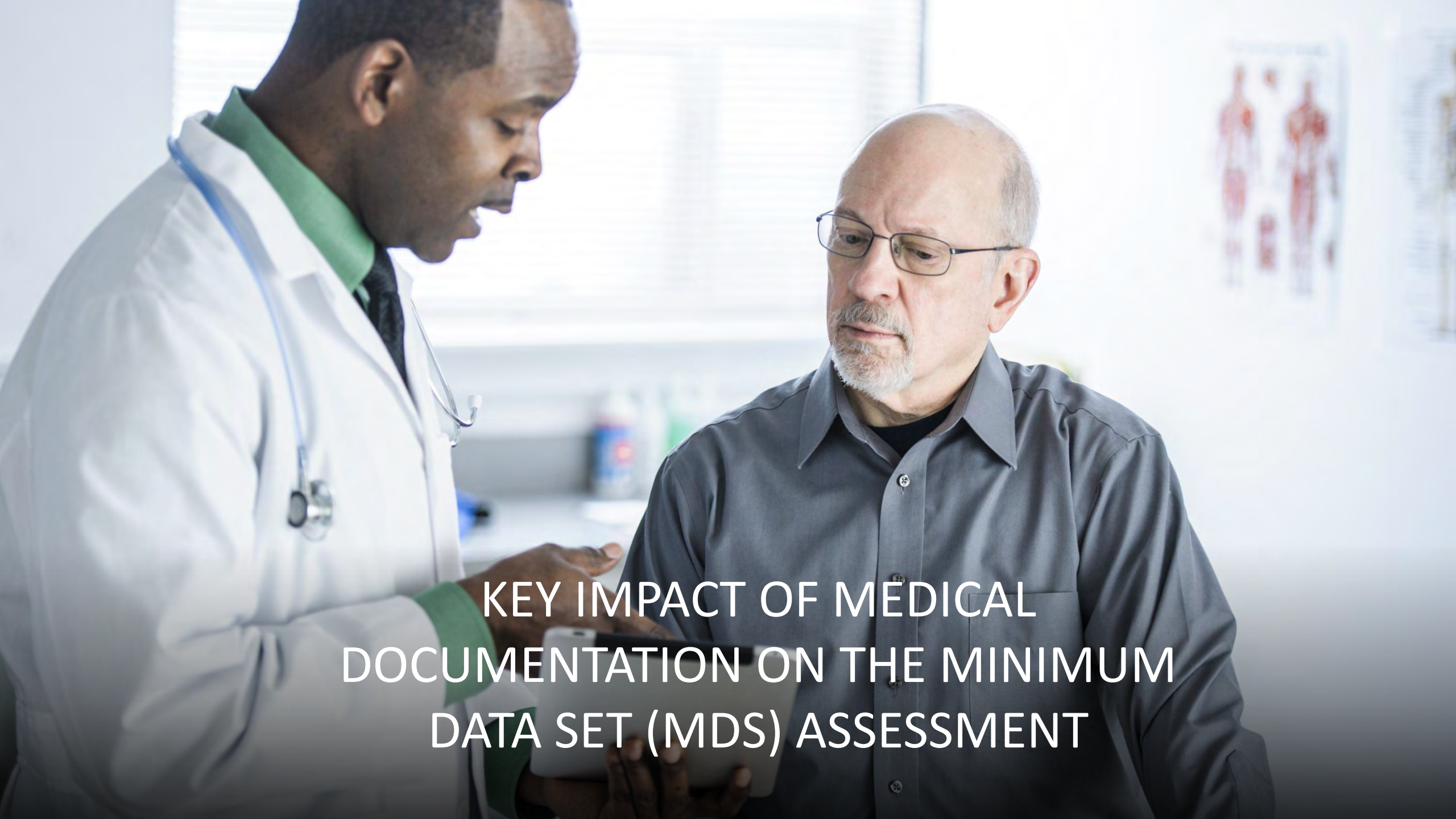
- Guidance added to investigate if there was sufficient documentation to support a medical condition identified, especially related to a diagnosis of schizophrenia
- Surveyors not questioning practitioner's medical judgement, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment

F697 – PAIN MANAGEMENT

- Revised guidance- added definition for acute, chronic, and subacute pain definitions to align with CDC
- Opioid treatment for pain needs to be appropriately assessed and individualized for reach resident
- Clinicians may consider prescribing immediate-release opioids instead of extended-release & long –acting opioids
- Provided resources from AMDA, JAMA, CDC, NIH, etc. related to opioid treatment
- Emphasizes resident rights to be informed about risks and benefits of proposed treatment

F697 – PAIN MANAGEMENT (CONTINUED)

- Review updates to guidance with Medical Director and with prescribers and consultant pharmacist
- Review/update policies & procedures related to pain medication
- Consider developing or implementing routine audits to determine if facility is following their own policies for pain management



KEY IMPACT OF MEDICAL DOCUMENTATION ON THE MINIMUM DATA SET (MDS) ASSESSMENT

MINIMUM DATA SET (MDS) ASSESSMENT

- Standardized tool used in nursing homes to evaluate resident's health, function status and care needs
- Ensures compliance with Medicare & Medicaid requirements

MINIMUM DATA SET (MDS) ASSESSMENT (CONTINUED)

Overview of MDS Assessment

- Mandated for all residents in nursing home
- Designed to collect essential information about resident's medical conditions, functional capabilities & psychosocial needs
- Critical component of the Resident Assessment Instrument (RAI), which includes MDS, Care Area Assessments (CAAs) and Resident Utilization Guidelines
- Provides standardized method for assessing residents, which helps to ensure care plans are tailored to their specific needs

MINIMUM DATA SET (MDS) ASSESSMENT (CONTINUED)

Purpose and Importance

- Care Planning- information gathered through the MDS used to develop, review & revise individualized care plans for residents
- Required to submit MDS assessments electronically to the federal MDS repository as part of the participation in Medicare & Medicaid programs
- Ensures facilities meet federal standards for resident care & quality monitoring

MDS SECTIONS-IMPACTED BY MD ORDERS/DOCUMENTATION/TEAM COMMUNICATION

- Section B – Hearing, Speech & Vision
- Section C – Cognitive Pattern (BIMS) (Delirium)
- Section D – Mood Interview
- Section E – Behaviors (rejection of care, wandering)
- Section GG – Functional Abilities
- Section H – Indwelling Catheter, Ostomy – incontinence (type)
- Section I – Active Diagnosis

MDS SECTIONS-IMPACTED BY MD ORDERS/DOCUMENTATION/TEAM COMMUNICATION (CONTINUED)

- Section J – Pain Management, Shortness of Breath, Falls, Surgery
- Section K – Swallow Disorder, Weight Loss/Gain, Nutritional Approaches
- Section L – Oral/Dental Status
- Section M – Sin Conditions, Pressure Ulcers, Arterial Wounds, Vascular Wounds, Diabetic wounds, etc.
- Section N – Medications (injections, insulin, high risk drug classes, antipsychotic meds, drug regimen review & f/u, etc.)

MDS SECTIONS-IMPACTED BY MD ORDERS/DOCUMENTATION/TEAM COMMUNICATION (CONTINUED)

- Section O – Special Treatments, Procedures, Programs (cancer treatment, respiratory treatment, IV meds, transfusions, dialysis, oxygen, vaccines, therapies, etc.)
- Section Q – Resident Participation and Discharge Planning
- Section V – Care Area Assessment Investigations
- Comprehensive Care Planning

Active Diagnosis & MD Documentation

Active Diagnoses in the last 7 days – Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ **I0100. Cancer** (with or without metastasis)

Heart/Circulation

- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal

- ☐ **I1100. Cirrhosis**
- ☐ **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ **I1400. Benign Prostatic Hyperplasia (BPH)**
- ☐ **I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

Infections

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

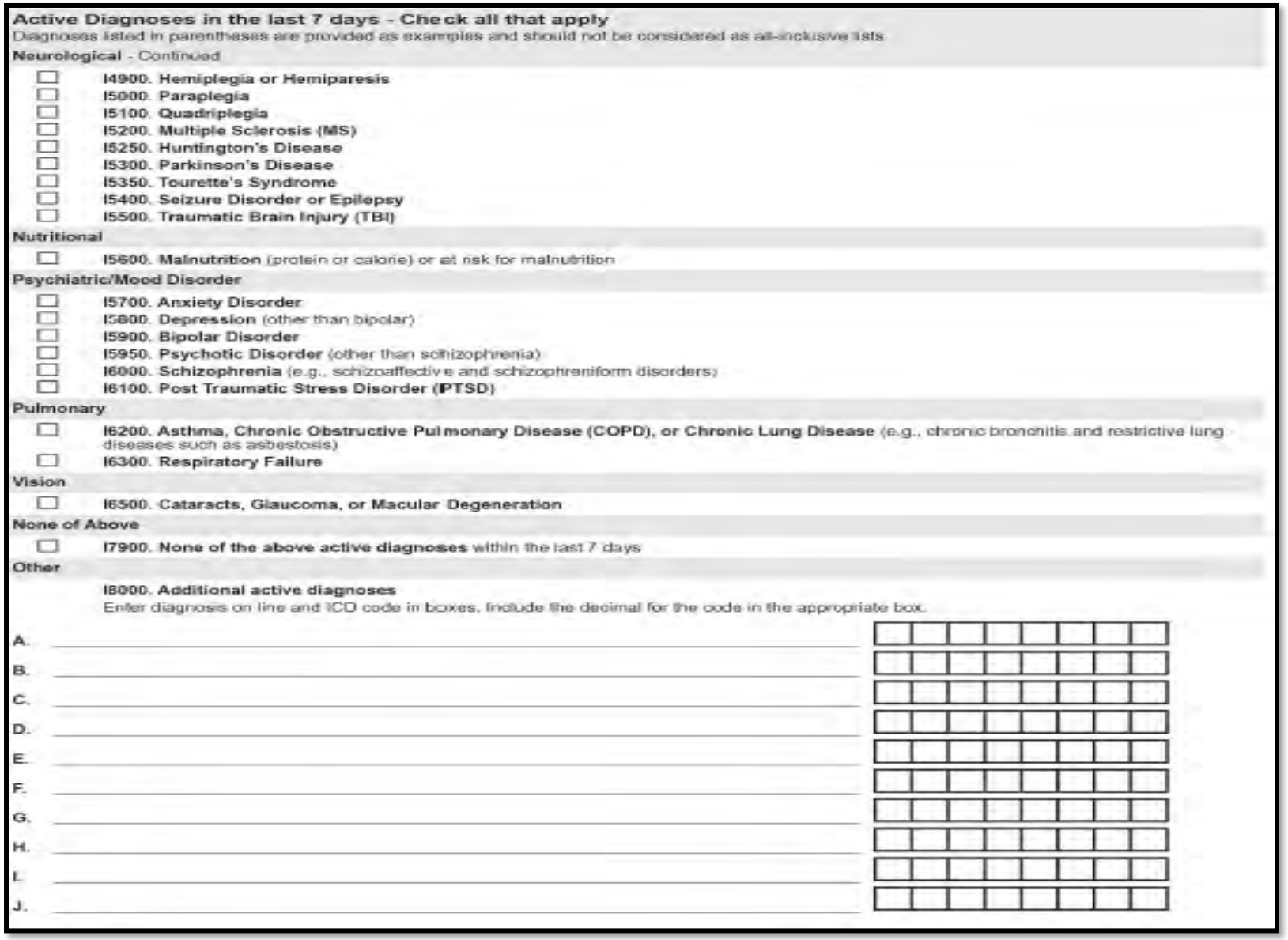
- ☐ **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ **I3800. Osteoporosis**
- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ **I4000. Other Fracture**

Neurological

- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

Active Diagnosis & MD Documentation



Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H. _____
I. _____
J. _____

ACTIVE DIAGNOSIS & MD DOCUMENTATION

Definitions:

Active Diagnoses: Physician-**documented diagnoses** in the **last 60 days** that has direct relationship to the resident current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death **during the 7 day look back period.**

Functional Limitations: Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.

ACTIVE DIAGNOSIS & MD DOCUMENTATION *(CONTINUED)*

2-step look back process used during Section I – Active Diagnosis

- Diagnosis Identification (1st step) **60–day look back period**
- Diagnosis Status: Active or Inactive (2nd step) is **7 day look back period**, except for I2300 UTI, which does not use 7 day look back period
- Require physician-documented diagnosis (or PA, NP, or CNS) in last 60 days
- Sources for physician diagnoses – progress notes, recent history and physical, transfer documents, discharge summaries, diagnosis problem list, and other resources as available
- Only diagnosis confirmed by physician can be entered in section

ACTIVE DIAGNOSIS & MD DOCUMENTATION *(CONTINUED)*

- Determine whether diagnoses are **active**
- Active diagnoses are diagnoses that have a direct relationship to resident's current functional, cognitive, or behavior status, medical treatments, nursing monitoring, or risk of death, **during the 7 day look back period**
- **Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7 day look back period, as these are considered inactive diagnoses**

MDS ERRORS – POTENTIALLY IMPACTED BY MD DOCUMENTATION

- Primary Diagnosis/Active Diagnoses (PDPM)
- UTI (QM)
- Recent Surgery Requiring SNF Care (PDPM)
- High-risk medications & indications for use
- Isolation (PDPM)
- Vaccinations (QM)

MDS ERRORS – POTENTIALLY IMPACTED BY MD DOCUMENTATION (CONTINUED)

- Drug Regimen Reviews
- GDR – contraindicated – lacks clear documentation/rationale
- Respiratory Failure – lack of diagnosis
- CVA & Sequelae – often missing impact of functional limitations, neurological or cognition status

PREADMISSION SCREENING & ADMISSION REVIEW (PASRR)

- All individuals admitted to a Medicaid certified SNF, regardless of payment source – MUST have Level I PASRR to rule out possible mental illness (MI), intellectual disability (ID), developmental disability (DD) or related conditions
- Suspected or have MI or ID/DD or related conditions – not to be admitted unless approved through Level II PASRR determination
- Residents covered by LEVEL II PASRR process may require certain care & services provided by nursing home and/or specialized services provided by the State

PREADMISSION SCREENING & ADMISSION REVIEW (PASRR) *(CONTINUED)*

- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition
- Significant Change in Status assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority in order to notify them of the resident's change in status

PREADMISSION SCREENING & ADMISSION REVIEW (PASRR) *(CONTINUED)*

- Referral for Level II resident review evaluation is required for individuals previously identified by PASARR to have a mental disorder, intellectual disability, or a related condition who experience a significant change

PREADMISSION SCREENING & ADMISSION REVIEW (PASRR) *(CONTINUED)*

- Examples of notification changes:
- Resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms
- Resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment
- Resident who experiences an improved medical condition—such that the residents' plan of care or placement recommendations may require modifications

PREADMISSION SCREENING & ADMISSION REVIEW (PASRR) *(CONTINUED)*

- Resident whose significant change is physical, but has behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living
- Resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASARR Level II evaluation and determination

QUESTIONS

AGENDA

Part II – *Overview of Key Areas: Nursing Role*

Melissa "Missy" Mansfield, BSN, MS, RN; Regional Vice President, Complete Care MidAtlantic

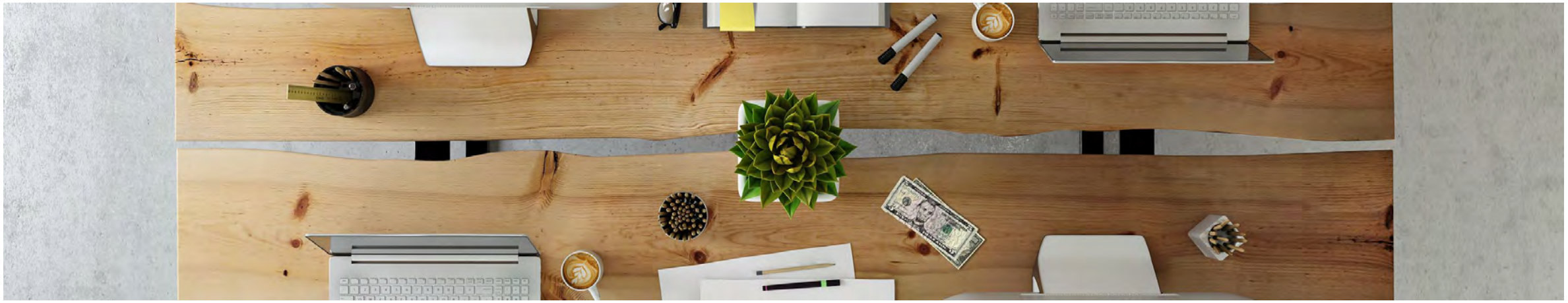
<u>Questions and Answers</u>

Moderator: Dr. Ziad K. Mirza

Co-Moderator: Dr. Fatima Naqvi

NURSING ROLE

Melissa “Missy” Mansfield, RN, MSN



COLLABORATION

- **Interdisciplinary alignment is essential** – nursing must coordinate with MDS, pharmacy partners, and providers to ensure assessments, care plans, and documentation reflect the resident's true clinical status.
- **Shared accountability** – regular interdisciplinary communication builds a unified understanding of CMS expectations and promotes a culture of compliance and quality.
- **Improved resident outcomes** – joint decision-making fosters proactive care, timely interventions, and stronger Quality Measure performance.

F605- RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS

When a new psychotropic medication has been prescribed or dose has been increased:

- Document non-pharmacological approaches used prior to administering the medication.
- Document informed consent: resident/ family/ representative must be informed of risks, benefits, and alternatives for the medication.

When a resident is admitted with a psychotropic medication without a clearly documented indication:

- Prescribing practitioner and IDT should determine if continuing the medication is justified.
- Coordinate a comprehensive medical and psychiatric evaluation.
- Explore prior medical records and elicit feedback from responsible party/ family regarding previous diagnoses.

F627 & 628 – TRANSFER & DISCHARGE

Combines guidance from F622-626 & F-660-661 under two new tags: F-627 and F-628

- Document that facility staff has assessed the resident's ability to care for themselves at home, and if they cannot, that there are interventions in place to ensure their safety at home.
  - Medication Administration
  - Wound Care/ Treatments
  - Mobility
- Must allow residents to return to the facility following hospitalization or therapeutic leave.

F 641 ACCURACY OF ASSESSMENTS & F 658 PROFESSIONAL STANDARDS

Added language regarding accuracy of documentation and MDS coding, specifically for schizophrenia.

- ❑ Ensure supporting documentation is present in medical record.
  - ✓ Proper diagnosis
  - ✓ Nursing notes with supportive documentation by attending physician, psych providers, etc.
- ❑ Collaborate with prescribers on the documentation requirements for psychotropic medications.
- ❑ Educate nursing staff on the documentation requirements when psychotropic medications are newly prescribed, increased, or changed.

F697 – PAIN MANAGEMENT

- Document individualized assessment and treatment plan for each resident.
- Document non-pharmacological interventions attempted prior to administration of pain medication.
- Document effectiveness of medication regimen and inform physician of same.
- Consider referral to pain specialist.
- Collaborate with consultant pharmacist to reduce polypharmacy.

Definitions Added
"Acute Pain" refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and is often caused by injury, trauma, or medical treatments such as surgery.
"Chronic Pain" refers to pain that typically lasts greater than 3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause.
"Subacute Pain" refers to pain that has been present for 1-3 months.

F757 – DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CONT'D.

- **Right to be informed** - document informed consent: resident/ family/ representative must be informed of risks, benefits, and alternatives for the medication. Resident/ family/ representative have the right to accept or decline.
- **Dose and duration** - based on a variety of factors, including the resident's diagnoses, signs and symptoms, current condition, age, coexisting medication regimen, review of lab and other test results.
- **Monitoring** - monitoring and accurate documentation of the resident's response to any treatment (such as, lab results, vital signs, progress notes, behavior flow sheets, medication administration records, and the consultant pharmacist's drug regimen review) is essential to evaluate the ongoing effectiveness, benefits, as well as risks of medication therapy.

Gather input from the IDT about the resident, including the resident's preferences and goals.

F757 – DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

- Medical record should include documentation of comprehensive assessment and rationale for chosen treatment options.
- Ensure that the initiation or change in a medication is not:
  - Due to a medical condition or problem (e.g., pain, fluid or electrolyte imbalance, infection, obstipation, medication side effect or polypharmacy) that can be expected to improve or resolve as the underlying condition is treated, or the offending medication(s) are discontinued;
  - Due to environmental stressors alone, that can be addressed to improve the symptoms; or
  - Due to psychological stressors alone, that can be expected to improve or resolve as the situation is addressed.

Circumstances that warrant evaluation of a resident's underlying medical condition and medication(s) include:

- *Admission or re-admission: Some residents may be admitted to the facility on medications that were started in the hospital or the community without a clear documented indication for why the medication was begun or should be continued. The prescribing practitioner and the IDT should subsequently determine if continuing the medication is justified by conducting a comprehensive evaluation*
- *A new or worsening change in condition/status*
- *An irregularity identified in the pharmacist's medication regimen review.*
- *New medication order as an emergency measure – When a resident is experiencing an acute medical problem or emergency and the acute phase has stabilized, the staff and prescriber should consider whether medications are still indicated.*

F880 – INFECTION PREVENTION AND CONTROL

Enhanced Barrier Precautions (EBP) – an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during *high contact* resident care activities.

MDRO Colonization / Infection – Contact precautions are used for residents infected or colonized with MDROs in the following situations:

- Presence of acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained;
- Co-infection with another organism for which Contact Precautions is recommended (e.g., norovirus);
- For a limited time, as determined in consultation with public health authorities, on units or in facilities during the investigation of a suspected or confirmed MDRO outbreak; and when otherwise directed by public health authorities.

F880 – INFECTION PREVENTION AND CONTROL (CONTINUED)

Facilities should:

- Ensure proper documentation of pertinent diagnoses and infection control interventions.
- Provide staff education and perform frequent rounds to determine compliance.
- Consult with IDT to determine length and duration of treatment.

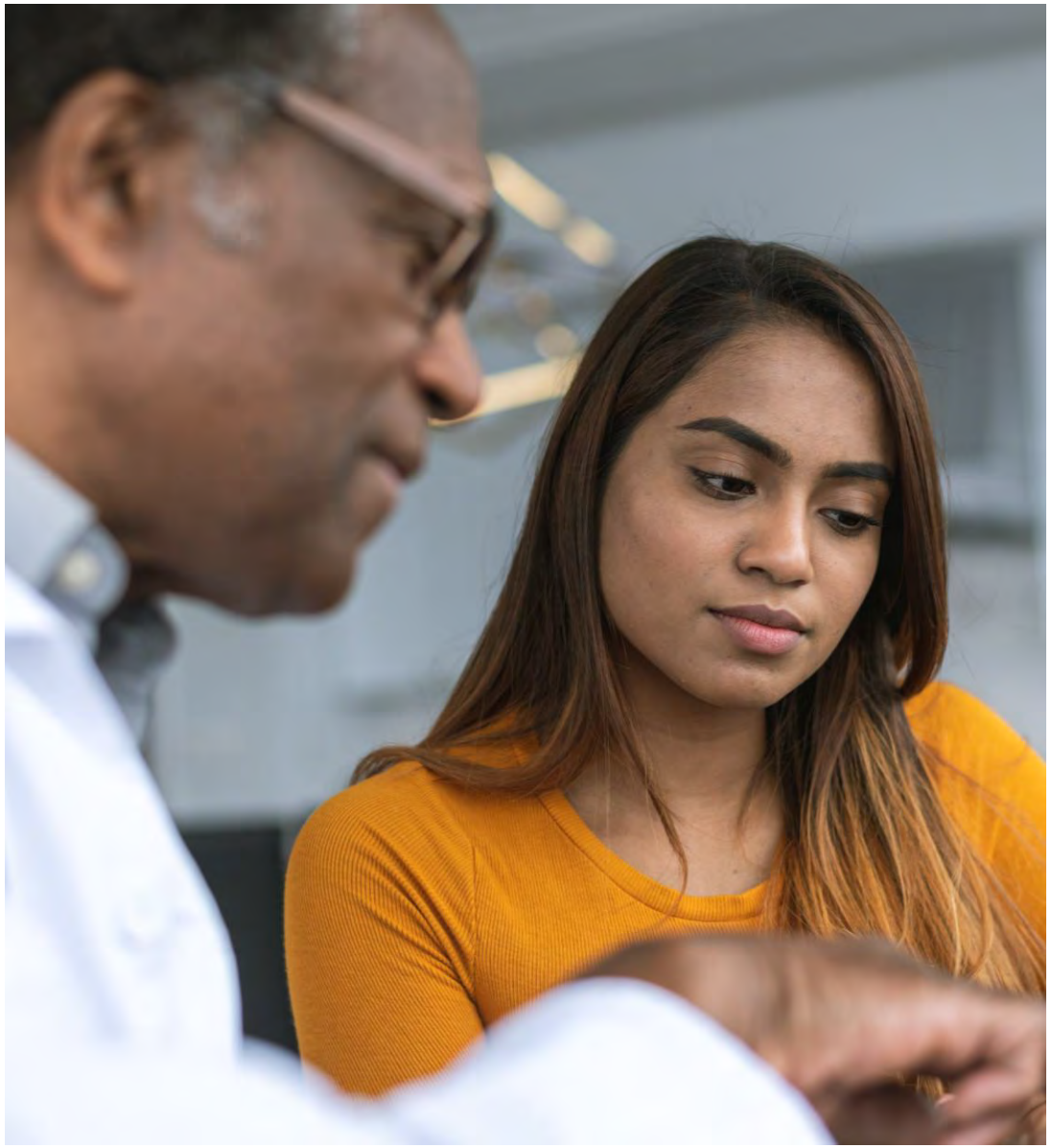
F887 – COVID-19 IMMUNIZATION

When COVID-19 vaccine is available to the facility, each resident and staff member is *offered* the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized.

- ❑ The resident's medical record should include documentation that indicates:
  - ✓ *That the resident/ representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and*
  - ✓ *Each dose of COVID-19 vaccine administered to the resident, or*
  - ✓ *If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.*

- ❑ The facility maintains documentation related to staff COVID-19 vaccination that includes:
  - ✓ *That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and*
  - ✓ *Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and*
  - ✓ *The COVID-19 vaccine status of staff.*

Medical Director may provide standing orders for annual COVID-19 immunization of facility residents and staff.



F 841 – RESPONSIBILITIES OF THE MEDICAL DIRECTOR

- Ensure your Medical Director is aware of and involved in:
  - ✓ Confirming adherence to properly diagnosing and prescribing medications.
  - ✓ Assisting with development and refinement of facility assessment.
  - ✓ Administrative decisions including recommending, developing, and approving facility policies related to residents' care.
  - ✓ Intervening when medical care is inconsistent with current accepted standards of care.
  - ✓ Active participation with QAPI committee.

Part II – *F605 and Chemical Restraints*

<u>Psychotropic Medication and Deprescribing</u>:

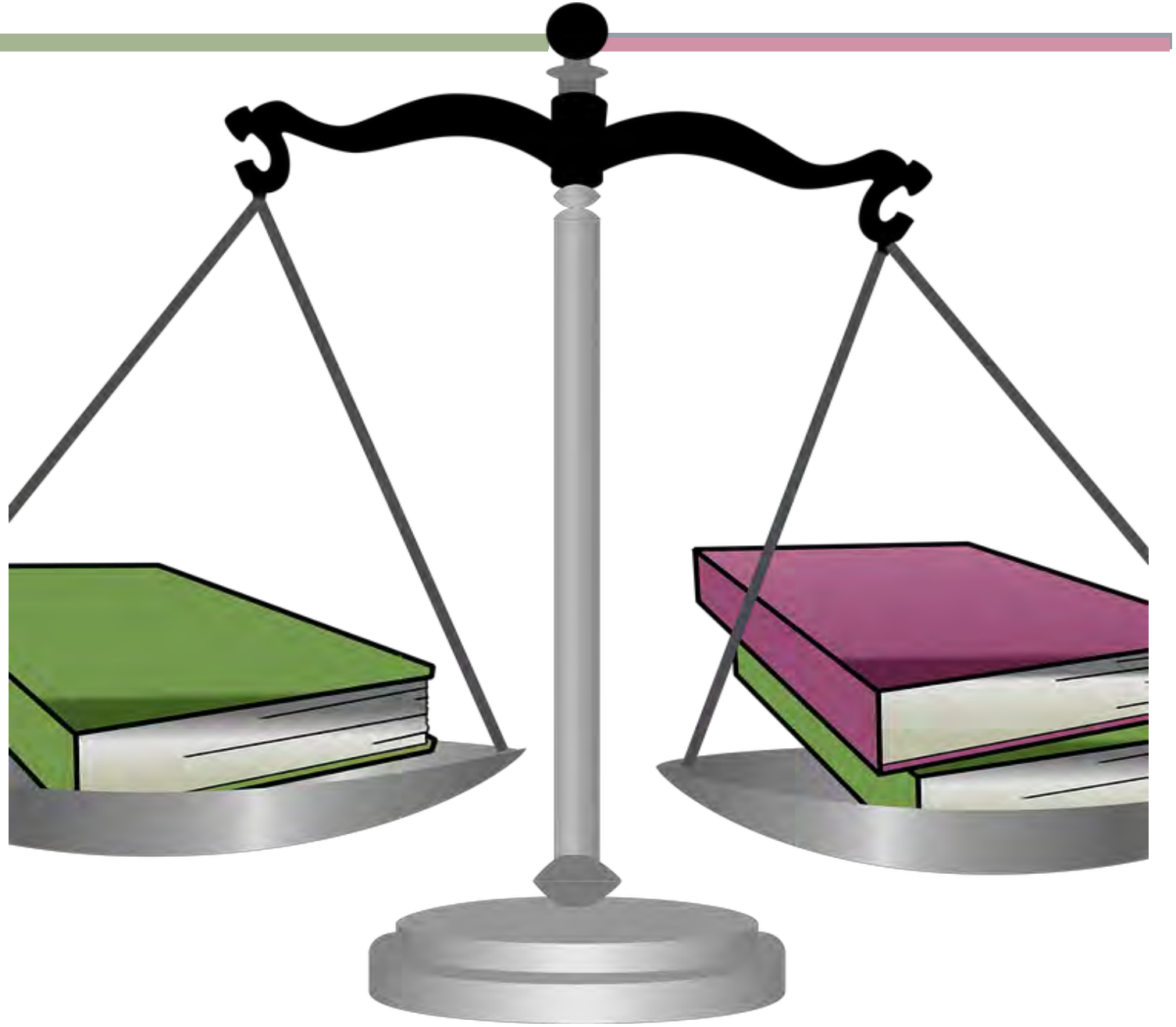
Dr. Naveen Maddineni

<u>Questions and Answers</u>

Moderator: Dr. Ziad K. Mirza

Co-Moderator: Dr. Fatima Naqvi

BALANCING THE SCALES: ANTIPSYCHOTIC USE & DEPRESCRIBING IN NURSING HOME PATIENTS – A RISK-BENEFIT APPROACH



TRAINING OBJECTIVES

1.Describe the April 28, 2025, revisions to CMS SOM Appendix PP, that focus on the updated definition and regulatory expectations for F605 and the Right to Be Free from Chemical Restraints.
2.Identify the risk benefit of antipsychotics and how to effectively deprescribe.
3.List the indications for antipsychotic medication use.
4.Differentiate between appropriate and inappropriate use of psychotropic medications in long-term care, based on resident diagnosis, documentation, and the presence of medical symptoms.

TRAINING OBJECTIVES

5. Apply evidence-based strategies and interdisciplinary practices to reduce the use of chemical restraints, including pharmacist-led medication reviews and nonpharmacological interventions.
6. Demonstrate proper documentation standards required to justify the clinical use of psychotropic medications under F605, including assessment, rationale, monitoring, and time limitations.
7. Explain the medical director’s role in overseeing psychotropic medication use, discharge planning, documentation, and quality assurance.

RESIDENT RIGHTS REGULATORY SECTION: §483.10 RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS (F-605)

CMS has revised regulations and guidance regarding chemical restraints and unnecessary psychotropic medications

- The regulations and guidance for the unnecessary use of psychotropics, originally found in F-758, have been incorporated into F-605
- Expectation that residents who have not previously used psychotropic drugs are not prescribed these drugs unless it is necessary to treat a specific condition and not for purposes of discipline or staff convenience
- The guidance regarding “convenience” has been revised to include situations when medications are used to cause symptoms consistent with sedation and/or require less effort by facility staff to meet the resident’s needs

PRESCRIBING

There must be adequate documentation of the indication for the psychotropic medication including:

- A documented clinical rationale
- Assessment of resident's condition
- Therapeutic goals
- Documentation that the facility has attempted behavioral (i.e., nonpharmacological interventions) and that these interventions have been deemed clinically contraindicated or unsuccessful prior to prescribing psychotropic medications.

RIGHT TO BE FULLY INFORMED

Informed Consent:

- Must be obtained prior to initiating or increasing a psychotropic medication
- Resident or Responsible Party (RP) must be informed of risks, benefits and alternatives and this must be documented.
- Resident or RP have right to accept or decline the initiation or increase

MONITORING

Monitoring for Efficacy and Adverse Consequences

- Providers should monitor and document the resident's response to treatment using:
  - Lab results
  - Behavior records
  - Progress notes
  - EMAR
  - Pharmacy Consultant Drug Regimen Reviews (DRRs)

PERIODIC REVIEW

- Periodic medication regimen reviews must be completed to determine the continued need for the medication
- Gradual Dose Reduction should be trialed documented success or failure
- PRN orders for psychotropic drugs are limited to 14 days.
  - If provider believes it is appropriate for the PRN order to be extended beyond 14 days, he/she should document their rationale and indicate the duration for the PRN order.
  - PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication.

COMMON INDICATIONS FOR ANTIPSYCHOTIC USE

The various common diagnosis are:

1. Schizophrenia
2. Schizoaffective disorder
3. Bipolar Disorder
4. Major depressive disorder with Psychotic features
5. Tourette’s syndrome
6. Huntington’s disease
7. Delusional disorder
8. Severe Dementia with Psychosis
9. Delirium

RECOGNITION

- How do we identify individuals who may have acute problematic behavior and altered mental function?
- Behavior is a symptom, like others. Unlike many other symptoms or condition changes, problematic behavior often affects other patients and staff. Often produces a sense of alarm and urgency to stop the symptom ASAP
- Professional approach is important to assess behavioral symptoms and altered mental function in much the same way as other symptoms

DELIRIUM AND PSYCHOSIS

- Symptoms of acute psychosis unlikely to respond adequately to nonpharmacological interventions alone

- All patients with delirium and psychosis should also receive environmental and supportive interventions at least until mental function stabilizes or begins to improve

WANDERING AND SLEEP DISTURBANCES

- Medical and pharmacologic options to address wandering are limited
- May be helped by addressing underlying causes; for example,
  - Reduce does of medications causing motor restlessness mistaken for agitation
  - Treat psychosis that leads a patient to wander into others' rooms to try to find nonexistent person

AGITATED BEHAVIOR

Possible causes:

- Exacerbation of underlying psychotic disorder (e.g., depression with psychosis)
- New onset of delirium
- Adverse reaction to medications that were added recently to address similar symptoms

BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS (BPSD)

- Consider and address medical (e.g., pain, delirium), psychiatric and environmental causes

- Consider nonpharmacological interventions to address nonspecific behavioral and psychological symptoms related to dementia before using medications

MEDICATION FOR BPSD

- No “magic bullets”
- No medication class demonstrated to have consistent, predictable benefits
- No established ways to predict who will respond or have long term benefits
- Even apparently successful medication interventions require re-evaluation
  - May need to be changed or discontinued, depending on subsequent results

RISKS WITH ANTIPSYCHOTIC USE

- Even when they are used appropriately there are risks
- When prescribed inappropriately the risks will generally outweigh the benefits of the medications
- Increased rates of stroke and death in older adults with dementia
- Sedation
- Postural Hypotension
- Extrapyramidal side effects
- Metabolic side effects (Weight gain, DM, HLD, etc.)

BARRIERS OR FACILITATORS WHEN ATTEMPTING TO DEPRESCRIBE PSYCHOTROPIC DRUG

OBJECTIVES

- The objective of this presentation is to discuss which factors nursing home general practitioners and nursing home staff experience as barriers or facilitators when attempting to deprescribe psychotropic drugs in nursing home residents.

BACKGROUND

- Behavioral and psychological symptoms of dementia are frequently experienced in the nursing home setting and place a substantial burden on patients, relatives and nursing home staff.
- This is the case despite their effects being limited, and there being a risk of side effects and adverse events for the patient.
- Reports show that up to 90% of older persons with dementia experience one or more symptom(s) of BPSD with the course of the disease.

BACKGROUND

- Anxiety
- Agitation
- Hallucinations
- Depression
- Apathy

BARRIERS OR FACILITATORS

1. Operationality and routines
2. Lack of resources and qualifications
3. Patient-related outcomes
4. Policies
5. Collaboration

COGNITIVELY HEALTHY PATIENT

- Face to face consultation
- Risk vs benefits weighed
- Common decision made

PATIENT WITH COGNITIVE IMPAIRMENT

- Physician has the main responsibility for Prescribing
- Additional people are involved in the process
- Licensed prescribers
- Nurse assistants
- Patient relatives
- Legal guardians

OPERATIONALITY AND ROUTINES

- Routines and systematic procedures for reviewing psychotropic drugs in nursing homes served as a facilitator to discontinuing or reducing inappropriate use

- Reports of pharmacists' recommendations could provide nursing home staff and general practitioners with a tool for change

LACK OF RESOURCES AND QUALIFICATIONS

- Staff reports lack of time needed to enable the use of Non-pharmacological treatments
- Education of the relatives was required to ensure their support in the deprescribing process
- Lack of time for the General practitioner to perform a thorough drug review

LACK OF RESOURCES AND QUALIFICATIONS

- General Practitioners and Nursing home staff lack the qualifications necessary to enable deprescribing
- Lack of possible alternatives
- Staff’s lack of knowledge concerning the side effects of antipsychotics

PATIENT-RELATED OUTCOMES

- Concerns of worsening of the symptoms if deprescribed
- Nursing home staff and relatives saw that it will negatively impact the patient quality of life

POLICIES

- National regulations
- Rating systems for Nursing homes

COLLABORATION

- Collaboration, communication, and the acknowledgement of the valuable contributions made by the different professionals deeply influence the deprescribing process
- Pharmacists' recommendations
- Nursing staff input

COLLABORATION

- Need for more educational opportunities for General practitioners and nursing home staff
- More nursing home staff
- More time with the patients

IMPLICATIONS AND FUTURE RESEARCH

- There is general belief in the effectiveness of psychotropic drugs for managing behavioral and psychological symptoms
- Document the frequency and severity of the behavior using a standardized assessment tool
- Relatives perspective

ROLE OF CONSULTANT PHARMACIST

Ensuring Compliance with CMS SOM Appendix PP – F605 (Chemical Restraints/Unnecessary Psychotropics)

Naudine Mokhtari, PharmD

OVERVIEW: CMS APPENDIX PP AND F605

- SOM Appendix PP is guidance to surveyors in long-term care settings; updated guidance became effective April 28, 2025

- F605 now F tag for “Freedom from chemical restraints/unnecessary psychotropic medications” (guidance formerly under F758 now consolidated under F605)

- Key regulatory requirements under 42 CFR §483.45(d) & (e); medications must be clinically indicated, lowest effective dose, monitored, periodic re-evaluation, gradual dose reduction(GDR) unless contraindicated, informed consent, nonpharmacologic interventions first

KEY RISK AREAS FOR NON-COMPLIANCE

- Use of psychotropic meds for staff convenience or discipline rather than clinical need = chemical restraint
- Lack of documentation of indication, monitoring, GDR attempts
- Inadequate use of documentation of non-drug interventions
- Poor staff education and awareness
- Surveyor may expect justification, audit records, track trends in psychotropic use
- Risk of high severity citations if sedation or harm is evident and not addressed

CONSULTANT PHARMACIST: CORE ROLES & MECHANISMS

- **Monthly Medication Regimen Review (MRR)/Drug Regimen Review**:
  - Consultant pharmacist reviews each resident's full chart, lab data, diagnoses, medication list, interactions, duplications, appropriateness. This is a regulatory expectation

- **Psychotropic review & GDR oversight**:
  - Flag psychotropic use, ensure nonpharmacologic first, ensure GDR attempts documented, ensure PRN orders are appropriate, duration limited, and rationale documented

CONSULTANT PHARMACIST: CORE ROLES & MECHANISMS

(continued)

- **Education & training:**
  - Educate nursing, medical, therapy staff on behavioral interventions, informed consent, adverse effects of psychotropics, documentation expectations

- **Policy, procedure and audit support:**
  - Help craft and review facility policies on psychotropic use, consent, monitoring, GDR, perform audits of psychotropic prescribing trends and compliance

CONSULTANT PHARMACIST: CORE ROLES & MECHANISMS

(Continued)

- **Participation in QAPI/QA Committees:**
  - Integrate medication compliance into quality improvement projects; provide reports & metrics

- **Consultation & intervention with prescribers**:
  - Communicate directly with attending physicians or medical director about recommendations, requiring rationale or acceptance/refusal documentation

HOW CONSULTANT PHARMACISTS SUPPORT F605 COMPLIANCE

- **Medication Reviews Ensure Clinical Justification** – Monthly Drug Regimen Reviews help verify that every psychotropic medication has a documented, valid clinical indication – core F605 requirement

- **GDR Monitoring Prevents Chemical Restraint Use** – Pharmacists flag cases where GDR hasn’t been attempted or documented, ensuring the facility doesn’t default to long-term psychotropic use without clinical need

HOW CONSULTANT PHARMACISTS SUPPORT F605 COMPLIANCE (CONTINUED)

- **Audit Trails Support Survey Readiness** – Pharmacist reports and interventions create a clear paper trail of oversight, which surveyors can review during audits – supporting compliance documentation
- **Education Reduces Inappropriate Prescribing** – Staff and prescriber education by pharmacists helps reduce misuse, especially when medications are being used for convenience or behavioral control (red flag under F605)
- **Policy Development and QA Involvement** – Pharmacists contribute to facility policies on psychotropic medication use, help set protocols for documentation and GDR and often participates in Quality Assurance & Performance Improvement (QAPI) initiatives – all of which surveyors expect to see

OUTCOMES OF EFFECTIVE COLLABORATION

- **Reduced survey citations** (F-605, F-757, F-758, F-759, F-760) – fewer financial penalties and reputational risk
- **Stronger survey readiness** through accurate documentation, drug regimen review notes, and QAPI tracking
- **Demonstrated medical director oversight** that surveyors look for
- **Fewer unnecessary medications** – lower pill burden and reduced polypharmacy
- **Decreased adverse drug events (ADEs)** such as falls, delirium, over-sedation, or hospital transfers
- **Improved resident function and quality of life** (mobility, alertness, mood)
- **Safer psychotropic prescribing** with appropriate indications, monitoring, and gradual dose reductions (GDR)

QUESTIONS

MEDICAL DIRECTOR ROLE

Dr. Ziad K. Mirza

SOM REV. 231; ISSUED: (07-09-25)

MEDICAL DIRECTOR F-TAG RESPONSIBILITY CROSSWALK

CMS State Operations Manual – Appendix PP

The key regulatory responsibilities of medical directors in long-term care facilities, based on CMS Appendix PP.

F841
MEDICAL DIRECTOR (§483.70(G))

F841 is the cornerstone of the medical director's role:

1. Ensure care policies are clinically sound and consistently applied
2. Coordination with attending physicians is essential especially when resolving conflicts or ensuring continuity of care

Oversee implementation of resident care policies.

Coordinate medical care across the facility.

Supervise attending physicians and ensure compliance.

F839
LICENSURE (§483.70(E))

- Ensures medical director is legally qualified to practice in the state
- Facilities must maintain documentation of licensure and verify that the medical director meets all professional standards

Ensure medical director holds a valid state license.

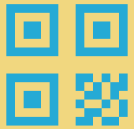
Verify credentials and qualifications.

F867
QAPI PARTICIPATION (§483.75(G)(2)(II))

- Play a vital role in QAPI
- Your clinical expertise helps:
  1. Identify patterns in care delivery
  2. Guide the facility in implementing evidence-based improvements

Active member of the Quality Assurance & Performance Improvement committee.

Review clinical trends and outcomes.



Recommend corrective actions.

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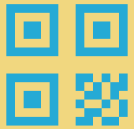


Recommend corrective actions.

F881 INFECTION CONTROL (§483.80(C))

- Role includes:
  1. Guiding infection control practices
  2. Ensuring antibiotic use is justified and monitored
- Helps prevent resistance and protects vulnerable residents

Support Antibiotic Stewardship Program.

Collaborate with Infection Preventionist.

Ensure compliance with CDC guidelines.

F842
MEDICAL RECORDS (§483.70(H))

- Must ensure that clinical documentation is:
  1. Complete
  2. Timely
  3. Secure
- Supports care continuity and legal compliance

Ensure accuracy and confidentiality of medical records.

Support documentation standards.

F656
CARE PLANNING
(§483.21(B)(1))

- Care plans must be:
  1. Individualized
  2. Updated as residents' conditions change
- Input ensures medical interventions align with resident goals and clinical best practices

Oversee development and revision of care plans.

Ensure plans reflect resident needs and medical conditions.

F842
MEDICAL RECORDS (§483.70(H))

- Must ensure clinical documentation is:
  1. Complete
  2. Timely
  3. Secure
- Supports care continuity and legal compliance

Ensure accuracy and confidentiality of medical records.

Support documentation standards.

F580 NOTIFICATION OF CHANGES (§483.10(G)(14))

Must ensure significant changes in a resident's status are promptly communicated to all relevant parties, including families and care teams

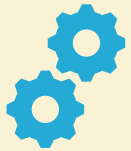
Ensure timely communication of changes in resident condition.

Coordinate with physicians and families.

F553
RESIDENT PARTICIPATION (§483.10(C)(2))

- Residents have right to participate in their care decisions
- Your role includes facilitating informed consent and honoring their choices, even when they differ from clinical recommendations

Support resident involvement in medical decisions.



Respect autonomy and preferences.

F757
PSYCHOTROPIC MEDICATIONS (§483.45(D))

- Psychotropic medications must be used judiciously
- Must document clinical justification and support efforts to reduce or discontinue use when appropriate

Monitor use and ensure justification.

Support gradual dose reduction (GDR) protocols.

BEHAVIORAL HEALTH (§483.40(D))

- Behavioral health is a growing focus in long-term care
- Must ensure that residents receive appropriate:
  1. Assessments
  2. Interventions
- Staff is trained to manage behavioral symptoms

Coordinate with behavioral health professionals.

Ensure appropriate care for residents with mental health needs.


CAR Meeting
GDR
Antibiotic Stewardship
QAPI
Medical Staff Meetings

SUMMARY