The National CONSUMER VOICE for Quality Long-Term Care

SUMMARY

Summary of CMS's Revised Guidance for Nursing Home Surveyors

On November 18, 2024, the Centers for Medicare and Medicaid Services (CMS) released revised guidance for nursing home surveyors. The updates appear in Appendix PP of the State Operations Manual, which state survey agencies are required to follow when surveying and assessing facility compliance with federal regulations. On January 15, 2025, CMS updated the guidance again and revised the effective implementation date. Surveyors will begin using this revised guidance starting March 24, 2025.

The new guidance includes:

- Added revised guidance and training for nursing services and Payroll-Based Journal (PBJ).
- Updated information regarding the prohibition on requiring a third party to guarantee payment for a resident's stay.
- Updated guidance on inappropriate transfers and discharges.
- More detailed guidance on the unnecessary use of psychotropic medications.
- Increased guidance on the misdiagnosis of schizophrenia in residents, particularly to hide the unnecessary use of psychotropic medications.

Below is a detailed summary of the updated guidance. The sections are broken down by "F-Tags," the numbers CMS assigns to violations.

Nursing Services and Payroll Based Journal, 42 C.F.R §483.35 (F725)

New language was added to include the definitions of "licensed nurse", "charge nurse" and "scope of practice". New language was also added to clarify that "facilities are required to provide licensed nursing staff 24 hours a day, along with other nursing personnel, including but not limited to nurse aides. Facilities must also designate a licensed nurse to serve as a charge nurse on each tour of duty".

Examples that may identify potential insufficient staffing were included in the revisions. They are:

- Falls
- Weight loss
- Dehydration
- Pressure ulcers
- Elopement
- Resident altercation

CMS added language requiring the team coordinator for a recertification survey to obtain the PBJ (Payroll Based Journal) staffing data report, as part of their offsite preparation and specifically stated "CMS expects every team member to be aware of the offsite preparation information prior to entering the facility".

Prohibition on a Third-Party Guarantee of Payment, 42 C.F.R §483.15(a)(3) (F620)

A long-term care facility must not request or require a third party to guarantee payment for a resident's stay out of their own funds. A resident's representative with legal access to the resident's funds, however, can be required to pay for facility care using the resident's funds or assets, as authorized by law.

CMS provides examples of language that is prohibited in admission contracts, such as:

- Language that holds both the resident and the representative or other individual jointly responsible for any sums due to the facility. Language that holds only the resident responsible is allowed.
- Language that holds the representative or other third party personally liable for breach of an obligation in the agreement, such as failing to apply for Medicaid in a timely and complete manner or allowing someone other than a signatory to the agreement to spend the resident's resources that would be used to pay the nursing home.
- Language that does not specifically mention a third-party guarantee but implies the resident could be discharged if the representative does not voluntarily agree to personally pay to prevent the discharge.
- Language that holds the representative or other individual personally liable for any amounts not paid to the facility in a timely manner because the representative or other individual did not provide accurate financial information or notify the facility of changes in the resident's financial information.

Current regulations allow facilities to seek financial information from the resident's representative with legal access to the resident's funds. However, CMS adds, "*If an individual does not actually have legal access to the resident's funds, the facility may not request or require the individual to pay the facility.*"

Transfer and Discharge, 42 C.F.R. §483.15(c) (F627, F628)

F622, F623, F624, and F625 have been relocated to either F627 or F628.

As part of this revision and reorganization of F-Tags in this section, CMS has removed the terms "facility-initiated" and "resident-initiated" when referring to discharges.

To strengthen existing regulations that protect residents from inappropriate discharges, language was added to ensure facilities develop and implement policies that allow residents to return to the facility following hospitalization and/or therapeutic leave. The

guidance also seeks to ensure that facilities do not transfer or discharge a resident in an unsafe manner and clarifies that "unsafe manner" is a location that does not meet the resident's needs, does not provide needed support, or does not meet the resident's preferences.

Guidance now emphasizes the importance of off-site preparation when surveyors are investigating noncompliance with transfer and discharge regulations.

Specifically, surveyors should:

- Contact the local ombudsman regarding complaints received related to inappropriate discharges.
- Review the history of complaints and survey history for indications of noncompliance.

CMS added guidance where noncompliance may exist:

- When evidence in the medical record does not support the basis for discharge.
- When evidence in the medical record shows a resident was not permitted to return following hospitalization or therapeutic leave.
- There is no evidence that the facility considered whether the resident's caregiver had the availability, capacity, and/or capability to perform needed care following the discharge.
- The post-discharge plan of care did not address a resident's limitations in their ability to care for themself.

New guidance titled *Successful Appeals on Discharges* states that a state survey agency **cannot** cite noncompliance exclusively based on a favorable ruling from an appeal hearing. Instead, the state survey agency must triage the complaint and conduct a survey in accordance with the timelines specified in Section 5079.9 of Chapter 5 of the State Operations Manual.

Finally, CMS states that, for citations at any level of scope and severity, if the discharged resident's health and/or safety is threatened in the setting where they are currently located, the facility's plan of correction should state that the facility will either re-admit the resident until a safe and compliant discharge can be done or coordinate the transfer of the resident to another setting where they will be safe. For situations where the resident's discharge location did not meet their health and/or safety needs, enforcement should be implemented immediately.

The Guidance reiterates the language at 483.15(c)(3) that requires facilities to send a copy of notices of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman Program.

Chemical Restraints/Unnecessary Psychotropic Medication, 42 C.F.R. §483.10(e), §483.12 (F605)

The practice of using psychotropic medications to sedate residents rather than providing person-centered hands-on interventions, referred to as chemical restraints, is often used

by understaffed facilities that lack the workers to provide hands-on care. For years CMS has sought to reduce the use of chemical restraints in nursing homes. An effort that began in 2011 to reduce inappropriate use of antipsychotic medications in nursing homes was found to have resulted in a corresponding increase in the use of other types of psychotropic medications to sedate residents. Further evidence suggests that the decline in antipsychotic drug use was likely attributable to the exclusion of individuals diagnosed with schizophrenia from the residents counted. As a result of this exclusion, there was a steady increase in schizophrenia diagnoses.

CMS added significant language to these sections to better define psychotropic and unnecessary drugs as well as provide specific language aimed at reducing medication errors.

Chemical Restraints: Convenience and Discipline

CMS reaffirms the rights of residents to be free from restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Guidance was added to address situations in which psychotropic medications are used to create convenience for staff, i.e., a chemical restraint. CMS provides examples of the effects on residents when psychotropic medications are used for staff convenience or discipline, such as sedation, withdrawal from activities, loss of autonomy and dignity, confusion, weight loss, and decline in physical functioning. The guidance defines key terms such as "convenience" and "discipline."

Comprehensive Assessment and Behavioral (Nonpharmacological) Interventions

CMS makes clear that any changes in medications (including initiating and discontinuing medications) must be informed by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms. The resident's medical record should include documentation of this evaluation and the rationale for the chosen treatment.

Further, to reduce chemical restraints, language has been added stating the facility must ensure that the resident's distress, which prompted the initiation or change in psychotropic medication, is not due to a safety concern, a medical condition or problem, environmental stressors, and/or psychological stressors alone.

CMS provides examples of the circumstances that warrant an evaluation of a resident's underlying medical condition such as admission/re-admission, a new or worsening change in condition, an irregularity identified in the pharmacist medication regimen review or a new medication order as an emergency measure.

Determining the Necessity to use Psychotropic Medications

While psychotropic medications should not be used unless necessary to treat a specific condition as diagnosed and documented in the resident's clinical record, a diagnosis alone does not warrant the use of psychotropic medications. The guidance emphasizes that there must be documentation that the facility attempted behavioral (nonpharmacological) interventions and that interventions were deemed inappropriate or unsafe for the resident. **Without evidence that nonpharmacological interventions have been ruled out, the use of psychotropic medication should be cited as noncompliance**.

Examples in which psychotropic medications may be indicated include when behavioral symptoms present a danger to the resident or others or when gradual dose reduction was attempted, but clinical symptoms returned.

CMS acknowledges that there are nursing home residents being improperly diagnosed with schizophrenia, which should be cited as noncompliance. If the noncompliance causes actual harm or the likelihood of serious harm to one or more residents, or the surveyor identifies a pattern of misdiagnosis (identified as impacting three or more residents), the survey team should discuss their findings with their state survey agency for consideration to refer the individual to the State Medical Board or Board of Nursing.

Resident's Right to be Informed (Informed Consent)

Residents have the right to be informed of and participate in their treatment. Before initiating or increasing psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives to the medication. The resident's medical record must include documentation supporting that the resident was provided with this information in advance of initiation or increase of a psychotropic medication and was able to choose the option they preferred. A written consent form may serve as evidence of a resident's consent to psychotropic medication, but other types of documentation are also acceptable. Importantly, the resident has the right to accept or decline the initiation or increase of psychotropic medication.

Dose and Duration

CMS highlights that the clinical rationale for continued use of a medication should be documented in the medical record, and provides examples of inappropriate duration such as:

- The initiation of a psychotropic medication was indicated but was not used for the lowest dose and least amount of time.
- The medication was initiated because of a time-limited condition, however there was no documentation showing that the original condition had been monitored or evaluated.
- A medication was administered beyond the stop date established by the prescriber, without evidence of clinical indication for continued use of the medication.

Gradual Dose Reduction

CMS added clarification that the time frames and duration of attempts to taper any medication must be consistent with accepted standards of practice and will depend on several factors, including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of medications. The medical record should reflect the date of the gradual dose reduction (GDR) attempt, the outcome of the dose reduction attempt, and the plan for future GDR attempts.

Monitoring and Adverse Consequences

In the case of multiple medication prescribers, the continuation of a medication needs to be evaluated to determine if the medication is still warranted. Medications prescribed by a specialist or begun in another care setting must be documented in the resident's medical

record. Surveyors are instructed to review the medical record to determine whether the prescribing practitioner provided a rationale. Without rationale, the use of the medication may be unnecessary and, as a result, non-compliant.

Comprehensive Care Plans, 42 C.F.R. §483.21(b)(3) (F658)

Mental Health Disorders/Schizophrenia Diagnoses

Guidance was added under F658 requiring the use of evidence-based criteria and professional standards when diagnosing mental health disorders. Medical professionals must utilize the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Further guidance was added as to what information should be included in the supporting documentation when a diagnosis is made.

CMS defines "insufficient documentation" of a mental health condition as the resident's mental health record is missing:

- Documentation (e.g., nurses' notes) indicating the resident has had symptoms, disturbances, or behaviors consistent with those listed in the DSM criteria, **and** for the period of time in accordance with the DSM criteria.
- Documentation from the diagnosing practitioner indicating that the diagnosis was given based on a comprehensive assessment, such as notes from a practitioner's visit.
- Documentation from the diagnosing practitioner indicating that the symptoms, disturbances, or behaviors are not attributable to (i.e., ruled out) the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., UTI or high ammonia levels).
- Documentation regarding the effect the disturbance is having on the resident's function, such as interpersonal relationships or self-care, in comparison to their level of function before the onset of the disturbance.

The medical record must include documentation of **ALL** of these items. If not, it constitutes insufficient documentation.

CMS also provides numerous examples of insufficient documentation, such as situations in which schizophrenia or another diagnosis is mentioned in the practitioner's note but does not include supporting documentation.

Further, schizophrenia, schizophreniform, and schizoaffective disorder are defined. It specifies what a surveyor should do if they identify a pattern (e.g., three or more) of residents who have a new diagnosis which lacks sufficient supporting documentation, and how it should be cited. The guidance directs the surveyor to discuss the findings with their supervisor to consider referrals to a state medical board as needed.

Accuracy of Assessments/Coordination/Certification, 42 C.F.R. §483.20(g) (F641)

The guidance provides instructions to surveyors when investigating whether the Minimum Data Set (MDS) contains sufficient documentation to support a resident receiving an antipsychotic medication and provides clarification regarding the use of electronic signatures on MDS forms.

The regulatory references and guidance located in F642 relating to coordination and certification of assessment were relocated to F641.

Language has been added that directs the surveyor to make a referral to the Office of the Inspector General if a pattern (three or more residents) of inaccurate MDS coding by staff has been identified.

QAPI/QAA, 42 C.F.R. §483.75(g) (F867)

Language was added regarding health equity concerns when obtaining feedback, collecting and monitoring data related to outcomes of subpopulations, and analyzing factors known to affect health equity. In addition, CMS has added a definition of the term "health equity." Language was added that facilities should consider factors that affect health equity and outcomes of their resident populations when establishing priorities in their QAPI program.

Pain Management, 42 C.F.R. §483.25(k) (F697)

Revisions to the guidance for acute, chronic, and subacute pain were made to align with CDC definitions. It was clarified that clinicians may consider prescribing immediate-release opioids instead of extended-release or long-acting options and emphasized the need for individualized opioid treatment plans. Resource links on opioid use were updated and expanded.

Infection Prevention & Control, 42 C.F.R. §483.80 (F880)

Guidance relating to infection control regarding Enhanced Barrier Precautions (EBP) in Nursing Homes to Prevent the Spread of Multidrug-resistant Organisms (MDROs) released in CMS Memo QSO-24-08-NH on March 20, 2024, was incorporated into Appendix PP along with new deficiency examples.

COVID-19 Immunization, 42 C.F.R. §483.80(d)(3) (F887)

Guidance related to requirements for facilities to educate residents or resident representatives and staff regarding the benefits and potential side effects associated with the COVID-19 vaccine and offer the vaccine released in QSO-21-19-NH on May 11, 2021 was incorporated into Appendix PP.

The CMS Guidance to Surveyors is an important tool for surveyors when inspecting nursing facilities for compliance with the regulations. It provides a blueprint for long-term care providers on meeting standards and is an important resource for nursing facility residents, their families and representatives, and advocates in their efforts to achieve quality care and quality of life and protect residents' rights.

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