Federal Regulation Update Effective April 28, 2025

Affinity Health Services

Affinity HEALTH SERVICES

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Background

18 Nov. 2024

the Centers for Medicare and Medicaid Services (CMS) released a memo titled "Long-Term Care (LTC) Surveyor Guidance Process: Significant Updates Aim to Enhance the Quality and Oversight of LTC Surveys.“

15 Jan. 2025

CMS released QSO-25-12-NH Revised Long-Term Care (LTC) Surveyor Guidance: Significant revisions to enhance quality and oversight of the LTC survey process

April 28, 2025

Surveyors will begin using this guidance to determine compliance with requirements on surveys beginning April 28, 2025.

Key Updates- Impact on the below Regulation

Nursing Services	Payroll Based Journal	Admission, Transfer, and Discharge	Chemical Restraints/Unnecessary Psychotropic Medication	Professional Standards and Medical Director
Minimum Data Set (MDS) Accuracy, Coordination, and Certification	Comprehensive Assessment After Significant Change	QAPI/QAA Improvement Activities	Cardio-Pulmonary Resuscitation (CPR)	Pain Management
	Physical Environment	Infection Prevention and Control	COVID-19 Immunization	

Nursing Services- payroll Based Journal (PBJ)

Sufficient Nursing Staff, RN 8 Hrs./7days/Wk., Full Time DON, & Payroll Based Journal

Guidance for investigations using the Payroll Based Journal Staffing Data Report has been added.

This report will be used as one of the sources of information indicative of potential noncompliance.

Instructions specific to staff interviews, observations, key elements of noncompliance, and deficiency categorization are also added to the guidance. Instructions to surveyors based on whether or not the report identified concerns were added to the guidance.

Investigative probes for the Director of Nursing requirements and deficiency categorization examples, as well as investigative procedures for evaluating compliance with the submission of direct care staffing information and payroll using the Payroll Based Journal Staffing Data Report were added to the guidance.

F725- Nursing Services

- The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

New Guidance

The facility is required to provide licensed nursing staff 24-hours a day, along with other nursing personnel, including but not limited to nurse aides. The facility must also designate a licensed nurse to serve as a charge nurse on each tour of duty.

Concerns such as falls, weight loss, dehydration, pressure ulcers, elopement and resident altercations can also offer insight into potential insufficient numbers of staff available in the facility.

Surveyors must discuss these concerns during team meetings and investigate how or if these adverse outcomes are related to sufficient staffing

New Guidance (cont.)

Compliance with State staffing standards does not necessarily determine compliance with Federal staffing standards that require a sufficient number of staff to meet all of the residents' basic and individualized care needs. If a facility does not meet state regulations for staffing, do NOT cite that as a deficiency here, but refer to Administration, F836, §483.70(b).

Cite this F-Tag only if there is non-compliance related to a facility not providing services by sufficient number of nursing personnel (licensed and non-licensed), not providing licensed nursing staff 24-hours a day, and/or does not have a licensed charge nurse on each tour of duty.

NOTE: *The actual or potential physical, mental, or psychosocial resident outcomes related to noncompliance cited at F725 should be investigated at the relevant tags, such as Abuse at §483.12, Quality of Life at §483.24, and/or Quality of Care at §483.25.* 2

Investigative Procedure

Use the Sufficient and Competent Nurse Staffing Critical Element Pathway, along with the interpretive guidance, and the procedures when determining if the facility meets the requirements for, or investigating concerns related to sufficient staffing.

The facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system (Refer to F851, §483.70(p)). When completing the offsite preparation for a recertification survey, the team coordinator must obtain the PBJ Staffing Data Report and evaluate PBJ data submitted by the facility.

This data is available through PBJ reports that can be obtained through CMS' survey system. This report, titled PBJ Staffing Data Report, must be utilized by surveyors on at least every recertification survey. The report contains information about overall direct care staffing levels as well as licensed nurse staffing.

PBJ Data Report Identifies if the Facility:

Reported no RN hours (F727)

Failed to have Licensed Nursing Coverage 24-hours/day (F725)

Reported excessively low weekend staffing (F725)

Has a one-star Staffing Rating (F725)

Failed to submit PBJ data for the quarter (F851)

Critical Element Pathway (Advanced Copy)

Offsite Prep- Review of PBJ Data

Observations

- Including posting daily staffing

Interviews

- Residents/Representative
- Front line Nursing Staff
- Kitchen Dietary Dining Staff
- DON or Staff Development

Outcome

Did the facility submit the required staffing information based on payroll data? No F851, cite scope and severity at “F”

Does the facility have an RN to serve as the DON on a full-time basis? No F727, cite scope and severity at a minimum of “F” N/A, the facility has a waiver for the DON requirements.

Does the facility ensure licensed nurse coverage 24-hours a day? No F725, cite scope at a minimum of “F” . N/A, if the facility has a waiver for LN coverage 24-hours per day.

Does the facility have an RN at least 8 consecutive hours a day for 7 days a week? No F727, cite scope at a minimum of “F”. N/A, if the facility has a waiver for the daily RN hours requirement.

Outcome (cont.)

Does the facility have sufficient nursing staff on a 24-hour basis to care for each resident's needs in accordance with their care plans? No F725

Does the facility's nursing staff have the knowledge, competencies and skills required to provide care and respond to each resident's needs? No F726

Does the facility have an RN at least 8 consecutive hours a day for 7 days a week? No F727, cite scope at a minimum of "F" N/A, if the facility has a waiver for the daily RN hours requirement.

Outcome (cont.)

Is Nursing staffing posted daily and include facility name, date, census, and the total number and actual hours worked per shift for licensed, and unlicensed staff responsible for resident care? No F732

Did the facility evaluate residents needs an acuity in their facility assessment to determine the number of qualified staff needed to meet each resident needs? No F838

Does the facility ensure licensed nurse coverage 24-hours a day? No F725

Did the facility ensure the DON serves as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents? No F727, cite scope at a minimum of “F”

Outcome (cont.)

Does the facility ensure full-time nurse aides complete a state-approved training and/or competency evaluation program within 4 months of starting work in the facility? No F728.

If a NA has not performed nursing or nursing-related services for monetary purposes in a continuous period of 24 months, did they complete a new training and/or competency evaluation program? No

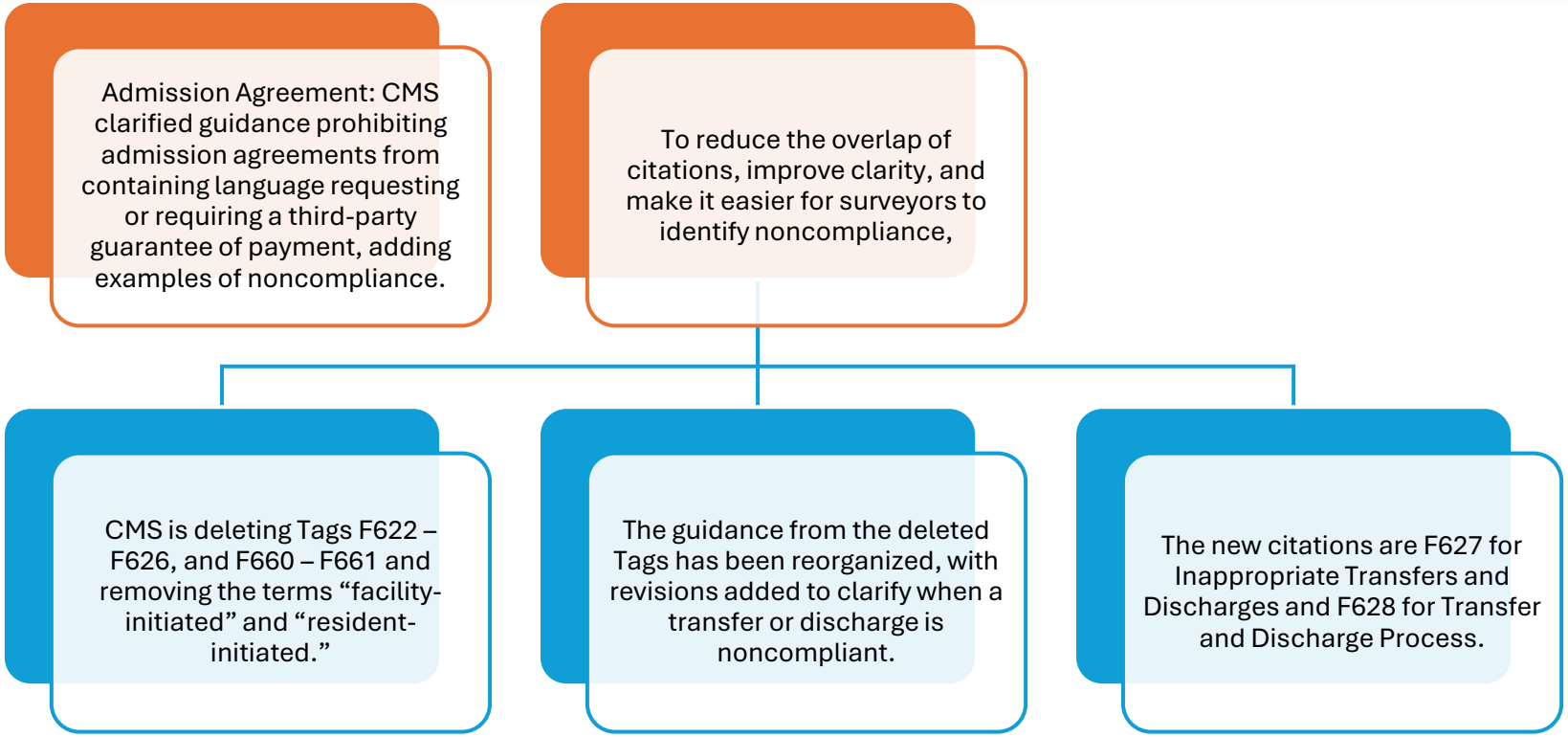
Does the facility complete a performance review of nurse aides at least once every 12 months, and provide regular in-service education based on the outcome of the review? No F730

Does the facility provide nurse aide in-services, at least 12 hours in a year, sufficient to ensure continuing competence, including dementia management, abuse prevention, areas of weakness as determined in the NAs performance reviews, facility assessment, special needs of residents determined by facility staff, and care of the cognitively impaired resident for those nursing aides providing care for individuals with cognitive impairments? No F947

To Do’s

PBJ	• Who assigns the roles • Who reviews • Who submits
Staffing	• Who monitors • Who Posts daily
Facility Assessment	• Resident acuity

Admission, Transfer and Discharge:



Admission, Transfer, and Discharge

F622–F626 and F660–F661 have been deleted

New F-tags

- F627
- F628

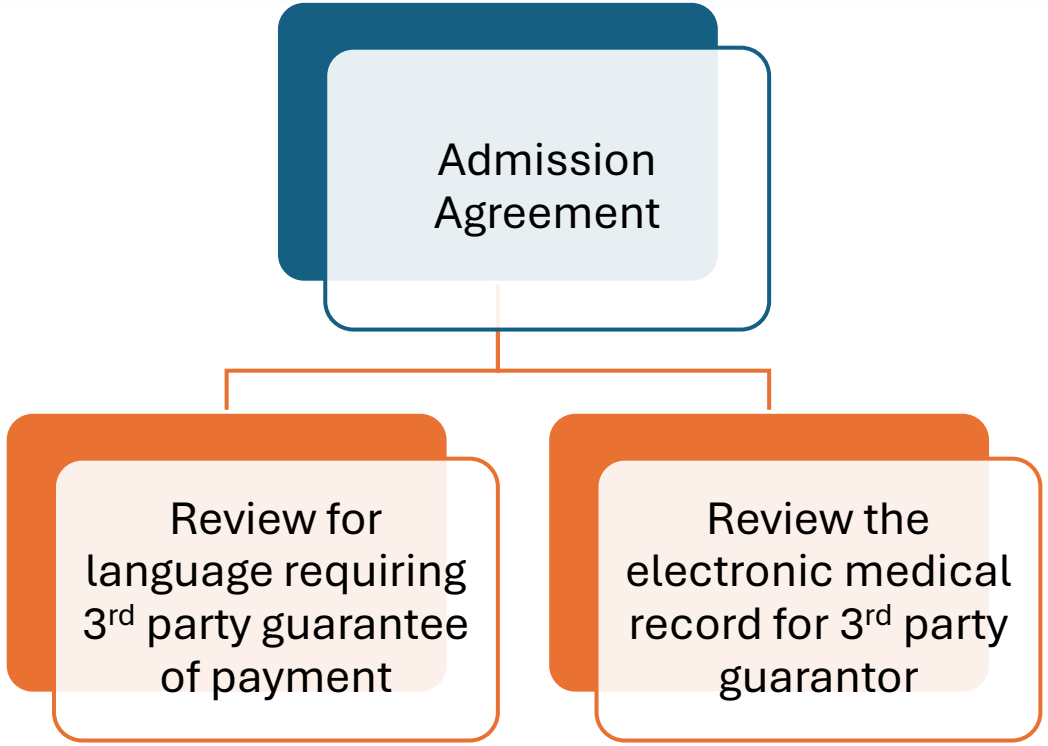
F620 Admission Agreement

Any language contained in an agreement that seeks to hold a third party personally responsible for paying the facility would violate this requirement

New Guidance prohibiting admission agreement language requiring a 3rd party to guarantee payment.

Language that specifically requests a third party to personally guarantee payment to a facility is noncompliant. Also, language can be noncompliant even if it does not specifically reference a “guarantee” by a third party.

To Do’s


Admission Agreement
Review for language requiring 3rd party guarantee of payment
Review the electronic medical record for 3rd party guarantor

F-627: Transfer and Discharge

Change noted under

Intent

Guidance

Required Documentation in the Resident's Medical Record

Investigation Protocol

Summary of Investigative procedure

Deficiency Category

F 627 Transfer and Discharge

Removal of “facility-Initiated” and “Resident Initiated”

Regardless of who initiated the facility ,must ensure the discharge is safe.

Offsite Prep includes surveyor contacting the local Ombudsman to see if there have been concerns related to the discharge process.

Intent

These regulations and guidance address inappropriate discharges and:

Ensure policies are developed and implemented which allow residents to return to the facility following hospitalization or therapeutic leave.

Ensure a facility does not transfer or discharge a resident in an unsafe manner, such as a location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident's preferences and, therefore, should not have occurred.

Ensure the discharge planning process addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

Discharges

Reasons for Discharge The five reasons discharges are allowed did not change with the updated guidance changes. They continue to be:

1. Discharge based on an inability to meet the resident's needs, but there is no evidence of facility attempts to meet the resident's needs, or no evidence of an assessment at the time of discharge indicating what needs cannot be met;

2. Discharge based on improvement of resident's health such that the services provided by the facility are no longer needed, but documentation shows the resident's health did not improve or actually declined;

3. Discharge based on the endangerment of the safety or health of individuals in the facility, but there is no documentation in the resident's medical record that supports this discharge;

4. Discharge based on failure to pay, however, there is no evidence that the facility offered the resident to pay privately or apply for Medical Assistance or that the resident refused to pay or have paid under Medicare or Medicaid;

5. Discharge occurs even though the resident appealed the discharge, the appeal is pending, and there is no documentation to support the failure to discharge would endanger the health and safety of individuals in the facility. Note: Facilities must determine if residents are appropriately oriented, prepared, and understand the discharge information provided to him or her.

Discharges

Reason for Discharge	Documentation Required
Discharge based on an inability to meet the resident's needs.	Documented attempts to meet the resident's specific needs and an assessment at the time of discharge indicating what needs cannot be met.
Discharge based on improvement of resident's health such that the services provided by the facility are no longer needed.	Documentation to show the resident's health has improved.
Discharge based on the endangerment of the safety or health of individuals in the facility.	Documented instances of examples of behaviors that have the protentional to endanger the safety or health of individuals in the facility.
Discharge based on the failure to pay.	Documentation that the facility offered the resident to pay privately or apply for Medical Assistance, or documentation that the resident refused to pay or have their stay paid for by Medicare or Medicaid.

Physician Documentation

Note: Where the discharge or transfer is necessary for the resident’s welfare and the facility cannot meet the resident’s needs or the resident's health has improved sufficiently so that the resident no longer needs the care of the facility, the resident’s physician must document information about the basis for the transfer and discharge.

483.15(C)(2) REQUIRED DOCUMENTATION *IN THE RESIDENT'S MEDICAL RECORD*

For circumstances *where the discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs or the resident's health has improved sufficiently so that the resident no longer needs the care of the facility,* the **resident's physician** must document information about the basis for the transfer or discharge.

Additionally, *if the facility determines it cannot* meet the resident's needs, the documentation made by the **resident's physician must** include:

The specific resident needs the facility could not meet

The facility efforts to meet those needs

The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

DEFICIENCY CATEGORIZATION

Additionally, for situations in which residents' discharge locations did not meet their health and/or safety needs, enforcement should be implemented immediately.

For example, a discretionary denial of payment for new admissions should be imposed to go into effect within 2 or 15 days (as appropriate), and remain in effect until a return to substantial compliance as evidenced by either:

- *the resident is readmitted and not discharged unless a safe and compliant discharge is done, or*
- *the facility coordinates a discharge to another setting where their needs will be met*

Medicaid

For discharges due to non-payment, ensure all Medicaid-eligible residents are provided oral and written information on how to apply for Medicaid.

Discharge Critical Element Pathway (Advanced Copy)

Off Site Prep	Record Review	Interview
• Contact Ombudsman • Review Complaints and Survey history	• MDS/CAA • Progress Notes • Care plan	• Resident/ Representative • Staff

Critical Elements Decisions

Does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., discharge is necessary for the resident's welfare, and the resident's needs could not be met in the facility; the resident no longer requires services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates).

Does evidence in the medical record support the basis for this resident's discharge, such as the attempts made to meet the resident's needs, or documentation from the resident's physician for the basis for the transfer or discharge?

If No Cite F627

Critical Elements Decisions

Was required discharge information per 483.15(c)(2)(i)-(ii), documented in the resident's record? If No, cite F627

For a transfer or discharge, was the appropriate information communicated to the receiving provider per 483.15(c)(2)(iii)? If No, cite F628

After a resident's hospitalization or therapeutic leave, did a facility permit the resident to return? If No, was a there a valid basis for the discharge according to 483.15(c)(1)? Note: If the reason the resident was not permitted to return was because the facility could not meet the resident's needs, refer to CE #1. If no, cite F627

Critical Elements Decisions

Did the facility discharge a resident while an appeal of the discharge was pending? If yes, cite F627

For a discharge, did the facility:

- Involve the IDT, resident and/or resident representative in developing and updating a discharge plan that reflects the resident's post-discharge needs, goals, and treatment preferences while considering caregiver support;
- Document that the resident was asked about their interest in receiving information about returning to the community and referrals made if the resident was interested in returning to the community;
- Assist the resident and/or resident representatives in selecting a post-acute care provider by using relevant data, if the resident went to another SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital)?

If No to any of these items, cite F627

Critical Elements Decisions

Did the facility

- Provide a discharge summary to the resident which includes a recapitulation of the residents stay, a final summary of the residents tatus, reconciliation of all pre- and post- discharge medications, and a discharge plan of care
- Convey the discharge summary to the continuing care provider or receiving facility at the time of discharge

If No, Cite F628

Critical Elements Decisions

Were the resident, resident representative, and ombudsman notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge, or as soon as practicable if the discharge meets one of the exceptions at 483.15(c)(4)(ii)? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)? If No, cite F628

For a discharge due to non-payment, did the facility provide the Medicaid-eligible resident with oral and written information on how to apply for and use Medicaid benefits? If no, cite F579. N/A if the resident was not Medicaid-eligible or the discharge was not related to non-payment

To do’s

Educate staff on the changes to the regulation

Ensure Discharges home have appropriate follow up care in place

Review Policy on discharge for return to facility language

Review AMA policy. Ensure language in place for safe discharge.

F-605:Respect and Dignity
Chemical Restraints/Unnecessary Psychotropic Medication

F758 has been removed, with its associated regulations and guidance incorporated into F605

483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

- ***(i)Anti-psychotic;***
- ***(ii)Anti-depressant;***
- ***(iii)Anti-anxiety; and***
- ***(iv)Hypnotic***

Chemical Restraints/Unnecessary Psychotropic Medication:

The regulations and guidance for the unnecessary use of psychotropics (F758) have been incorporated into F605.

This change will help to streamline the survey process, increase consistency, and strengthen our message that facilities must prevent the unnecessary use of psychotropic medications.

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.

Additional guidance has been added to emphasize requirements related to the right to be fully informed of and participate in or refuse treatment, noting that before initiating or increasing a psychotropic medication, the resident must be notified of and have the right to participate in their treatment, including the right to accept or decline the medication.

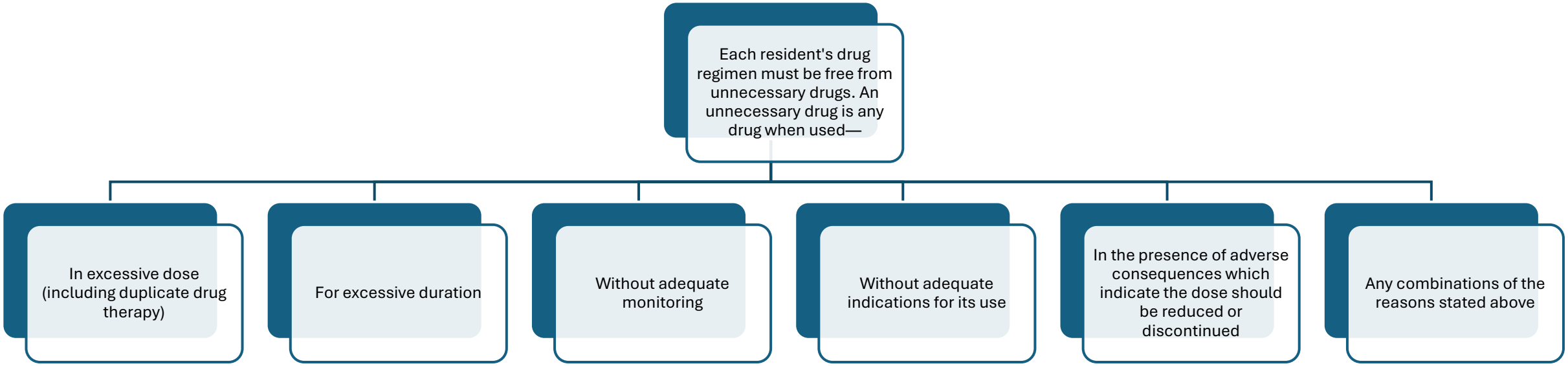
Unnecessary Medications (F757) has been revised to only include guidance for non-psychotropic medications. The revised Unnecessary Medications, Chemical Restraints/Psychotropic Medications, and Medication Regimen Review Critical Element Pathway also includes investigative elements to align with the revised guidance.

Definition of Convenience (new)

Convenience refers to the unnecessary administration of a medication that causes (intentionally or unintentionally) a change in a resident's behavior (e.g., sedation) such that the resident is subdued and/or requires less effort from staff.

Therefore, if a medication causes symptoms consistent with sedation (e.g., excessive sleeping, drowsiness, withdrawal, decreased activity), it may take less effort to meet a resident's behavioral needs, which meets the definition of convenience.

Unnecessary Drugs



F605 Freedom From Chemical Restraint and Unnecessary Psychotropic Medication Intent

The intent of these requirements is to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.

Also, residents must only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated.

Additionally, medication should only be used to treat resident's medical symptoms and not used for discipline or staff convenience, which would be deemed a chemical restraint.

F-605:Respect and Dignity
Chemical Restraints/Unnecessary Psychotropic Medication

483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

F-605:Respect and Dignity
Chemical Restraints/Unnecessary Psychotropic Medication

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

Resident's Right to be Informed

In accordance with the requirements at §483.10(c), residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.

The resident has the right to accept or decline the initiation or increase of a psychotropic medication.

To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she 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.

If a psychotropic medication has been initiated or increased, and there is not documentation demonstrating compliance with the resident's right to be informed and participate in their treatment, noncompliance with §483.10(c) exists and F552 must be cited.

Critical Element Pathway (Advanced Copy)

Review Comprehensive assessment and Care plan

Observation of the resident

Record Review

Interviews

- Resident/ Representative
- Nurse aide, Nurses, DON, Social Services
- Attending Physician
- Medical Director
- Pharmacist

Critical Element Decisions

For **Unnecessary Medications**: Did the facility ensure each resident's medication regimen was free from unnecessary medications?

If No, cite F757.

If No and the unnecessary medication is a psychotropic medication, cite F605.

Critical Element Decisions

Psychotropic Medications, did the facility ensure that:

- the medication is necessary to treat a specific, diagnosed, and documented condition which includes symptoms which may be causing distress to the resident or others
- the medication is not sedating the resident, but rather is treating the resident's medical symptoms;
- alternative treatments, such as behavioral (nonpharmacological) interventions, were attempted and that these interventions have been deemed clinically contraindicated;
- a GDR was attempted and non-pharmacological approaches to care were implemented, unless clinically contraindicated;
- PRN use is only if necessary to treat a specific, diagnosed, and documented condition;
- PRN orders for psychotropic medications which are not for antipsychotic medications are limited to 14 days, unless the attending physician/prescribing practitioner documents a rationale to extend the medication;
- PRN orders which are for antipsychotic medications are limited to 14 days, without exception and the attending physician/prescribing practitioner did not renew the order without first evaluating the resident?

If No to any of the above, cite F605.

Critical Element Decisions

For the **Medication Regiment Review** (MRR)

Did the licensed pharmacist

- Conduct an MRR, at least monthly, that included a review of the resident's medical record
- Conduct a MRR more frequently, as needed
- Report irregularities to the attending physician, medical director and the DON

Did the attending physician document

- Review of identified irregularities
- The action, if any
- A rationale if no action is taken

Critical Element Decisions (MRR cont.)

Has the facility developed and implemented MRR policies and procedures?

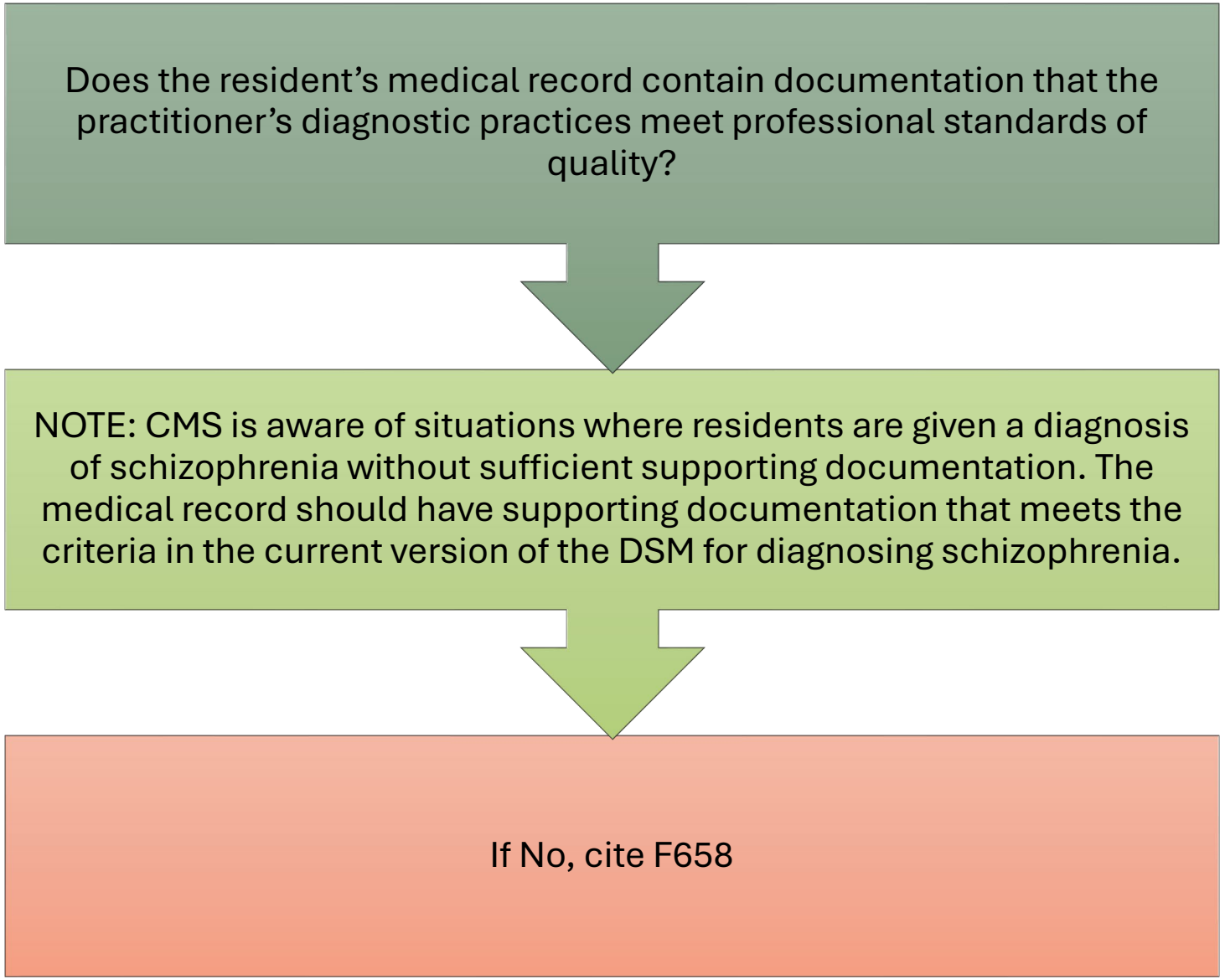
- Do they address, at a minimum:
  - Time frames for steps in the MRR process
  - Steps the pharmacist must take when an irregularity requires urgent action.
- If No to any of the above, cite F756.

Critical Element Decisions

For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand? If No, cite F655.

If the condition or risks related to medications were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible and the impact upon the residents' function, mood, and cognitions? If No, cite F636

Critical Element Decisions



To Do’s

1

Review residents receiving psychoactive medication. Ensure consent is in place.

2

Review process and policy for the initiation and increase in psychoactive medications

3

Ensure policy includes new admissions

4

Educate physicians on diagnosis criteria and required consent

F 658 Professional Standards and F841 Medical Director:

Instructions for investigating adherence to professional standards of practice when concerns arise regarding residents diagnosed with a condition without sufficient supporting documentation for which antipsychotic medications are an approved indication were added to the guidance at Professional Standards (F658). Guidance for citing noncompliance and examples were also included.

Clarification regarding the Medical Director's responsibilities related to the implementation of resident care policies was added to the guidance at F841. Specifically, ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and issues related to the coordination of medical care and implementation of resident care policies identified through the facility's quality assessment and assurance committee and other activities were incorporated into the guidance. Interviewing the facility Medical Director was also incorporated into the Unnecessary Medications and Quality Assurance & Performance Improvement (QAPI) pathways.

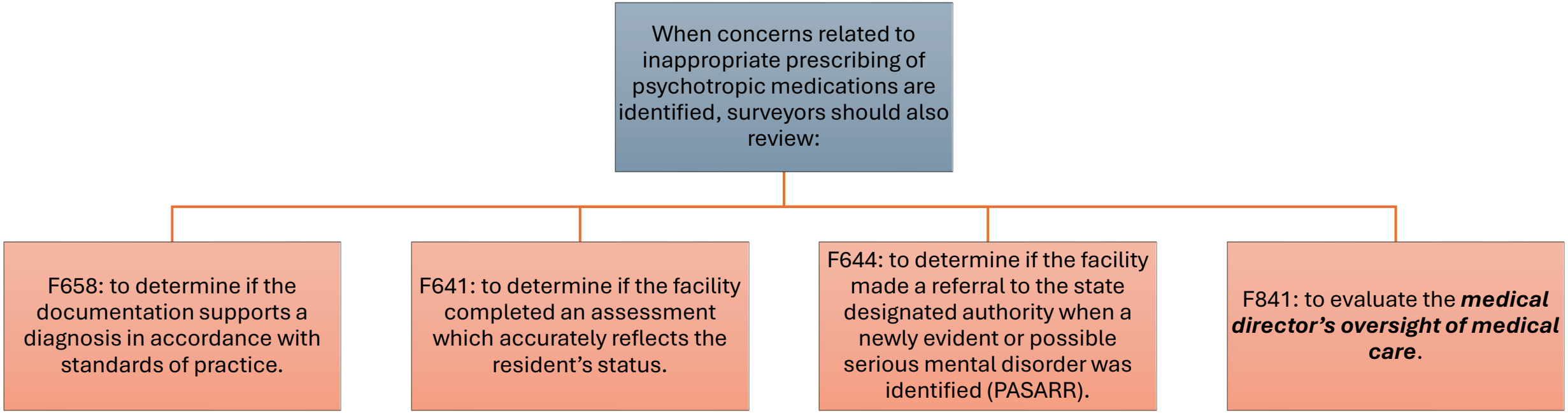
Professional Standards and Medical Director

Focus of standards related to prescribing antipsychotic medications related to appropriate indication for use

Mental disorder diagnosis using evidence-based criteria and professional standards, such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and documented in the resident's medical record.

CMS directed surveyors to cite IJ's in the absence of the appropriate documentation related to the use of antipsychotic medication use without appropriate indications.

F 841Medical Director



F841 Medical Director

Medical director responsibilities must include:

- Implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care.
- Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her. (Refer to F868).
- Addressing issues related to the coordination of medical care and implementation of resident care policies identified through the facility's quality assessment and assurance committee and other activities.
- Active involvement in the process of conducting the facility assessment (Refer toF838).

F841 Medical Director (New Guidance)

Discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care, for

Example: physicians assigning new psychiatric diagnoses and/or prescribing psychotropic medications without following professional standards of practice

To Do’s

EDUCATE THE PHYSICIANS AND MEDICAL DIRECTOR ON THE DOCUMENTATION REQUIREMENTS FOR PSYCHOTROPIC MEDICATIONS

EDUCATE THE MEDICAL DIRECTOR OF THE EXPECTATION TO INTERVEIN WITH ORDER/ DIAGNOSING DOES NOT MEET PROFESSIONAL STANDARDS OF CARE.

EDUCATE THE MEDICAL DIRECTOR ON EXPECTATION FOR INVOLVEMENT IN POLICY AND PROCEDURE DEVELOPMENT

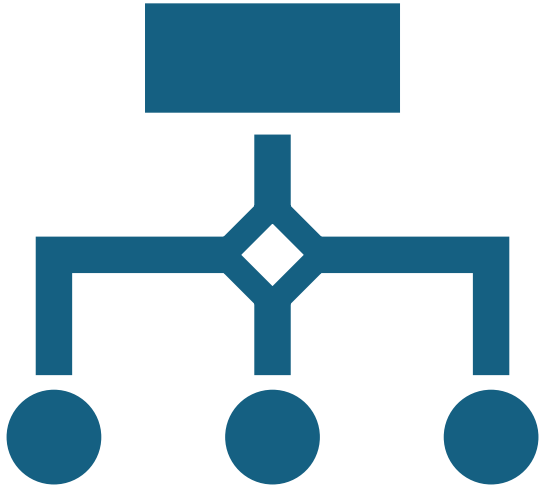
Accuracy/Coordination/Certification

Instructions for investigating Minimum Data Set (MDS) assessment accuracy and determining whether noncompliance exists when a concern related to insufficient documentation to support a medical condition is identified for a resident receiving an antipsychotic medication were added to the guidance in Accuracy of Assessment (F641).

The regulatory references and guidance under Coordination/Certification of Assessment (F642) are being relocated to Accuracy of Assessment (F641), and tag F642 has been deleted

F-642 Coordination / Certification of Assessment

Regulatory requirements §483.20(h)-(j) have been relocated to F641.



F-641 Accuracy of Assessment
The assessment must accurately reflect the resident's status.

One or two assessments with inaccurate MDS diagnosis coding should be cited as isolated.

If the surveyor identifies a pattern (i.e., three or more) of inaccurate coding for any new diagnosis (such as schizophrenia) with no supporting documentation by a physician, the surveyor should cite the scope of the non-compliance at a minimum of pattern or widespread as appropriate, make a referral to the State Board of Nursing, and see the guidance below in Investigative Procedures for making a referral to the Office of the Inspector General.

Comprehensive Assessment after Significant Change: F637

Revisions were made to update the language to reflect the levels of assistance a resident receives for self-care and mobility activities to align with Section GG of the MDS.

- Examples of Decline include, but are not limited to:
- Resident's decision-making ability has changed;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E Behavior;
- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since last assessment;
- Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as *partial/moderate assist, substantial/maximal assistance, dependent, resident refused, or not attempted* since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days).
- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type, when it was not used before;
- Emergence of a condition/disease in which a resident is judged to be unstable.

F637: Comprehensive assessment After Sig Change

Examples of Improvement include, but are not limited to:

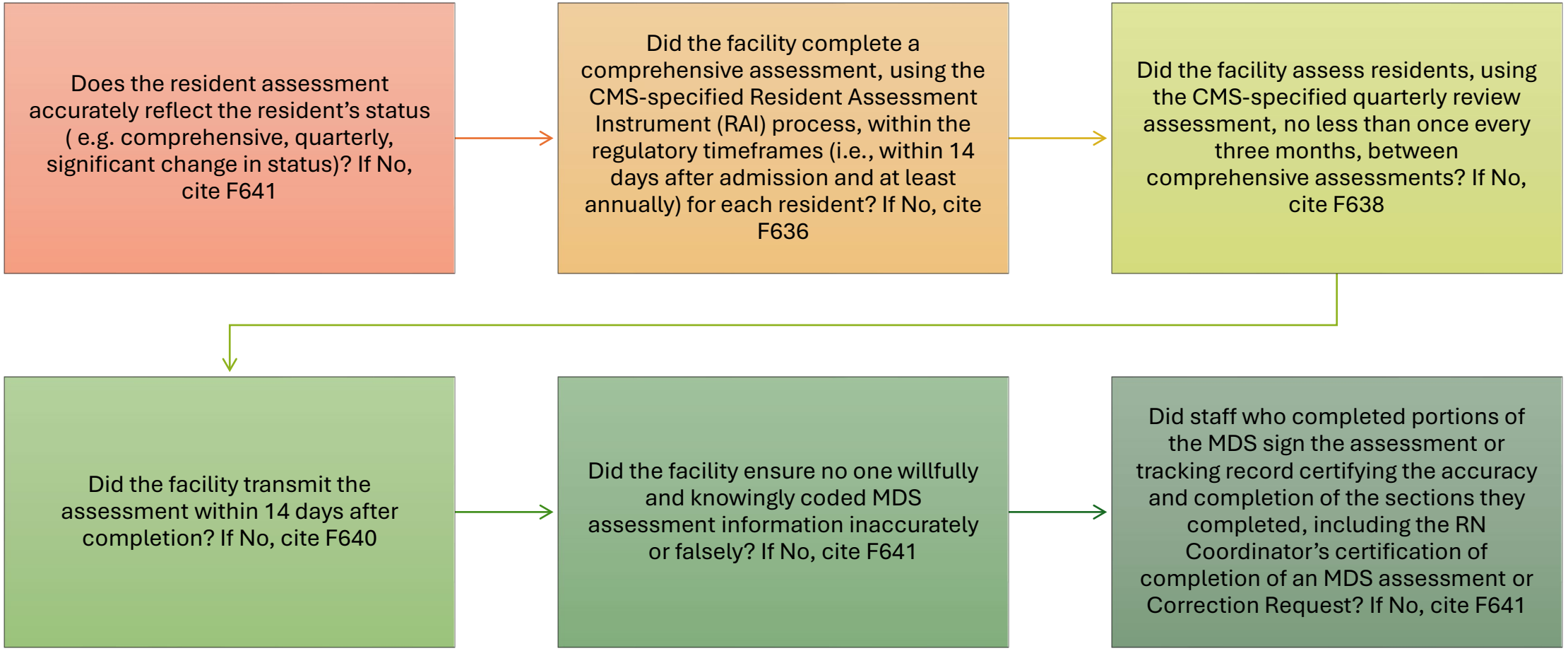
Any improvement in ADL physical functioning area (at least 1) where a resident is newly coded as *Independent, Setup or clean-up assistance, or Supervision or touching assistance* since last assessment and does not reflect normal fluctuations in that individual's functioning;

Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;

Resident's decision making ability improves;

Resident's incontinence pattern improves;

Critical Element Pathway



To Do’s

Review and update the policy and procedure for accuracy of assessment.

Educate RNAC’s on the requirements to capture a diagnosis on the MDS

F 867-QAPI

New guidance was added incorporating health equity concerns when obtaining feedback, collecting and monitoring data related to outcomes of sub-populations, and analyzing factors known to affect health equity, such as race, socioeconomic status, or language when investigating medical errors and adverse events. Facilities should also consider factors that affect health equity and outcomes of their resident population when establishing priorities in their QAPI program.

Interviewing the facility Medical Director was also incorporated into the Unnecessary Medications and Quality Assurance & Performance Improvement (QAPI) pathways.

F-867 QAPI/QAA Improvement Activities

Definition Added

- ***"Health equity"*** *refers to* ***t****he attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. From the CMS Framework for Health Equity, April 2022, https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity.*

https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cmsframework-for-health-equity.

F-867 QAPI/QAA Improvement Activities- Feedback

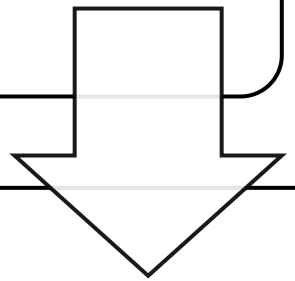
Feedback must be obtained from direct care staff, other staff, residents and resident representatives, as well as other sources, and be used to identify problems that are high-risk, high-volume, and/or problem-prone, as well as opportunities for improvement.

Feedback from residents is necessary to understand what quality concerns are important to them, their perspectives, values and priorities, as well as the impact of the facility's daily routines on their physical, mental, and psychosocial well-being.

Facilities should consider feedback related to concerns about health equity. For example, does the facility address the needs of individuals with disabilities, limited English proficiency, with different cultural or ethnic preferences, or other health equity concerns? Additional information on addressing health equity can be found at the CMS Framework for Health Equity site

F-867 QAPI/QAA Improvement Activities- Adverse Events

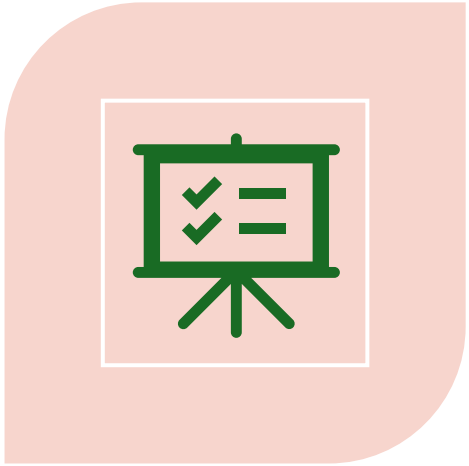
Nursing homes must develop and implement written policies and procedures that enable the facility to systematically identify and investigate for medical errors and adverse events, including how the facility will analyze and use data relating to errors/events to develop activities to prevent future occurrences.



Data analysis should include an evaluation of factors known to affect health equity, such as race, sexual orientation, socioeconomic status, or preferred language.

Critical Element Pathway (Advanced Copy)

DID THE FACILITY DEVELOP AND IMPLEMENT P&PS FOR DATA COLLECTION SYSTEMS, FEEDBACK, MONITORING, ANALYSIS, AND ACTION, INCLUDING ADVERSE EVENT MONITORING? NO F867



DID THE FACILITY/QAA COMMITTEE PRIORITIZE ITS IMPROVEMENT ACTIVITIES; DEVELOP AND IMPLEMENT ACTION PLANS; MEASURE THE SUCCESS OF ACTIONS, AND TRACK PERFORMANCE; CONDUCT AT LEAST ONE PIP ANNUALLY; AND REGULARLY REVIEW, ANALYZE, AND ACT ON DATA COLLECTED? NO F867

Critical Element Pathway (Advanced Copy)

For each area of systemic non-compliance identified by the survey team, did the facility identify the issue prior to the survey? No F865

For each systemic issue identified that the QAA Committee was aware of, did the facility make good faith attempts to correct quality deficiencies? No F865

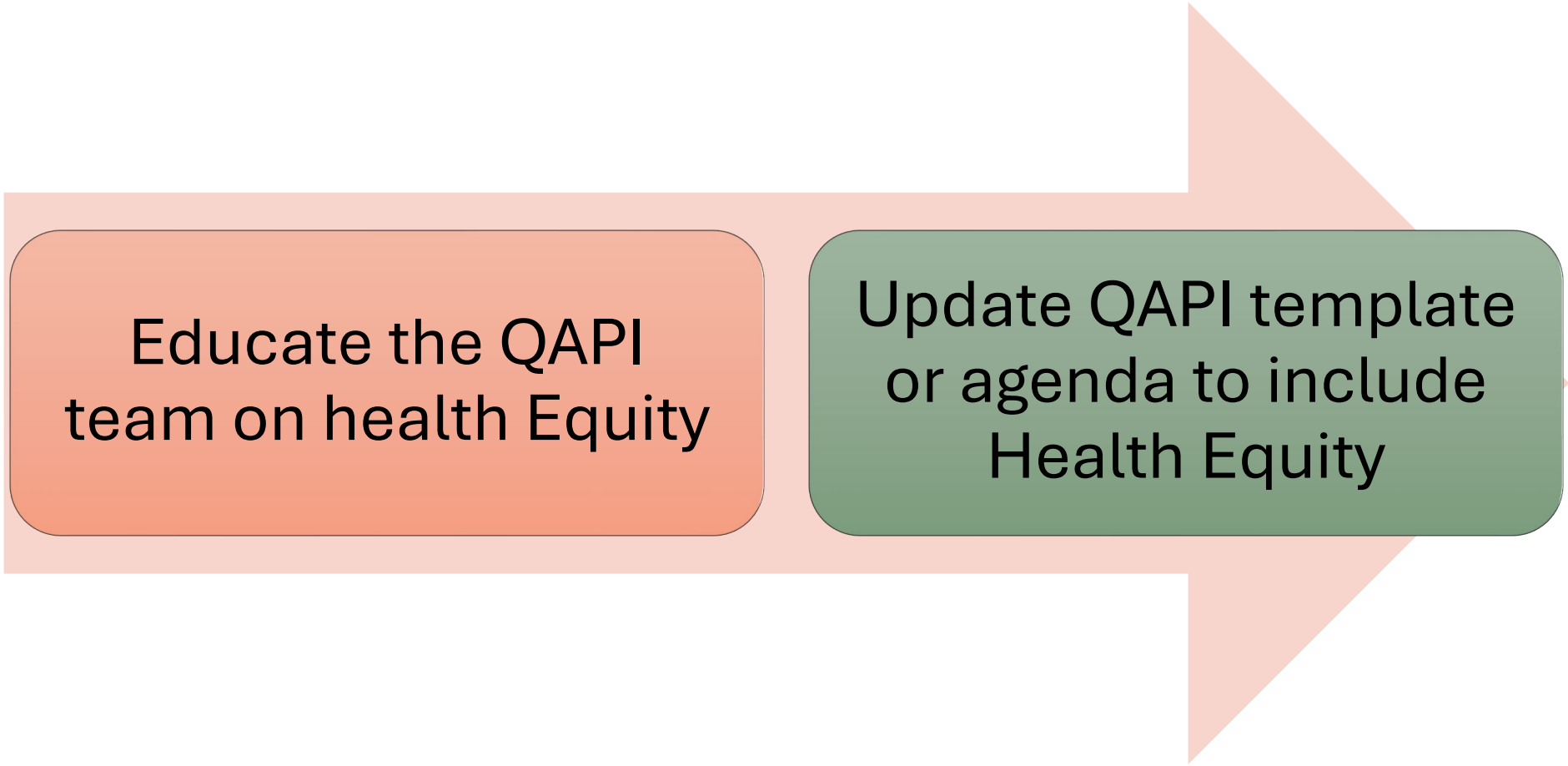
Did the medical director fulfill his/her responsibilities for the implantation of resident care policies and/ or coordination of medical care in the facility? No F841

Critical Element Pathway (Advanced Copy)

Does the facility have a QAA committee that consists of the minimum required members and meets at least quarterly? No F868

Did the facility implement and maintain a comprehensive QAPI program and plan, disclose records upon request, and have governance and leadership oversight? No F865

To Do’s


Educate the QAPI team on health Equity
Update QAPI template or agenda to include Health Equity

F 678 Cardio-Pulmonary Resuscitation (CPR)

Updates were made to CPR certification to align with current nationally accepted standards.

F678: Advanced Directives:

CPR Certification

- Staff must maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes *a* hands-on *session either in a physical or virtual instructor-led setting in accordance with accepted national standards*.
- For concerns related to *CPR certification that meets accepted professional standards* the survey team should consider §483.21(b)(3)(ii), Services Provided by Qualified Persons, F659 and/or *§483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. F836.*

Pain management:

Revisions to the guidance for acute, chronic, and subacute pain were made to align with CDC definitions.

CMS also 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.

Additionally, resource links on opioid use were updated and expanded.

F-697 Pain Management- New Definitions

Acute Pain *refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery. (From the Centers for Disease Control and Prevention (CDC)).*

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. (From the CDC).*

Subacute Pain *refers to pain that has been present for 1–3 months. (From the CDC).*

F-697 Pain Management

Use of Opioids for Pain Management—Prescribing practitioners may find that opioid medications are the most appropriate treatment for acute pain, *subacute pain, and* chronic pain in some residents.

Opioid treatment for pain needs to be appropriately assessed and individualized for each resident.

However, because of increasing opioid addiction, abuse, and overdoses, prescribers should use caution when prescribing opioids, and consider using alternative pain management approaches, when appropriate.

When opioids are used, the lowest possible effective dosage should be prescribed for the shortest amount of time possible after considering all medical needs and the resident should be monitored for effectiveness and any adverse effects.

When starting opioid therapy for acute, subacute, or chronic pain, clinicians may consider prescribing immediate-release opioids instead of extended-release and long-acting.

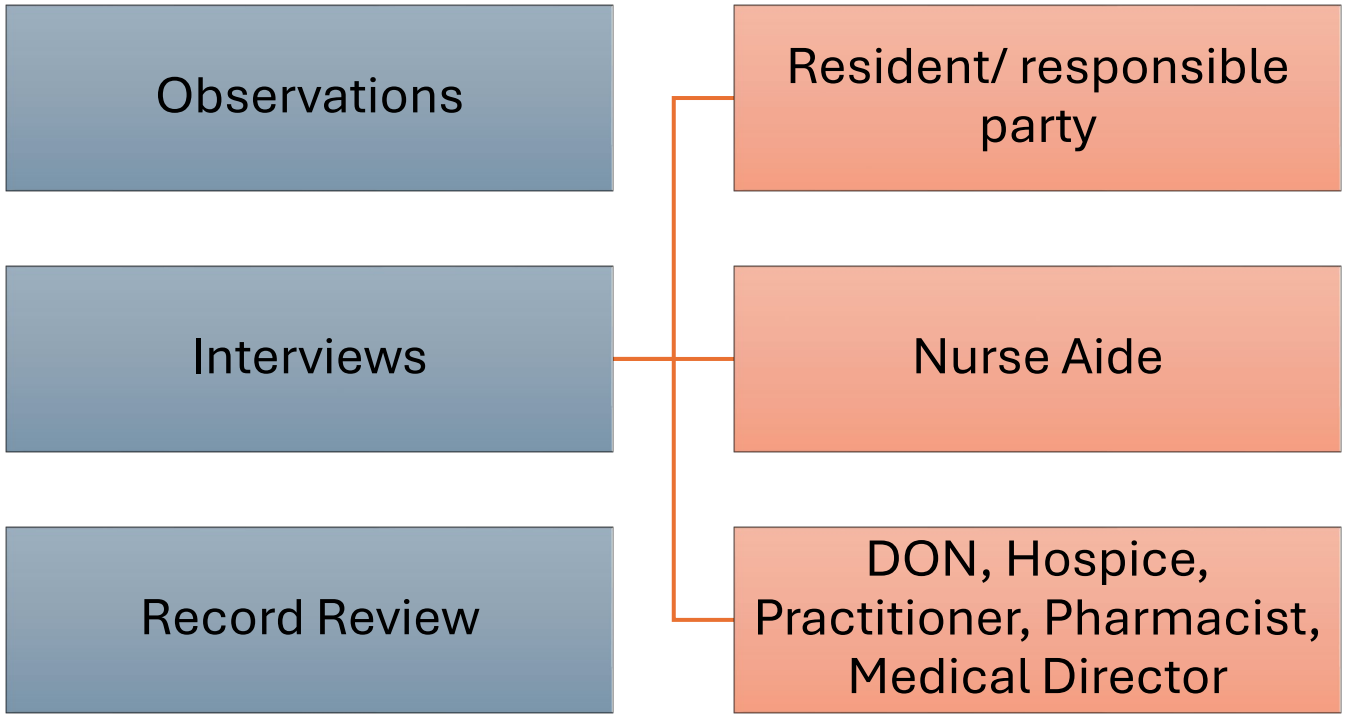
F-697 Pain Management- NOTE

Requirements at 483.10(c)(5) describe the resident's right to be informed of the risks and benefits of the proposed treatment. For concerns related to informing the resident or resident representative of the risks of opioid use for pain, refer to F552.

For additional information, refer to:

- Exposure-Response Association Between Concurrent Opioid and Benzodiazepine Use and Risk of Opioid-Related Overdose in Medicare Part D Beneficiaries, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2685628.
- National Institute on Drug Abuse Benzodiazepines and Opioids, https://nida.nih.gov/research-topics/opioids/benzodiazepines-opioids
- Geriatricpain.org, Resources and Tools for Quality Pain Care, https://geriatricpain.org/
- The Society for Post-Acute and Long-Term Care Medicine (AMDA) opioid The Society for Post-Acute and Long-Term Care Medicine (AMDA) Opioids in Nursing Homes https://paltc.org/opioids%20in%20nursing%20homes
- Centers for Disease Control Clinical Practice Guidelines for Prescribing Opioids for Pain https://www.cdc.gov/opioids/patients/guideline.html

Critical Element Pathway
(Advanced Copy)



Critical Element Decisions

Did the facility identify, treat, monitor, and manage the resident's pain to the extent possible in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences? If No, cite F697

For Newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/ she was able to understand? If no , cite F655

Critical element Decisions

If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition? If No, cite F636

If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant? If No, cite F637

Does the most recent assessment accurately reflect the resident's status (i.e., comprehensive, quarterly, significant change in status)? If No, cite F641

To Do’s

Educate the responsible discipline on the added definitions

Review and update the pain management policy and procedure

Infection Prevention & Control

Infection control guidance regarding Enhanced Barrier Precautions in Nursing Homes to Prevent 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.

Changes to Federal Regulations- Infection Control Review Effective 3/24/2025

Infection Prevention & Control:
Infection control guidance regarding Enhanced Barrier Precautions in Nursing Homes to Prevent 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:
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 (*previously* released in CMS Memo QSO-21-19-NH on May 11, 2021), was incorporated into Appendix PP.

Enhanced Barrier Precautions (EBP)

Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.

Enhanced Barrier Precautions (EBP)

EBP are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.

EBP are indicated for residents with any of the following:

- Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or
- Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.

Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.

Enhanced Barrier Precautions (EBP)

Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP.

EBP should be used for any residents who meet the above criteria, wherever they reside in the facility.

*Facilities **have discretion** in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC.*

Enhanced Barrier Precautions (EBP)

For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:

Dressing	*Bathing/showering*	*Transferring*	*Providing hygiene*
Changing Linens	*Changing briefs or assisting with toileting*	*Device care or use: central line, urinary catheter, feeding tube, Tracheostomy/ Ventilator*	*Wound care: any skin opening requiring a dressing*

Enhanced Barrier Precautions(EBP) Note:

In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility.

Residents are not restricted to their rooms or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

Facilities have discretion on how to communicate to staff which residents require the use of EBP. CMS supports facilities in using creative (e.g., subtle) ways to alert staff when EBP use is necessary to help maintain a home-like environment, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities..

Enhanced Barrier Precautions(EBP)

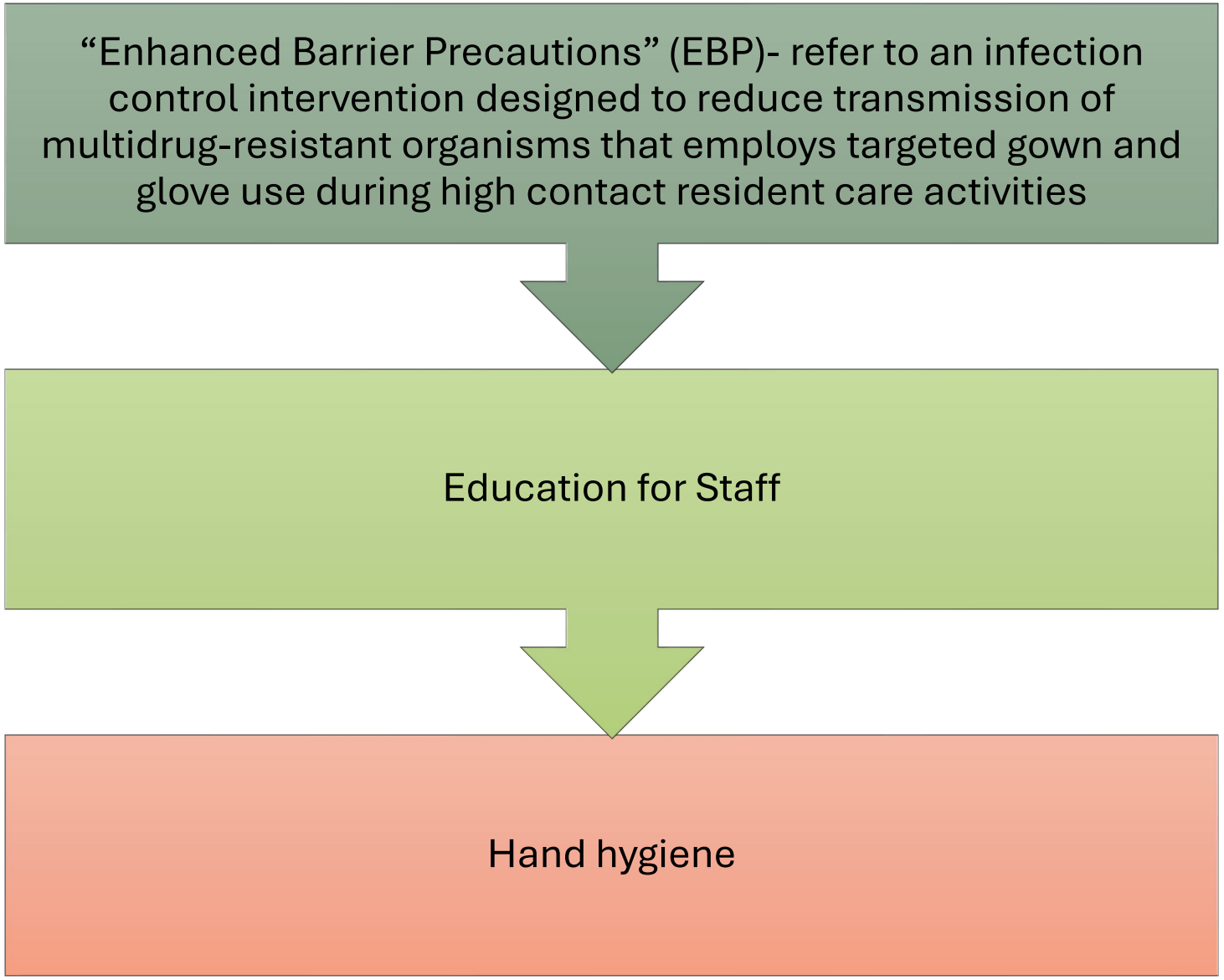
Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. Discretion may be used in the placement of supplies which may include placement near or outside the resident's room.

PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.

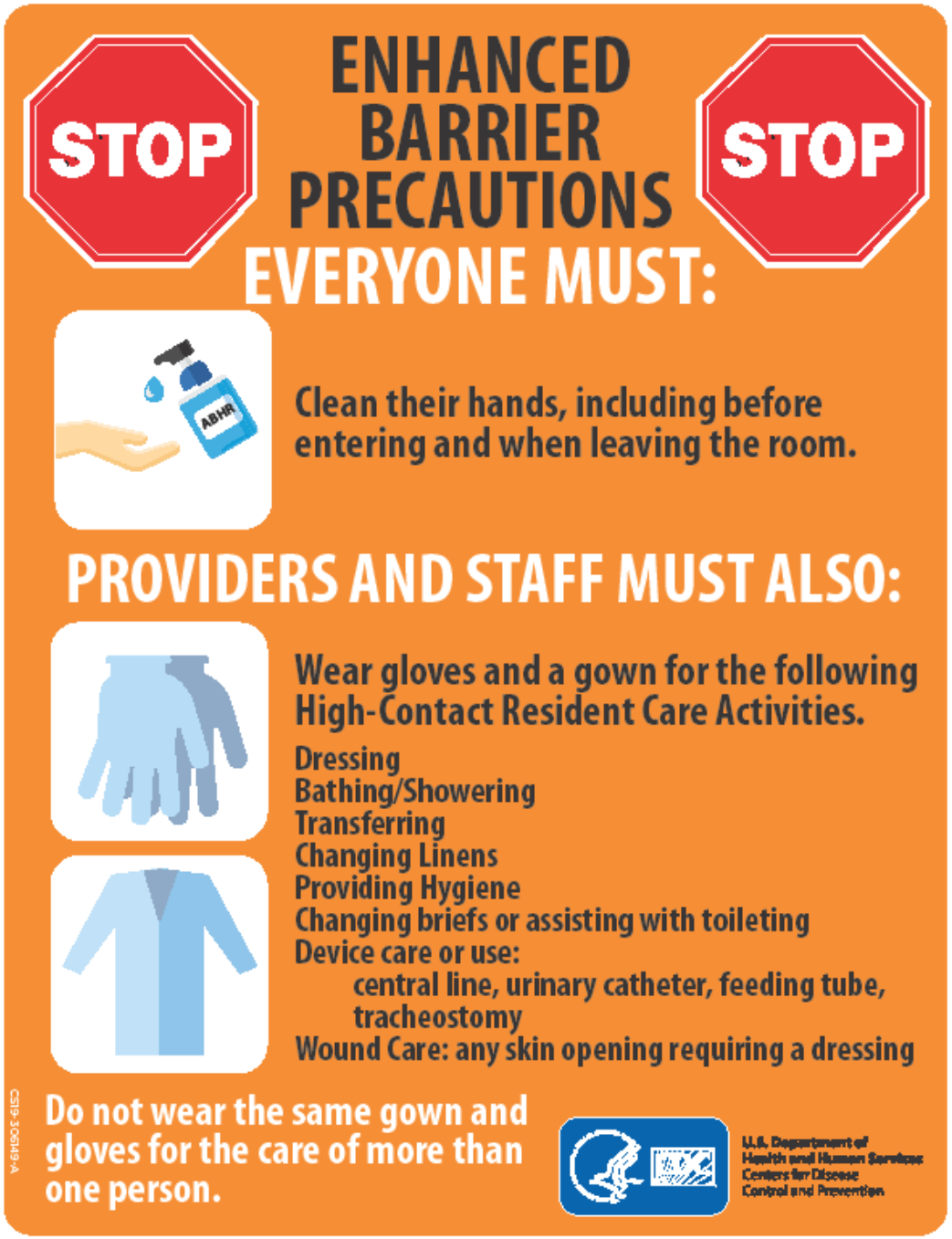
For example, staff entering the resident's room to answer a call light, converse with a resident or provide medications **and** who do **not** engage in a high-contact resident care activity would likely not need to employ EBP while interacting with the resident.

Surveyors will evaluate the use of EBP when reviewing sampled residents for whom EBP are indicated and focus their evaluation of EBP use as it relates to CDC-targeted MDROs.

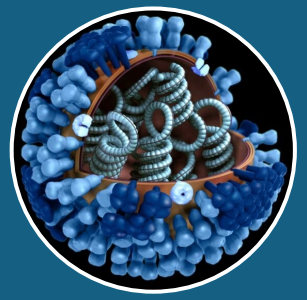
Enhanced Barrier Precautions



CDC Signs


STOP
ENHANCED BARRIER PRECAUTIONS
STOP
EVERYONE MUST:
ABHR
Clean their hands, including before entering and when leaving the room.
PROVIDERS AND STAFF MUST ALSO:
Wear gloves and a gown for the following High-Contact Resident Care Activities.
Dressing
Bathing/Showering
Transferring
Changing Linens
Providing Hygiene
Changing briefs or assisting with toileting
Device care or use:
central line, urinary catheter, feeding tube, tracheostomy
Wound Care: any skin opening requiring a dressing
Do not wear the same gown and gloves for the care of more than one person.
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

COVID-19 Immunization:



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 CMS Memo QSO-21-19-NH on May 11, 2021, was incorporated into Appendix PP.

F887 Infection Control- COVID-19 Immunization

483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:

- (i) 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;
- (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
- (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;

F887 Infection Control- COVID-19 Immunization

(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.

(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;

F887 Infection Control- COVID-19 Immunization

The resident's medical record includes documentation that indicates, at a minimum, the following:

- That the resident or 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.

Before offering....

All staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine

Each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine

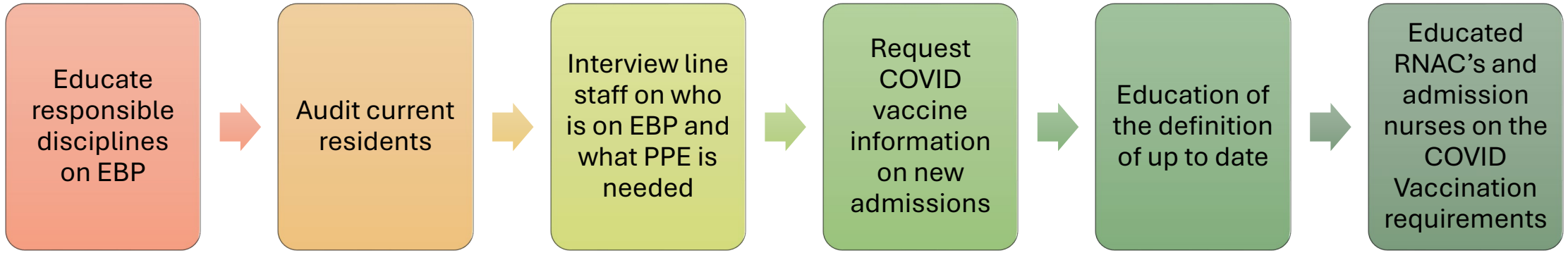
In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.

F887 Infection Control- COVID-19 Immunization

The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:

- ***That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;***
- ***Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and***
- ***The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).***

To Do’s


Educate responsible disciplines on EBP
Audit current residents
Interview line staff on who is on EBP and what PPE is needed
Request COVID vaccine information on new admissions
Education of the definition of up to date
Educated RNAC’s and admission nurses on the COVID Vaccination requirements

References

CMS

- QSO-25-12NH: REVISED: Revised Long-Term Care (LTC) Surveyor Guidance: Significant revisions to enhance quality and oversight of the LTC survey process

CDC

- Centers for Disease Control and Prevention (CDC): Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC

THANK YOU FOR YOUR TIME AND ATTENDANCE

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