"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

SOM Appendix PP Updates: Part 1

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AMERICAN NURSES CREDENTIALING CENTER

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.
- **Contact hours** for this program will be awarded for 1 week after the live presentation.

Learning Objectives

SOM Appendix PP Updates: Part 1

- Understand the overall changes to SOM appendix PP
- Generally, describe the individual changes
- Recognize the Critical element Pathway revisions
- Apply these changes to facility survey preparedness
- (Admissions/Transfer/Discharge, Chemical Restraints/Unnecessary Psychotropic Medication, Professional Standards and Medical Director, MDS Accuracy/Coordination/Certification, and Comprehensive Assessment after Significant Change.)

Resources

- QSO-25-12-NH
- Nursing Home Survey Resources
- CMS guidance training for nursing home surveyors and providers: Long Term Care Appendix PP Regulatory and Interpretive Guidance Updates – Effective March 2025

Why these Revisions

- CMS is committed to continuously enhancing the effectiveness and efficiency of our oversight and compliance programs for nursing homes.
- By doing so, we ensure that our primary responsibility, protecting the health and safety of residents, remains at the forefront of our efforts.
- Through a data-driven approach, we identify areas for improvement and implement solutions that strengthen the quality of care provided across facilities.
- Health and safety updates are regularly made to address emerging trends in deficiency citations nationwide.
- This ensures that our guidance remains aligned with current standards of practice and reflects the evolving needs of residents.
- These updates are essential to maintaining the integrity of nursing home care.

When will these revisions take effect

- CMS will publish these updates in Appendix PP of the State Operations Manual (SOM) in **March, 2025** for State Survey Agencies (SAs), long-term care facilities, and the public to understand how compliance will be assessed.
- This guidance will also be available to surveyors in the Automated Survey Process Environment (ASPEN) system starting **March 24, 2025**. Surveyors will begin using the guidance to determine compliance at that time.

General Revisions: Admission, Transfer and Discharge:

Admission, Transfer and Discharge:

- **Admission Agreement:** CMS clarified guidance prohibiting admission agreements from containing language requesting or requiring a third-party guarantee of payment, adding examples of noncompliance.
- To reduce the overlap of citations, improve clarity, and make it easier for surveyors to identify noncompliance, CMS is deleting Tags F622 – F626, and F660 – F661 and removing the terms “facility-initiated” and “resident-initiated.”
- The guidance from the deleted Tags has been reorganized, with revisions added to clarify when a transfer or discharge is noncompliant. The new citations are **F627 for Inappropriate Transfers and Discharges** and **F628 for Transfer and Discharge Process**.
- The Discharge and Hospitalization Critical Elements Pathways have been revised to accommodate these revisions.

Admission, Transfer and Discharge

- **F620**
- **§483.15(a)(3) Third Party Guarantee of Payment**
  - The facility must not request or require a third party to accept personal responsibility for paying the facility bill out of his or her own funds as a condition of admission, expedited admission, or continued stay in the facility.
  - 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.
  - language in the admission agreement 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.
  - Any language contained in an agreement that seeks to hold a third party personally responsible for paying the facility would violate this requirement.
  - Admission agreements which contain other language which confers personal liability upon a third party, represent noncompliance with this provision.
  - Such language is noncompliant if it appears in the main document that a facility uses as its admission agreement or in other documents that are signed at admission. In addition, after a resident is admitted, the facility cannot use such language in agreements regarding a resident's continued stay in the facility.

Admission, Transfer and Discharge

- **F627**
  - §483.15(c) Transfer and discharge-
  - §483.15(c)(1) Facility requirements
  - §483.15(c)(2) Documentation.
  - §483.15(c)(7) Orientation for transfer or discharge.
  - §483.15(e)(1) Permitting residents to return to facility.
  - §483.15(e)(2) Readmission to a composite distinct part.
  - §483.21(c)(1) Discharge Planning Process
  - §483.21(c)(2) Discharge Summary

Admission, Transfer and Discharge

- **F627**
  - These regulations and guidance address inappropriate discharges and Specify the limited conditions under which a skilled nursing facility or nursing facility may transfer or discharge a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation.
  - 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.

Admission, Transfer and Discharge

- **F628**
  - §483.15(c)(2) Documentation
  - §483.15(c)(3) Notice before transfer
  - §483.15(c)(4) Timing of the notice
  - §483.15(c)(5) Contents of the notice
  - §483.15(c)(6) Changes to the notice.
  - §483.15(c)(8) Notice in advance of facility closure
  - §483.15(d) Notice of bed-hold policy and return
  - §483.15(d)(1) Notice before transfer
  - §483.21(c)(2) Discharge Summary

Admission, Transfer and Discharge

- **F628**
  - The intent of this tag is to ensure the facility adheres to all of the applicable components of the process for transferring or discharging a resident which include documentation and information conveyed to the receiving provider, the notice of transfer or discharge, notice of bed-hold policy, and completing the discharge summary.

Chemical Restraints/ Unnecessary Psychotropic Medication:

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.

Chemical Restraints/Unnecessary Psychotropic Medication

- **F605**
  - §483.10(e) Respect and Dignity.
  - §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation
  - §483.12(a) The facility must—. . .
  - §483.12(a)(2) Ensure that the resident is free from chemical restraints
  - §483.45(c)(3) A psychotropic drug
  - §483.45(d) Unnecessary drugs
  - §483.45(e) Psychotropic Drugs
  - §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs
  - §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions
  - §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary
  - §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in
  - §483.45(e)(5),
  - §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days

Chemical Restraints/Unnecessary Psychotropic Medication

- **F605**
  - 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.
  - The regulations and guidance are not intended to supplant the judgment of a practitioner in consultation with facility staff, the resident, and his/her representatives and in accordance with professional standards of practice.
  - Rather, the regulations and guidance are intended to ensure psychotropic medications are used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). However, surveyors must review the resident's medical record for evidence which supports and documents the clinical indication for psychotropic medication use.

Unnecessary Medication

- **F757**
  - §483.45(d) Unnecessary Drugs—General.
  - §483.45(d)(1) In excessive dose (including duplicate drug therapy);
  - §483.45(d)(2) For excessive duration;
  - §483.45(d)(3) Without adequate monitoring;
  - §483.45(d)(4) Without adequate indications for its use
  - §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued;
  - §483.45(d)(6) Any combinations of these reasons

Unnecessary Medication

- **F757**
  - The intent of these requirements is to ensure each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.
  - The regulations and guidance are not intended to supplant the judgment of a practitioner in consultation with facility staff, the resident, and his/her representatives and in accordance with professional standards of practice.
  - However, surveyors are expected to investigate the basis for decisions and interventions affecting residents.
  - For example, a resident's medical record should contain documentation that demonstrates how the practitioner arrived at their decision(s) in accordance with the professional standards of practice.

Professional Standards and Medical Director

Professional Standards and 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

- **F658**
- **§483.21(b)(3) Comprehensive Care Plans**
  - The services provided or arranged by the facility, as outlined by the comprehensivecare plan, must—
  - (i) Meet professional standards of quality.
- The intent of this regulation is to assure that ALL services, as outlined by the comprehensive care plan, being provided meet professional standards of quality.
- Mental Disorders are diagnosed by a practitioner, using evidence-based criteria and professional standards, such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and are supported by documentation in the resident's medical record.
- Supporting documentation should include, but is not limited to, evaluation of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation.

Professional Standards and Medical Director

- When residents are admitted to the facility with a mental health diagnosis, supporting documentation should include, but is not limited to:
  - The PASARR evaluation and determination report from the State Mental Health Authority;
  - Facility attempts to obtain documentation regarding the mental health diagnosis from the previous provider(s);
  - Validation of the resident's mental health diagnosis by the practitioner in accordance with professional standards of practice, such as reviewing information available in the medical record, including information from the previous provider(s), discussions about the diagnosis and history with the resident or resident representative, conducting a comprehensive evaluation, the need for a psychiatric or other consultations if necessary, and their determination of the resident's diagnosis.
- **DEFICIENCY CATEGORIZATION**
  - If the surveyor identifies a pattern (e.g., three or more) of residents who have a new diagnosis which lacks sufficient supporting documentation, the surveyor should cite the scope of the non-compliance at a minimum scope of pattern (e.g., level 2 = "E," Level 3 = "H," or Level 4 = "K"),
  - Additionally, the surveyor should discuss the findings with their state agency to consider referringl a physician, nurse practitioner, clinical nurse specialist, or physician assistant to their respective state board (e.g., state medical board, state nursing board, etc

Professional Standards and Medical Director

- **F841**
- §483.70(g) Medical director.
- §483.70(g)(1) The facility must designate a physician to serve as medical director.
- §483.70(g)(2) The medical director is responsible for—
  - (i) Implementation of resident care policies; and
  - (ii) The coordination of medical care in the facility.
- 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.
  - Active involvement in the process of conducting the facility assessment Administrative decisions including recommending, developing and approving facility policies related to resident's care. Resident care includes the resident's physical, mental and psychosocial well-being
  - 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

Professional Standards and Medical Director

- **An example of Level 2, no actual harm, with a potential for more than minimal harm, that is not immediate jeopardy, includes**
  - The medical director, who is responsible for overseeing the medical care in the facility, was made aware of residents newly diagnosed with schizophrenia by their physician and/or other practitioner and their medical records did not contain documentation to support the new diagnoses.
  - The medical director did not review the medical records for these residents nor did he/she discuss the new diagnoses with the residents' physician and/or diagnosing practitioner.
  - This practice resulted in residents being potentially misdiagnosed with schizophrenia and receiving antipsychotic medications.
  - None of the residents experienced harm, but they were at risk for harm by receiving treatment, including antipsychotic medications, when they may not have been clinically indicated. Note: If this occurred on three or more residents, at minimum, this would be cited at a scope of pattern (e.g., "E").

Accuracy/Coordination/ Certification:

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.

Accuracy/Coordination/Certification:

- **F641**
  - §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
  - §483.20(i) Certification.
  - §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.
  - §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
  - §483.20(j) Penalty for Falsification.
  - §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly—
    - (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
    - (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.
  - §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.

Accuracy/Coordination/Certification:

- The intent of these regulations is to assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.
- **Inaccurate MDS Diagnosis Coding:** CMS is aware of situations where residents are given a diagnosis of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia.
- For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.
- Surveyors should investigate this concern through record review and interviews with staff who completed the assessment. Surveyors are not questioning the physician's medical judgement, but rather, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment.

Accuracy/Coordination/Certification:

- 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.
- **Patterns of MDS Assessment and Submissions:** MDS information serves as the clinical basis for care planning and care delivery and provides information for Medicare and Medicaid payment systems, quality monitoring and public reporting. MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process.
- A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures. All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

Accuracy/Coordination/Certification:

- A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher Patient Driven Payment Model (PDPM) scores, untriggering Care Area Assessments (CAAs) or unflagging Quality Measures (QMs), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or attempts to avoid reporting negative quality measures.
- Such practices may include, but are not limited to, a pattern or high prevalence of the following:
  - Submitting MDS Assessments (including any reason(s) for assessment, routine or non- routine) or tracking records, where the information does not accurately reflect the resident's status as of ARD, or the Discharge or Entry date, as applicable;
  - Submitting correction(s) to information in the internet Quality Improvement Evaluation System (iQIES) where the corrected information does not accurately reflect the resident's status as of the original ARD, or the original Discharge or Entry date, as applicable, or where the record it claims to correct does not appear to have been in error;
  - Submitting Significant Correction Assessments where the assessment it claims to Advance Copy correct does not appear to have been in error;

Accuracy/Coordination/Certification:

- Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met;
- Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Entry Tracking information, or correction(s) to information in the iQIES system.

- **INVESTIGATIVE PROCEDURES**
  - Use the Resident Assessment Critical Element Pathway a) when MDS concerns are noted but you are not using a care area pathway (i.e., the care area did not require further investigation), or b) for concerns about the facility's MDS data completion or submission activities, along with the above guidance, when determining if the facility meets the requirements for, or investigating concerns related to resident assessment.
  - Surveyors are expected to focus on MDS coding accuracy but are not expected to investigate possible falsification of the resident assessment instrument.
  - If the surveyor identifies a pattern (i.e., three or more residents) of inaccurate MDS coding by staff who completed, signed, and certified to the accuracy of the portion of the assessment they completed, and there are indications or concerns that the individual who completed the section(s) in question knew the coding was inaccurate, a referral should be made to the Office of Inspector General for investigation of falsification.

What's Next?

- Get prepared for compliance with these revisions as part of your routine survey preparedness processes.
- Download a copy of SOM Appendix PP Advance Copy and review complete revisions as a team.
- Starting **March 24, 2025**, surveyors will begin using the guidance to determine compliance.
- Prepare for survey with the critical element pathways. It's what the surveyors use.
- MDS accuracy is a must. Use it for what it was designed to do.

QUESTIONS?