

## **BACK TO SCHOOL: A SUMMARY OF CMS' RECENT PHASE 2 AND PHASE 3 RoP GUIDANCE UPDATES FOR NURSING HOMES**

*August 11, 2022*

On June 29, 2022, the Centers for Medicare & Medicaid Services (CMS) issued [QSO-22-19-NH](#), Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phases 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide. This document outlines significant updates to guidance within Appendix PP of the CMS State Operations Manual (SOM) on the Medicare Phase 2 and Phase 3 Requirements of Participation (RoPs) revisions (originally issued in 2016). CMS provided an advanced copy of the revised SOM Appendix PP detailing these updates ([available at the bottom of the QSO page here](#)). Key areas addressed as part of these updates include abuse and neglect, admission and discharge, matters involving mental health and substance use disorders, nurse staffing and reporting requirements, residents' rights, circumstances involving inaccurate diagnoses/assessments, medication management, infection control, limitations on resident arbitration agreements, assessment of psychosocial outcomes, and facility reporting of suspected criminal activity, among other areas. State surveyors will begin using this new guidance to identify noncompliance beginning October 24, 2022. Further details on these updates are as follows:

### **FREEDOM FROM ABUSE, NEGLECT, & EXPLOITATION**

CMS updated guidance on resident rights, particularly F-Tag F600 (Freedom from Abuse, Neglect, or Exploitation). Concerning what constitutes "abuse," CMS offered two key clarifications. First, CMS clarified that not every argument or disagreement that occurs "during the course of normal social interactions" among residents constitutes "abuse." Rather, surveyors are instructed to refer to the definition of "abuse," that in turn references actions which result in "physical harm, pain or mental anguish." This information may be valuable to facilities insofar as it focuses the analysis of whether abuse has occurred on the impact of conduct on a purported victim. Second, with respect to sexual activity among residents, CMS also highlighted that facilities must ensure residents have the capacity to consent. This places an onus on facilities to conduct such capacity evaluations where appropriate, noting the general right of residents to engage in consensual sexual activity. Beyond the above highlights, CMS also noted that a facility must revise a resident's care plan if the resident's needs or preferences change because of an incident of abuse.

Concerning what constitutes "neglect," CMS updated its definition of "neglect" to reference "the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Notably, CMS drew a distinction between limited instances of non-compliance resulting in injury (for example, a resident who is not assisted with ambulating as required in a care plan and experiences

a fall) with instances of “neglect.” In drawing this distinction, CMS highlighted that neglect occurs when a facility “knew or should have known” that goods or services were not being provided to a resident, but “continued to fail to take action necessary to avoid the potential for harm, or actual harm to the resident.” In other words, singular failures on the part of individual staff members will not generally be imputed to the facility for the purposes of citing neglect unless the facility knew or should have known of such failures and failed to intervene. Consistent with this clarification, CMS further highlighted that the “failure to implement an effective communication system across all shifts to communicate among staff, practitioners, and resident representatives” may also constitute “neglect.”

## TRANSFER AND DISCHARGE REQUIREMENTS

CMS included significant clarifications relating to transfer and discharge under F-Tags F622 through F626. Clarifications include:

- If a resident leaves against medical advice (AMA) because he or she was pressured, forced, or intimidated into doing so, the discharge shall be deemed facility-initiated and subject to investigation. Consequently, facilities should take care to ensure AMA discharges properly signify circumstances in which a resident genuinely wishes to leave the facility of his or her own volition, and that documentation clearly supports the categorization.
- Residents who are admitted in anticipation of only residing in the facility short-term (for example, a “short-term rehabilitation stay”) have a right to remain in the facility even if they ultimately decide to stay beyond the time that they were initially anticipated to discharge. Under such circumstances, even though the resident was initially admitted for a “short-term stay,” a facility may only discharge the resident against his or her will if one of the grounds for an involuntary discharge at 42 C.F.R. § 483.70(c)(1)(i)(A)-(F) is satisfied (e.g., nonpayment, etc.). CMS specifically highlighted that noncompliant involuntary discharges under such circumstances may warrant further investigation of potential prohibited payor source discrimination on the part of a facility.
- If a resident’s Medicare coverage is ending (for example, based on a lack of skilled need or exhaustion of Part A of benefits), the resident must be offered an opportunity to remain in the facility by paying privately for his/her care or applying to a third-party payor for coverage (e.g., Medicaid). Further, a resident who has applied for Medicaid and complied with applicable document submission requirements may not be discharged while his or her Medicaid application remains pending.
- Where a facility wishes to discharge a resident involuntarily while the resident remains in the hospital, the grounds for initiating the discharge must exist as of the time the discharge is initiated. On this point, CMS referenced a hypothetical in which a resident is discharged to the hospital for hitting a staff member. While remaining in the hospital, the facility discovers that the resident had not been provided pain medication as prescribed at the time of the incident, and further determines that the resident would likely not have engaged in violent conduct if he or she had been properly administered pain medications. CMS’s guidance indicates that, under such circumstances, the facility would not have grounds to initiate an involuntary discharge on the basis of the above conduct, since the conditions giving rise to that conduct could be alleviated by administering medications as prescribed upon the resident’s return.
- Where the circumstances of an involuntary discharge change (for example, a proposed discharge location, or the underlying reason for the discharge), the subject resident must be provided a new discharge notice reflecting such change(s), which may afford the resident a new opportunity to appeal the discharge.

## MENTAL ILLNESS & SUBSTANCE ABUSE

CMS provided added guidance with respect to management of mental illness and substance abuse disorders among facility residents, notably with respect to F-Tags F740 through F745 (generally covering “Behavioral Health” among residents). In particular, CMS emphasized requirements for facilities to properly assess residents for mental illness and substance use disorders upon admission (and to avoid admitting residents whom the facility is not equipped to treat). CMS further emphasized the need for facilities to ensure they employ staff capable of identifying mental illness and substance use disorders among incoming residents. CMS also provided guidance on care planning and proper use of resident behavioral contracts. In particular, CMS highlighted the fact that such contracts should not be used as a means of establishing grounds for involuntary discharge (for example, if a resident refuses to comply with the contract terms). Rather such contracts should be used to update applicable care plans where a resident is non-compliant with the terms of a behavior contract. CMS emphasized the need for facilities to consider non-pharmacological interventions to manage behavioral concerns among residents, and to ensure recommendations provided as the result of psychological or professional evaluations are followed. On this point, CMS emphasized that, where a resident engages in serious self-harm, which could have been prevented if a facility had implemented a recommended intervention included in a psychological/professional assessment, grounds may exist for a finding of immediate jeopardy. Facilities should therefore ensure they are thoroughly reviewing and implementing such interventions or documenting why such interventions cannot or should not be implemented. With respect to the above points, CMS provided a list of online resources under F740 to assist providers in identifying and properly care planning for various mental illness and substance use disorders among residents.

Beyond guidance related to F-Tags F740 through F745, CMS also provided guidance on substance use/abuse and illegal substances in the context of F557 (Respect, Dignity/Right to have Personal Property) and F689 (Free of Accident Hazards/Supervision/Devices). Concerning F557, CMS elaborated on the limits of what a facility can do to address the presence of illegal substances among residents. Specifically, CMS directed that a facility shall not “act as an arm of law enforcement” upon a determination that a resident has access to illegal substances (CMS included a similar note in new guidance under of F563 concerning visitors bringing illegal substances into a facility). The facility can confiscate any substances in plain view but should otherwise refer such matters to local law enforcement and not search resident belongings without the resident/representative consent. Concerning F689, CMS included a detailed discussion of electronic cigarettes, indicating that, “because these devices are not without risk and have accidents associated with them, facilities have a responsibility to oversee their use and provide supervision to maintain an accident-free environment.” Concerning substance abuse and the use of illegal substances, CMS emphasized the need to properly care plan and protect resident safety where such issues are present in a facility. To that end, staff members are expected to be able to identify the signs of substance abuse among residents and be prepared to intervene in case of emergency by administering naloxone and/or CPR, as well as non-pharmacological solutions. Finally, facilities are expected to provide appropriate warnings and advice to residents who may be planning on departing the facility to seek access to alcohol or drugs. CMS instructed that, where a resident intentionally leaves the facility (for example, to seek access to illegal substances), such an occurrence may qualify as an elopement even if the resident has decision-making capacity, if the facility is unaware of the resident’s departure. Based on these updates, facilities should ensure they are monitoring residents at risk for or experiencing substance abuse issues and to plan for and monitor them accordingly.

## NURSE STAFFING/PAYROLL-BASED JOURNAL

CMS added guidance pertaining to F725 (Sufficient Nursing Staff) and F851 (Payroll Based Journal). With respect to nurse staffing under F725, CMS indicated that compliance with state staffing standards may not necessarily equate to compliance with RoPs if more staff are needed to meet the needs of residents. CMS included references to conditions which might signify insufficient staffing (for example, overuse of positioning alarms among residents), and included a detailed list of questions that can be asked of staff in order to verify whether staffing is adequate. Concerning F851, CMS instructed surveyors to rely on Certification And Survey Provider Enhanced Reports (CASPER) to determine if a facility submitted the required staffing information through the Payroll Based Journal (PBJ).

## RESIDENT RIGHTS: VISITATION RESTRICTIONS

In response to the COVID-19 pandemic, CMS included additional guidance under F-Tag F563 (Right to Receive/Deny Visitors) to address visitation in the event of a communicable disease outbreak. Specifically, CMS advised that, during a communicable disease outbreak, a facility should modify its visitation practices to follow current CMS and Centers for Disease Control and Prevention (CDC) guidelines. Such modifications may include offering outdoor or virtual visitation, providing signage with hygiene instructions, ensuring access to hand hygiene supplies, and informing visitors of potential risk to residents and transmission-based precautions (TBP), among other efforts.

## POTENTIAL INACCURATE DIAGNOSES AND/OR ASSESSMENTS

CMS added new guidance under F-Tags F658 (Services Provided Meet Professional Standards) and F641 (Accuracy of Assessments) regarding potentially inaccurate diagnoses or coding of schizophrenia in residents. As CMS highlighted, such misdiagnoses can result in inappropriate administration of psychotropic medications. To address such situations, surveyors are instructed to determine whether misdiagnoses are the result of a failure of a facility to provide accurate assessments and/or the failure of an individual professional to adhere to professional standards for assessments (which may in turn implicate notice being provided to applicable professional licensing boards). It is recommended that facilities ensure professionals who provide resident assessments are aware of these updates and the importance of ensuring that such assessments are thorough and accurate.

## PHARMACY SERVICES

CMS included a number of updates in relation to pharmacy services (F-Tags F755 through F761), most notably F-Tag F758 (Free from Unnecessary Psychotropic Medications/PRN Use). In particular, CMS directed that:

*Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented. Risks associated with psychotropic medications still exist regardless of the indication for their use (e.g., nausea, insomnia, itching), therefore the requirements pertaining to psychotropic medications in §483.45(e) apply to the four categories of drugs (anti-psychotic, anti-depressant, anti-anxiety and hypnotic) listed in §483.45(c)(3) without exception.*

CMS further directed that:

*Other medications not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotic medications can also affect brain activity and should not be used as a substitution for another psychotropic medication listed in §483.45(c)(3), unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice and in accordance with §483.45(d)(4).*

In other words, otherwise non-psychotropic medications will be treated as psychotropic medications for the purpose of RoP compliance if they are being used as a psychotropic medication substitute.

Beyond these updates, CMS also included reminders to surveyors that gradual dose reduction (GDR) of psychotropic medications should occur in modest increments over time to minimize withdrawal symptoms, and that the use of multiple psychotropic medications can increase the risk of adverse consequences in residents. Given this guidance, facilities may anticipate surveyors reviewing these aspects of GDR more thoroughly in the future.

## INFECTION PREVENTION & CONTROL

CMS updated guidance for F-Tags related to infection control, most notably F-Tags F880 (Infection Prevention & Control) and F882 (Infection Preventionist Qualifications/Role). Concerning F880, CMS expanded on its general infection control guidance, including instructions relating to cleaning of soiled/heavily touched surfaces, as well as a note that facilities failing to follow public health authority directives should be reported to local/state officials. Beyond these general notes, CMS also provided extended discussion of requirements for facilities to maintain a water management program to prevent the spread of Legionella, including applicable assessment and monitoring efforts, as well as requirements for facilities to implement appropriate transmission-based precautions in the event of a constellation of new symptoms among residents which may signify a communicable disease. Finally, CMS also included guidance under F880 on addressing multidrug-resistant organisms (MDROs).

Concerning F882, CMS outlined several key requirements for a facility's required infection preventionist, including qualifications, hours of work (which must be at least part-time), and specialized training necessary for the role, among other areas.

## ARBITRATION REQUIREMENTS

CMS provided detailed guidance on F-Tag F847 (Entering into Binding Arbitration Agreements), which generally directs that a facility may not require a resident/representative to sign an agreement for binding arbitration as a condition of admission. Concerning F847, CMS outlined key requirements that a facility must fulfill with respect to arbitration agreements, including that it must: 1. Explain the agreement to the resident/representative in a way they understand; 2. Inform the resident/representative that they are not required to enter into the arbitration agreement as a condition of admission; and 3. Inform the resident/representative that an arbitration agreement may be rescinded within 30 days of signature (which cannot be used as grounds for an involuntary discharge after admission). Concerning arbitration agreements themselves, CMS highlighted that: 1. They must not contain any language that prohibits/discourages the resident/representative from communicating with government officials; and 2. They must include language directing that signing of the arbitration agreement is not required as a condition of admission. Beyond these highlights, facilities should

also note that binding arbitration agreements must allow for the selection of a neutral arbitrator and convenient venue agreed upon by both parties. Facilities must retain a copy of the signed agreement to be available for inspection upon request for five (5) years after the resolution of the dispute. Finally, facilities should also ensure they account for any state-level requirements governing the use of arbitration agreements within admission documents.

## THE “REASONABLE PERSON” & THE PSYCHOSOCIAL OUTCOME SEVERITY GUIDE

CMS released an updated [Psychosocial Outcome Severity Guide](#) to clarify the “reasonable person” concept used in evaluating the severity of psychosocial outcomes resulting from noncompliance. The revised version emphasizes that the “reasonable person” should be interpreted as a reasonable person *in the resident’s position*. Thus, in determining the severity of the deficiency’s impact, surveyors can consider factors such as the resident’s physical or mental vulnerability, the resident’s trust in the facility, and the resident’s reliance on the facility to fulfill his or her basic needs. CMS also noted that, due to a resident’s inability to express him or herself, the true psychosocial result of abuse may not be apparent at the time of investigation.

## REPORTING POLICY REQUIREMENTS

CMS relocated certain requirements included under F-Tag F608 (Reporting of Reasonable Suspicion of a Crime) into F-Tags F607 (Develop/Implement Abuse/Neglect, etc. Policies) and F609 (Reporting of Alleged Violations). Specifically, CMS moved the requirements at 42 C.F.R. 483.12(b)(5)(ii)-(iii) (requiring posting of employee rights and prohibiting retaliation against employees for reporting crimes) into F607. CMS also moved the requirements at 42 C.F.R. 483.12(b)(5)(i)(A)-(B) (requiring annual notifications to covered individuals of their obligation to report suspicions of crime) into F609. Beyond the above reorganizations, CMS also added guidance under F607 outlining facilities’ obligations to develop policies and procedures on communicating and coordinating situations of abuse, neglect, misappropriation, and exploitation with the facility Quality Assurance & Performance Improvement (QAPI) program. With respect to F609, CMS added guidance highlighting that the mere presence of a policy on reporting of crimes is not sufficient for compliance, but that a facility must ensure such policies are properly implemented. CMS also added substantial guidance under F609 on reporting crimes through initial and follow-up investigation reports, as well as examples and discussion of reportable and non-reportable incidents relating to mental/verbal conflict, sexual contact, physical altercations, injuries of unknown source, neglect, and misappropriation of resident property/exploitation. Finally, CMS included under F609 an “Investigative Protocol” for policies and procedures related to reporting of reasonable suspicion of a crime. Providers are encouraged to review the guidance in the revised SOM Appendix PP under F607 and F609, especially the newly added guidance outlined above.

## OTHER CHANGES

Beyond the above items, CMS also included updated guidance in the following areas:

- F700 (Bed Rails): CMS included additional guidance under F700 outlining facilities’ obligations to consider available alternatives prior to installing and using bed rails, and to evaluate appropriateness and safety of using bed rails for different types of resident beds.
- F697 (Pain Management): CMS updated its guidance on the use of opioids for pain management, emphasizing the importance of ensuring opioids are prescribed at the lowest possible effective dosage for the shortest amount

of time in light of concerns around opioid abuse. CMS also noted that facilities should take into account residents with a history of opioid use disorder (OUD), and to consider non-opioid pain medications or non-pharmacological approaches to pain management.

- F699 (Trauma-Informed Care): CMS added new guidance concerning “Trauma-Informed Care” under F-Tag F699, defined generally as “an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma.” The guidance outlines general approaches that facilities can take with respect to assessing and accounting for past trauma, re-traumatization triggers, and cultural sensitivities among residents. Providers are encouraged to review this guidance, noting that failure to implement culturally competent and/or trauma-informed care is now listed as a key element of noncompliance.

## WHAT THIS MEANS FOR PROVIDERS

The above highlights are not inclusive of all updates required under the revised Appendix PP guidance and other guidance materials released in connection with QSO-22-19-NH. Providers are strongly encouraged to review the revised Appendix PP guidance in detail to ensure they have a comprehensive understanding of the updates that will come into effect on October 24, 2022, and to make any adjustments to their policies, procedures, and practices accordingly. Facilities should also ensure applicable leadership, staff, and other stakeholders within the facilities are notified of the upcoming guidance changes. CMS has made additional training materials available through its [Quality, Safety, and Education Portal](#). We have included links to these materials below. If you have any questions or need further guidance regarding QSO-22-19-NH or the revised Appendix PP or other related materials issued by CMS, please contact a member of Hancock Daniel’s [Long-Term Care & Post-Acute Care](#) team.

SUBJECT AREA	TRAINING VIDEO	TRAINING SLIDES
Resident Rights	<a href="#">Video</a>	<a href="#">Slides</a>
Freedom from Abuse & Neglect	<a href="#">Video</a>	<a href="#">Slides</a>
Psychosocial Outcome Severity Guide	<a href="#">Video</a>	<a href="#">Slides</a>
Admission, Transfer, & Discharge Rights	<a href="#">Video</a>	<a href="#">Slides</a>
Quality of Life	<a href="#">Video</a>	<a href="#">Slides</a>
Quality of Care	<a href="#">Video</a>	<a href="#">Slides</a>
Trauma-Informed Care	<a href="#">Video</a>	<a href="#">Slides</a>



Physician Services	<a href="#">Video</a>	<a href="#">Slides</a>
Nursing Services	<a href="#">Video</a>	<a href="#">Slides</a>
Behavioral Health Services	<a href="#">Video</a>	<a href="#">Slides</a>
Pharmacy Services	<a href="#">Video</a>	<a href="#">Slides</a>
Food & Nutrition Services	<a href="#">Video</a>	<a href="#">Slides</a>
Administration	<a href="#">Video</a>	<a href="#">Slides</a>
PBJ Data Submission	<a href="#">Video</a>	<a href="#">Slides</a>
Quality Assurance & Performance Improvement (QAPI)	<a href="#">Video</a>	<a href="#">Slides</a>
Infection Control	<a href="#">Video</a>	<a href="#">Slides</a>
Compliance & Ethics Program	<a href="#">Video</a>	<a href="#">Slides</a>
Physical Environment	<a href="#">Video</a>	<a href="#">Slides</a>
Training Requirements	<a href="#">Video</a>	<a href="#">Slides</a>

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