Q&A with IDOH (February 13, 2025)

Q1: Hoping to get some clarification: Resident's Right to be informed states "PRIOR to initiating or increasing a medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication." In an emergent situation such as need for hospitalization, timely initiation of an antibiotic, wound care treatment, etc.; and the nurse is unable to reach the resident representative, can the nurse proceed with the physician's order as it is in the best interest of the resident?

A: A good faith effort to notify the family/resident representative is key, and this should be documented. The nurse would initiate the physician ordered treatments if they were in the best interest of the resident.

F580 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.10(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment (or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or therapy that has not been used on that resident before).

Q2: Does a facility need consent prior to GDR attempts?

A: It would go back to resident/family/representative rights to be informed. Possibly when initiating, educate the resident/family/representative that there could be a GDR. We would not look for consent for GDRs unless a concern was brought to our attention.

F605

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.

Q3: Discharge -- does this consider that a resident admitted can change and new conditions, behaviors are new and then because things change ..... the facility can no longer meet the needs. Example: a resident admitted to a facility that is not a vent provider and then becomes in need of vent --- I am sure they can be transferred?

A: Yes, they would then be transferred to a facility that could meet their needs and would follow all the transfer and discharge guidance.

Q4: Is it only informed written consents signed by resident or resident representative are the only one acceptable prior to initiation of psychotropic medication? Can a verbal consent be considered as well?

A: Answering the question, yes verbal consent would be considered. Documentation of this consent should include that the resident/family/representative was informed of the benefits, risks, any alternatives, including any black box warnings for antipsychotic medications. Follow the facility policy for verbal notification/consent.

New Guidance for effective 3/24/25

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 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.

Q5: Do these requirements apply to the Respite stay planned discharge back home?

A: This is a question we can pose to CMS. There is no mention of respite care specifically in the Appendix PP of the State Operations Manual. The facility should have an admission/discharge policy that should include respite care if they provide that service. We would expect the discharge summary, medication reconciliation, etc. We would not expect the 30-day notice.

RAI Manual

Respite refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and an OBRA Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission. Entry and discharge MDS must be completed.

Q6: EBP - PPE be placed outside the resident room?

A: Refer to the next question Q7

Q7: For EBP rooms, would placing the gowns in a holder just inside the room door be acceptable? Or do they have to remain outside of the room. Originally we were told to place EBP PPE inside the resident rooms

A: We do not have concerns with PPE being stored inside the room if it is accessible before high contact activities. Other TBP such as Contact Isolation would follow current recommend guidance and facility policy.

F 880:

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..

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.

Q8: A provider stated to me that she had participated in recent Q-Source training during which they were informed that there would be no further "interactions" between staff and surveyors during the survey process after 2/24"- basically, no ability to provide additional information, discuss concerns, etc. I have not read anything that would lead me to believe this is accurate. Are you aware of the origin of this statement?

A: We have not heard this.

Q9: During the same training, the provider indicated it was taught facilities would need "wet signatures" for consent for any psychoactive medications (e.g., documented telephone consent and/or e-signatures would not be accepted). I have not read anything that would lead me to believe this is accurate. Are you aware of the origin of this statement?

A: We have not heard this. The guidance does not mention "wet signatures."

New guidance for 3/24/25

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Q10: Per review of the interpretive guidance for chemical restraints, it would appear that notification/consent is now required for any initiation, increase or decrease of any psychoactive medication (routine or PRN). Would you concur that is correct? It will be per facility policy that manner in which consent is gained and documented. Would you concur that this is correct?

A: The new guidance does not address notification with GDRs. Refer to Q2.

New guidance for 3/24/25

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Q11: A provider questioned whether there would be any exception for the resident on hospice who has a PRN anxiety ordered (and continued) due to the dying process.

A: The resident/family/representative would be informed and consent received prior to psychoactive medication initiation. If the medication is PRN, the order would need to be renewed every 14 days as per the regulation.

F605 new guidance: Associated risks (e.g., nausea, insomnia, itching) exist regardless of the indication for their use, therefore the psychotropic medication requirements 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.

F 684 Hospice services

Symptom Management - Symptom management may include controlling nausea, vomiting, uncomfortable breathing, agitation, and pain. Symptom management may include both pharmacological and nonpharmacological interventions consistent with the resident's choices and goals for comfort, dignity and desired level of alertness. (For concerns related to medications, refer to F605 Chemical Restraints/Unnecessary Psychotropic Medications and F757 Unnecessary Medications);

F697 Pain

Medication regimens for residents receiving end of life, palliative, or hospice care may include opioids alone or combining opioids and benzodiazepines; their use must be consistent with accepted standards of practice for this specialty of care.

Q: Regarding the revised language in "CPR" which states, "training includes a hands-on session either in a physical or virtual instructor-led setting"- can you confirm this would include synchronous virtual, during which the instructor is virtual but has the ability to assess the performance on the mannequin real-time? I am told there is equipment/programs now, during which the mannequin/program can sense the compressions, etc., and will beep when performed inaccurately, thus, the virtual

instructor can attest to hands-on performance. Are these types of programs what is acceptable as "virtual instructor-led settings?"

A: After reviewing virtual programs, there are virtual programs that come with kits for hands-on work, with the virtual instructor. There would have to be a live virtual hands-on session with a mannequin or other kit items.

Q: I had a provider contact me and was under the impression the facility MUST offer RSV vaccinations. As there is no source of payment for the Medicaid recipient, the provider questioned how this is to be accomplished. I responded that my understanding is the facility must offer/provide influenza, pneumococcal and COVID. While education of RSV (and other vaccinations) is helpful, I don't' see them as mandated. Can you clarify?

A: There is no guidance in the SOM that directly reflects RSV vaccinations.