Virginia Long-Term Care Clinician Network Monthly Forum

May 21, 2025

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues.

Please use the chat box:

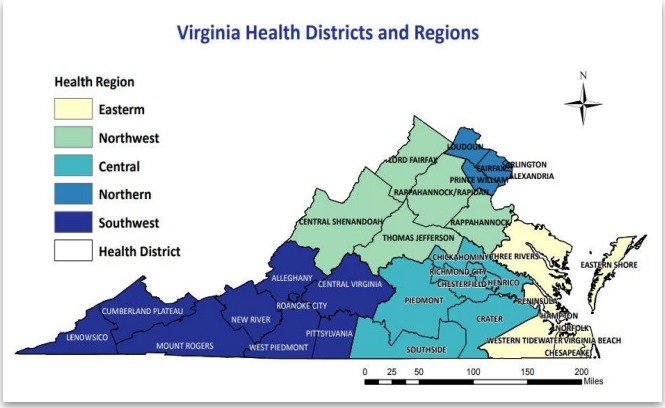
Your name

Any summer vacation suggestions or plans?

Happy Graduation for folks who have family graduating this May or June!

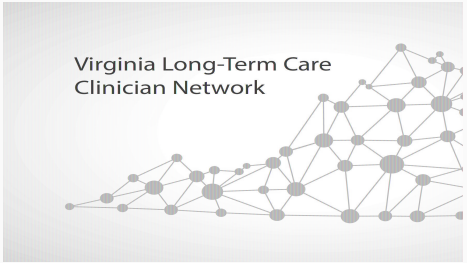
Welcome New Members!

Michael Steinberg - Northwest, Northern
Arline Bohannon - Central
Sarah Wells - Eastern
Colette LaVoy - Eastern
Heather Mullen - Eastern
Tabitha Smith - Eastern



Remind your work colleagues to attend so they can get Education, Support and CME!

304 Members Strong!



For great resources: look for previous slide sets and newsletters under *Forums & Events* and *Resources* on our website.

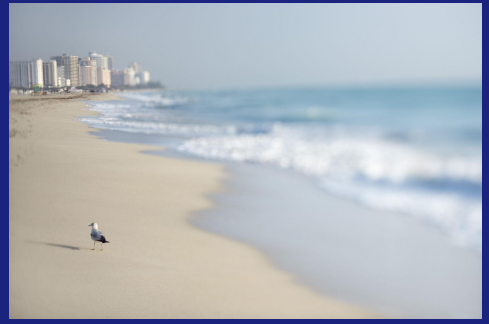
ltccn.vcu.edu

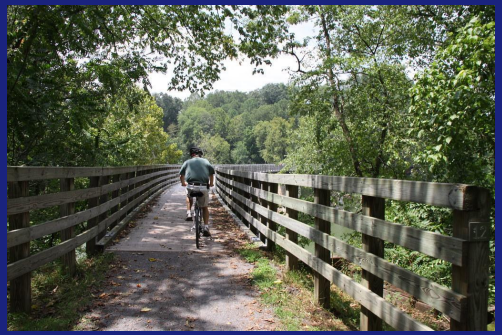
Poll

1. One Week
2. Two Weeks
3. Three Weeks
4. Month
5. Sabbatical for extended time

(pictured: Va Beach, Historic Williamsburg, Creeper Trail, Torpedo Factory, Carter Mountain)

Since working in health care what is the longest vacation you have ever taken?





Ice Breaker Question

Do your facilities have input from insurance companies about hospital transfers to improve outcomes?

A. Yes
B. No
C. No idea?

A Guardian investigation finds insurer quietly paid facilities that helped it gain Medicare enrollees and reduce hospitalizations. Whistleblowers allege harm to residents

UnitedHealth Group, the nation's largest healthcare conglomerate, has secretly paid nursing homes thousands in bonuses to help slash hospital transfers for ailing residents - part of a series of cost-cutting tactics that has saved the company millions, but at times risked residents' health, a Guardian investigation has found.

Those secret bonuses have been paid out as part of a UnitedHealth program that stations the company's own medical teams in nursing homes and pushes them to cut care expenses for residents covered by the insurance giant.

In several cases identified by the Guardian, nursing home residents who needed immediate hospital care under the program failed to receive it, after interventions from UnitedHealth staffers. At least one lived with permanent brain damage following his delayed transfer, according to a confidential nursing home incident log, recordings and photo evidence.

"No one is truly investigating when a patient suffers harm. Absolutely no one," said one current UnitedHealth nurse practitioner who recently filed a congressional complaint about the nursing home program. "These incidents are hidden, downplayed and minimized. The sense is: 'Well, they're medically frail, and no one lives for ever.'"

UnitedHealth said the suggestion that its employees have prevented hospital transfers "is verifiably false". It said its bonus payments to nursing homes help prevent unnecessary hospitalizations that are costly and dangerous to patients and that its partnerships with nursing homes improve health outcomes.

https://www.theguardian.com/us-news/2025/may/21/unitedhealth-nursing-homes-payments-hospital-transfers

April 2025 Regulatory Updates

for PALTC Clinicians

Carl J. “Christian” Bergman, MD, CMD, FACP, AGSF
Associate Professor, Division of Geriatric Medicine, VCU

I have no relevant conflicts of interest.

Recent Regulatory Changes

QSO-25-14-NH

https://www.cms.gov/files/document/qso-25-14-nh.pdf

Effective April 28, 2025

Appendix PP of the State Operations Manual Modifications

Last major update since 2016, “phase 3” prior Appendix PP updates were to roll out right before COVID, around 2017 - 2020

F Tag Changes

1. **F-605 (Right to be Free From Chemical Restraints / Unnecessary Psychotropic Medications)**
2. F-620 (Admission Agreement)
3. **F-627 (Inappropriate Transfer or Discharge)**
4. **F-628 (Transfer/Discharge Process)**
5. F-641 (Accuracy/Coordination/Certification of Assessments)
6. F-658 (Services Provided Meet Professional Standards)
7. F-678 (Cardio-Pulmonary Resuscitation CPR)
8. **F-697 (Pain Management)**
9. F-725 (Sufficient Nursing Staff)

F Tag Changes

11. F-727 (RN 8 Hrs/7 Days/Wk, Full Time DNS)
12. F-732 (Posted Nurse Staffing Information)
13. **F-757 (Drug Regimen is Free from Unnecessary Medications)**
14. **F-841 (Responsibilities of Medical Director)**
15. F-851 (Payroll-Based Journal)
16. **F-867 (QAPI/QAA Improvement Activities)**
17. **F-880 (Infection Prevention and Control)**
18. **F-887 (COVID-19 Immunization)**
19. F-918 (Bedroom Equipped/Near Lavatory/Toilet)

Psychotropic Meds

F-605 (Right to be Free From Chemical Restraints / Unnecessary Psychotropic Medications)

- Combines F-605 (Free from Chemical Restraints) with F758 (Free From Unnecessary Psychotropic Meds)
- General reminders,
  - Psychotropic Drugs - antipsychotic, antidepressant, anti-anxiety, hypnotic
  - Unnecessary Drugs red flags
    - Excessive dose / duplicate drug therapy
    - Excessive duration (ie GDR)
    - Monitoring? Indication for Use
    - Worsening side effects without changes in medication
  - Gradual Dose Reduction, PRN limits to 14 days

Psychotropic Meds

F-605 (Right to be Free From Chemical Restraints / Unnecessary Psychotropic Medications)

- New Components
  - Special guidance around “convenience” and “discipline”
  - Strong emphasis of documentation of non pharm interventions
  - Right to be informed, ie consent
    - does not specify written vs. verbal but documentation must be documented in medical record (risks/benefits, alternatives, free to choose treatment)
  - Special emphasis on documentation to support schizophrenia diagnosis

Appendix PP

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.

Unnecessary Medications

F-757 (Drug Regimen is Free from Unnecessary Medications)

- Reminders, drug is unnecessary in following situations
  - Excessive dose (or duplicate therapy)
  - Excessive duration
  - Without adequate monitoring
  - Without adequate indications for use
  - Ongoing use despite adverse side effects
- New
  - Discusses need for ongoing comprehensive assessment - did the underlying condition improve? Did it resolve?
  - Think
    - Antibiotics (end date, UTI 3-5 days, abx >10 days require strong rationale)
    - Antipsychotics started in hospital for delirium (may be continued on admission but once resolved, need to discontinue)

Appendix PP

"Adequate Indications for use" *refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals, and after any safer treatments have been deemed clinically contraindicated. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals.*

Appendix PP

Duplicate therapy *refers to two or more medications of the same pharmacological class/category without a clear distinction of when one medication should be administered over another. Duplicate therapy is generally not indicated, unless current clinical standards of practice and documented clinical rationale confirm the benefits of multiple medications from the same class or with similar therapeutic effects. Some examples of potentially problematic duplicate therapy include use of more than one medication containing the same ingredient, use of more than one drug within the same class, or medications from different therapeutic categories with similar effects or properties.*

The risk for polypharmacy and duplicate therapy is particularly high during transitions of care, especially if medications are not tracked closely between locations or within the care settings. Documentation is necessary to clarify the rationale for each medication and the approach to monitor the benefits and any adverse consequences.

Transfers and Discharges

F-627 (Inappropriate Transfer or Discharge)
F-628 (Transfer/Discharge Process)

- Updated guidance on discharge in an unsafe manner (location, services/support, resident preferences).
- Updated guidance on return to the facility (cannot decline a resident return without an updated assessment of the resident stating that residents needs cannot be met or safety/health of others is in danger).

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

In *situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility,* documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

Pain Management

F-697 (Pain Management)

- New definitions, updated guidance on opioid management, “right to be informed” of risks of opioid use

“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)).*

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

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Pain Management

F-697 (Pain Management)

- Initiate opioids for pain management - “may consider prescribing immediate-release opioids” instead of long-acting
- Use of PRN - see paragraph

Pain Management

Factors influencing the selection and doses of medications include the resident's medical condition, current medication regimen, nature, severity, and cause of the pain and the course of the illness. Analgesics may help manage pain; however, they often do not address the underlying cause of pain. Examples of different approaches may include, but are not limited to: administering lower doses of medication initially and titrating the dose slowly upward, administering medications "around the clock" rather than "on demand" (PRN); or combining longer acting medications with PRN medications for breakthrough pain. Recurrent use of or repeated requests for PRN medications may indicate the need to reevaluate the situation, including the current medication regimen. Some clinical conditions or situations may require using several analgesics and/or adjuvant medications (e.g., antidepressants or anticonvulsants) together. Documentation helps to clarify the rationale for a treatment regimen and to acknowledge associated risks.

Medical Director

F-841 (Responsibilities of Medical Director)

- General long-standing requirements
  - implementation of resident care policies
  - coordination of medical care in the facility
- New requirements
  - expansion of resident care policies to include “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 QAA (“having a designee does not change or absolve the Medical DIrector to fullfill his or her role as a member of the QAA committee”)
  - active involvement in facility assessment - F838

Medical Director

In addition, the medical director responsibilities should include, but are not limited to:

- *Administrative decisions including recommending, developing and approving facility policies related to residents 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; and*

Medical Director

INVESTIGATIVE **PROCEDURES**

If a deficiency has been identified regarding a resident's care, also determine if the medical director had knowledge or should have had knowledge of a problem with care, or physician services, or lack of resident care policies and practices that meet current professional standards of practice and failed:

- To get involved or to intercede with other physicians or practitioners to facilitate and/or coordinate medical care; and/or
- To provide guidance for resident care policies.

Interview the medical director about his/her:

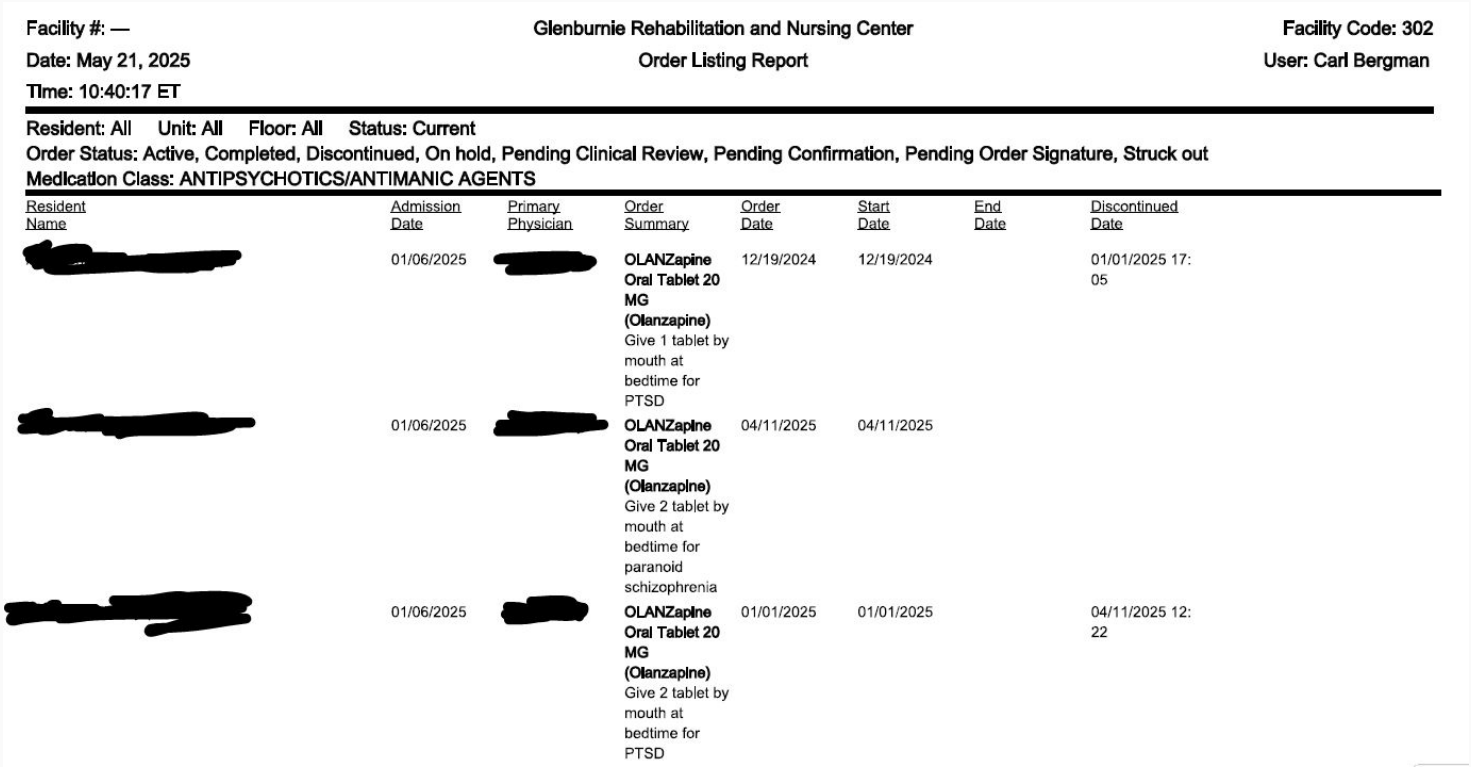
- Involvement in assisting facility staff with resident care policies, medical care, and physician issues;
- Understanding of his/her roles, responsibilities and functions and the extent to which he/she receives support from facility management for these roles and functions;
- Process for providing feedback to physicians and other health care practitioners regarding their performance and practices, including discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current professional standards of care;
- Input into the facility's scope of services including the capacity to care for residents with complex or special care needs, such as dialysis, hospice or end-of-life care, respiratory support with ventilators, intravenous medications/fluids, dementia and/or related conditions, or problematic behaviors or complex mood disorders;
- His/her participation or involvement in conducting the Facility Assessment and the Quality Assessment and Assurance (QAA) Committee.

Medical Director

F-841 (Responsibilities of Medical Director)

- Opportunities for Medical Directors
  - Attend weekly risk meeting
  - Attend QAPI monthly
  - Attend weekly QM meeting
  - Host a quarterly or monthly medical staff meeting
  - Ask for an order listing of psychotropic medications with indication for use, duration, and last medication change (see example next page)
  - Meet weekly or monthly with DON/Administrator regarding resident care and staffing concern
  - Yearly, review facility assessment for staffing
  - Yearly, review facility policies/procedures, both administrative and clinical/nursing

Medical Director - Order Listing Report



Facility #: —
Glenburnie Rehabilitation and Nursing Center
Facility Code: 302
Date: May 21, 2025
Order Listing Report
User: Carl Bergman
Time: 10:40:17 ET

Resident: All Unit: All Floor: All Status: Current
Order Status: Active, Completed, Discontinued, On hold, Pending Clinical Review, Pending Confirmation, Pending Order Signature, Struck out
Medication Class: ANTIPSYCHOTICS/ANTIMANIC AGENTS

Resident Name	Admission Date	Primary Physician	Order Summary	Order Date	Start Date	End Date	Discontinued Date
[redacted]	01/06/2025	[redacted]	**OLANZapine Oral Tablet 20 MG (Olanzapine)** Give 1 tablet by mouth at bedtime for PTSD	12/19/2024	12/19/2024		01/01/2025 17:05
[redacted]	01/06/2025	[redacted]	**OLANZapine Oral Tablet 20 MG (Olanzapine)** Give 2 tablet by mouth at bedtime for paranoid schizophrenia	04/11/2025	04/11/2025		
[redacted]	01/06/2025	[redacted]	**OLANZapine Oral Tablet 20 MG (Olanzapine)** Give 2 tablet by mouth at bedtime for PTSD	01/01/2025	01/01/2025		04/11/2025 12:22

Medical Director - Antipsychotics Report

Active Antipsychotic Medications at Glenburnie

Putpsoe of this document / list is to track all antipsychotics at Glenburnie (QM involved is SS antipsychotics and LS antipsychotics). Need to look at medication, indication/dx, duration, GDR, if schizophrenia documentation correct?, etc.). Run
antipsychotics are after day 100 regardless of whether started here or before.

Resident Name	Original Admission Date	Days since admission	SNF/ITC Resident	Antipsychotic Drug Name	Dose	Frequency	Indication	if Schizophrenia, date w/ documentation	Primary Attending	PTA Med	Date Medication Started	Date Medication Dose Last Adjusted
[redacted]	12/19/2024	153	LTC	olanzapine	40 mg	nightly	paranoid schizophrenia	12/24/2024 in psych note	[redacted]	Yes	12/19/2024	Increased 1/1/25
	5/9/2025	12	SNF	olanzapine	5 mg	BID	psychotic disorder			Yes	5/9/2025	
	10/30/2024	203	LTC	quetiapine	25 mg	nightly	bipolar disorder with psychotic features			No	12/31/2024	Increased 3/8/25

SS QM Trigger	LS QM Trigger	GDR (last date/documented?)	Notes / Actions
No	Yes but need to correct Dx	3/12/25 - docuemnted that GDR clinically contraindicated	none
			clarify diagnosis
No	Yes	failed GDR 1/13/25; restarted 3/8/25; clinically contraindicated 3/7/25	none

QAPI/QAA

F-867 (QAPI/QAA Improvement Activities)

- New definition for health equity
- Directs facilities to:
  - consider feedback related to health equity
  - monitor data on outcomes related to health equity
  - consider factors that impact health equity
  - include an evaluation of factors known to affect health equity (race, sexual orientation, socioeconomic status, preferred language, etc.)

Infection Prevention and Control

F-880 (Infection Prevention and Control)

- Added new definition of enhanced barrier precautions
- 4 situations when contact is required vs. enhanced barrier (see next slide)

EBP v. Contact

Implementing Contact versus Enhanced Barrier Precautions

This table only applies to MDROs not all pathogens that may require use of transmission-based precautions.

Resident Status	Contact Precautions	Use EBP
Infected or colonized with any MDRO and has secretions or excretions that are unable to be covered or contained	Yes	No
Infected or colonized with a CDC-targeted MDRO **without** a wound, indwelling medical device or secretions or excretions that are unable to be covered or contained.	No	Yes
Infected or colonized with a non-CDC targeted MDRO **without** a wound, indwelling medical device, or secretions or excretions that are unable to be covered or contained.	No	At the discretion of the facility
Has a wound or indwelling medical device, **and** secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO.	Yes, unless/until a specific organism is identified.	Yes, if they do not meet the criteria for contact precautions.
Has a wound or indwelling medical device, **without** secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO.	No.	Yes.

Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen.

MDRO Colonization / Infection

MDRO Colonization and Infection

Contact precautions are used for residents infected or colonized with MDROs in the following situations:

- *Presence of acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained;*
- *Co-infection with another organism for which Contact Precautions is recommended (e.g., norovirus);*
- *For a limited time period, as determined in consultation with public health authorities, on units or in facilities during the investigation of a suspected or confirmed MDRO outbreak; and*
- *When otherwise directed by public health authorities.*

COVID-19 Immunization

F-887 (COVID-19 Immunization)

- **New Ftag - content originally in separate tag under QSO memo in 2021**

Surveyor Review Documents and Critical Element Reviews

Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) Review

- ☐ Does the facility collect, use, and monitor data for the QAPI program that represents its full range of facility care and services? *If no, review the P&Ps for how the facility identifies, collects, analyzes, and routinely (e.g., quarterly) monitors data for systemic high-risk, high-volume, and/or problem-prone areas, including adverse events, and based on the facility assessment (F838).*
- ☐ Does the facility use feedback (e.g., from residents, resident representatives and staff) as part of its QAPI program? *If no, review the P&Ps for how the facility obtains and uses feedback from residents and staff to identify issues and improvement opportunities.*
- ☐ After implementing actions to improve performance, does the facility measure its success and track performance to ensure improvements are realized and sustained? *If no, review the P&Ps for how the facility monitors the effectiveness of its performance improvement activities to ensure improvements are sustained.*
- ☐ Does the facility conduct at least one performance improvement project (PIP) annually that focuses on high-risk or problem-prone areas, identified by the facility, through data collection and analysis?
- ☐ Does the QAA committee regularly review and analyze data collected under the QAPI program and resulting from drug regimen reviews, *prioritize activities,* and *develop and implement plans of action to correct identified quality deficiencies*?

Note: For concerns related to the development and implementation of policies and procedures to coordinate with the QAPI program regarding situations of abuse, neglect, misappropriation of resident property, and exploitation, see F607 (§483.12(b)(4)).

1. **Did the facility develop *and implement P&Ps* for data collection systems, *feedback,* monitoring, *analysis, and action,* including adverse event monitoring?** ☐ **Yes** ☐ **No F867** *(if the surveyor is able to validate QAPI activities and is not prompted to review P&Ps, mark Yes)*

2. **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?** ☐ **Yes** ☐ **No F867**

Surveyor Review Documents and Critical Element Reviews

Sufficient and Competent Nurse Staffing Review

INTERVIEWS

Residents/Resident Representatives or Family Members:

Staff Sufficiency *(probes addressed during the initial pool process and/or investigations)**:***

- ☐ *Do you feel that there is enough staff to meet your needs without having to wait a long time? If no, can you provide an example of your concern? Is there a specific time of day or weekends that are more problematic?*
- ☐ *Has anything occurred because you had to wait for staff to respond and assist you? How often does this occur? For example, not being assisted per toileting plan and incontinence occurs, or staff taking too long to respond to call light resulting in a fall.*
- ☐ *Do you routinely eat in your room? If so, is this your choice? If it is not your choice, why are you routinely eating in your room?*
- ☐ *If needed, is assistance provided to help you get to and from areas in the NH, such as the dining room or activities?*
- ☐ *Are you able to wake, dress, eat, or engage in other activities at times you prefer? If not, why not?*
- ☐ *Do you get your medications on time?*
- ☐ *Has the facility informed you that care could not be provided because there wasn't a LN available?*

If the surveyor is aware of the absence of an RN for at least 8 consecutive hours a day on one or more days also ask:

- ☐ *Has the facility informed you that care could not be provided because there wasn't an RN available (e.g., IV medication)?*

Staff Competency:

- ☐ *Do you think the nursing staff are experienced and knowledgeable when providing your care? If not, what concerns have you experienced? For example, was there a time when you didn't feel well, if so, did staff assist you? Did you require hospitalization?*

Front-Line Nursing Staff (nurses and nurse aides) Interviews:

During interactions with staff ask if they feel they have enough staff to meet resident needs and the training/skills needed to provide the care required. If no, interview staff further using the probes below to further evaluate staff sufficiency and competency.

Surveyor Review Documents and Critical Element Reviews

Unnecessary Medications, *Chemical Restraints*/Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Interviews:

- ☐ *Has a resident had a change in condition, diet, weight loss, dehydration, or acute illness? If so, what was done to assess the possible complications for these changes due to medications?*
- ☐ *How are medication-related issues communicated to other staff, the attending practitioner or prescribing practitioner, and resident and, if appropriate, resident representative?*

Attending Physician:

F757

- ☐ *What is the clinical indication for why the medication is being used (e.g., antipsychotic for dementia or other high-risk medications)?*
- ☐ *How do you assess whether each medication is effective?*
- ☐ *How did you involve the resident in decisions regarding medications?*
- ☐ *Have you been informed that the resident had any adverse reaction or side effects? If so, how were the side effects or adverse reaction addressed?*
- ☐ *How do you evaluate whether medications should be initiated, continued, reduced, discontinued, or otherwise modified? How often is the evaluation for modification conducted?*
- ☐ *Why does the resident have multiple medications in the same class?*
- ☐ *Are you included in the IDT meeting for this resident?*
- ☐ *If the amount of any medication exceeds the manufacturer's recommendations, clinical or evidence-based practice guidelines, or standards of practice, what is the rationale?*

F605 -- use the questions from F757 along with the following:

- ☐ *If the resident is on a psychotropic medication, when did you attempt to reduce the medication and what were the results?*
- ☐ *What other approaches were attempted prior to the use of a psychotropic medication and/or while attempting a GDR?*
- ☐ *When was a GDR last completed? What was the result?*
- ☐ *If a GDR was not attempted, was a clinical rationale provided for not performing the GDR?*

Surveyor Review Documents and Critical Element Reviews

Unnecessary Medications, *Chemical Restraints*/Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Interviews:

Attending Physician, Medical Director, and DON:

F756

- ☐ *Did you receive a written report of irregularities identified during the MRR?*
- ☐ *How is the MRR process conducted for short-stay residents?*
- ☐ *How does the facility ensure a review of medications for GDRs?*
- ☐ *Did you make a change in the resident's medication in response to the identified irregularity(ies) or document a rationale if you didn't make a change in the medication regimen?*

Medical Director:

F757 and/or F605

- ☐ *When a concern is identified related to a practitioner's adherence to facility policies on establishing a diagnosis and prescribing medications, how are you made aware?*
- ☐ *What is your process for discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current professional standards of care?*
- ☐ *Were you aware that a medication was ordered for the resident and there was a a lack of documentation by the prescribing practitioner to support the diagnosis?*
  - *If yes, how did you address the lack of documentation?*
  - *If no, why not?*

Surveyor Review Documents and Critical Element Reviews

Record Review for residents with a diagnosis of schizophrenia:

When reviewing records for unnecessary medications, surveyors may find residents who are diagnosed with schizophrenia without sufficient supporting documentation. In these situations, does the medical record include documentation that meets the criteria in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for diagnosing schizophrenia:

- ☐ *Symptoms, disturbances, or behaviors consistent with and for the required period of time in accordance with the DSM criteria.*
- ☐ *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, and symptoms.*

Surveyors should look for documentation that supports the diagnosis of schizophrenia, however, it is the facility's responsibility to provide evidence of compliance. Surveyors should ask the facility to direct them to the section of the resident's medical record that supports the diagnosis. If the facility cannot provide supporting documentation or directs surveyors to a section of the medical record that does not have sufficient documentation, the facility is noncompliant for failing to provide sufficient evidence that professional standards of practice were followed. Note: The documentation must have occurred prior to start of the survey.

NOTE: A medical record note stating "schizophrenia," or "Seroquel/Quetiapine for schizophrenia" alone without other documentation as described above does not meet professional standards of quality to diagnose someone with schizophrenia.

Open Forum

Any questions or ideas from the talk?

Share an unidentifiable case to discuss

Do you have resources or professional meetings you could share in chat?

News/Reminders

Report all suspected cases of measles to your local health department immediately to ensure rapid testing and investigation.

ACIP April 15 and 16 Meeting:

- LTC pertinent: updates on RSV vaccination for adults 75 and older, risk based RSV lowered from 60 to 50 years,
- The meeting was shortened so only votes were: meningococcal disease, RSV vaccines for adults, and chikungunya (*note recent change to live attenuated vaccine not over 60)
- No influenza vaccines were included.
- New CDC director signatures on these updates pending once director in place. More information:

Business of Medicine Symposium
Presented by the Post-Acute and Long-Term Care Medical Association
June 4, 2025
Virtual

VAMDA Annual Conference - Excellence in Long Term Care
September 13, 2025
Virginia Beach

PALTmed Advocacy Summit
Presented by the Post-Acute and Long-Term Care Medical Association
October 27-28, 2025
Kimpton Hotel Monaco, Washington, DC

Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
	VCU Health designates this live activity for a maximum of ***1.00 AMA PRA Category 1 Credits***^{TM}. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education designates this activity for a maximum of ***1.00 ANCC*** contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for ***1.00 AAPA Category 1 CME credits***. PAs should only claim credit commensurate with the extent of their participation.

Disclosure of Financial Relationships

Disclosure of Commercial Support:

We acknowledge that no commercial or in-kind support was provided for this activity.

Claiming CE Credit

Submit Attendance

1. *If you have **not participated in a VCU Health CE program** in the past:*
   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
   a. Text the course code to (804) 625-4041.
   b. The course code for today's event is: 34862 *within **5** days of the event*

Complete Evaluation & Claim Credit, *(within 60 days of the event)*

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

Need help? ceinfo@vcuhealth.org

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Thank you for joining us!

Updates and News - See News Updates via email

Next Monthly Forum: **Wednesday, June 18, 4-5 pm**

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at vcoa@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu