Selected 2025* CMS Regulations Impacting the Treatment of Hallucinations and Delusions Associated With PD Psychosis

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The following information is provided for educational and scientific exchange purposes only.

Why is this important?

- All LTC team members must help ensure appropriate use of psychotropic medications
- Use of these medications must comply with all applicable clinical and regulatory guidelines
- Revisions to CMS requirements[1] and the State Operations Manual[2] provide important guidance relevant to the use of antipsychotic agents for the treatment of hallucinations and delusions associated with PD psychosis

Note: This document is not intended to be a comprehensive review of applicable CMS regulations nor is it intended as legal advice. Please consult the full regulations for complete information.

Could using an antipsychotic for hallucinations and delusions associated with PD psychosis be considered a chemical restraint?[2]

Summary from F605: Chemical Restraints

The facility must ensure that the resident is free from physical or **chemical restraints** imposed for purposes of **discipline** or **convenience** and that are not required to treat the resident's **medical symptoms**.

- Prior to psychotropic initiation, informed consent and non-pharmacological interventions must be documented.

See F605 §483.12(a)(2)

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, indicating that any medications that may contribute to/cause sedation should be re-evaluated as they could be considered a chemical restraint.

Does an antipsychotic medication for PD psychosis require a gradual dose reduction?[2]

Summary from F605: Chemical Restraints

The facility must ensure that residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions unless clinically contraindicated in an effort to discontinue these drugs.

- Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence. Compliance with the requirement to perform a GDR may be met if, for example, within the first year in which a resident is admitted on a psychotropic medication, a facility attempts a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.
- Some residents with specific, enduring, progressive, or terminal conditions such as chronic depression, PD psychosis, or recurrent seizures may need specific types of psychotropic medications or other medications which affect brain activity indefinitely.

See F605 §483.45(e)(2); previously discussed in F758

How does CMS define unnecessary drugs?[2]

Summary from F605: Chemical Restraints

Each resident's drug regimen must be free from **unnecessary drugs.**

Based on a comprehensive assessment of a resident, the facility must ensure that: Residents who have not used psychotropic drugs not receive these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.

- 'Other' medications e.g., anticonvulsants, antihistamines (not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotic) can also affect brain activity and should not be used as a substitution for the psychotropics, unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice.

See F605 §483.45(d) and §483.45(e)(1)

Staff convenience or resident discipline may be considered if psychotropic has caused symptoms consistent with **prolonged sedation** (e.g., excessive sleeping, drowsiness, withdrawal, decreased participation in activities).

Prior to psychotropic initiation, informed consent and non-pharmacological interventions **MUST** be documented.

Do hallucinations and delusions associated with PD psychosis need to be addressed?[2]

Summary from F740: Behavioral Health Services

Each resident must receive, and the facility must provide, the necessary behavioral health care and services to attain or maintain the **highest practicable physical, mental, and psychosocial well-being**, in accordance with the comprehensive assessment and plan of care.

- Residents should receive an individualized approach to behavioral health care, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.
- Behavioral health care and services should reflect the resident's goals for care, while maximizing his/her dignity, autonomy, privacy, socialization, independence, choice, and safety.

See F740 §483.40

Medical Director

Summary from F841: Medical Director

Responsibilities include ensuring practitioners adhere to facility policies on diagnosing and prescribing medications and intervening when medical care is inconsistent with current standards of care

See F841

References

1. Centers for Medicare and Medicaid Services (CMS) Requirements for Participation under the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. Available at: https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities. Accessed October 11, 2023.
2. Centers for Medicare & Medicaid Services. State Operations Manual: Revised Long-Term Care (LTC) Surveyor Guidance: Significant revisions to enhance quality and oversight of the LTC survey process. Baltimore, MD; 2025. Available at: https://www.cms.gov/files/document/qso-25-12-nh.pdf. Accessed March 7, 2025.

Abbreviations: CMS = Centers for Medicare & Medicaid Services; GDR = gradual dose reduction; LTC = long-term care; PD = Parkinson's disease.