ABSOLUTE SCOOP

DID YOU KNOW?

Since the Mega Rule of 2017, PRN antipsychotic orders may not exceed 14 days.

If the order is to continue after 14 days, the physician must re-evaluate the resident in person, document the clinical rationale, and issue a new 14-day order.

ANTIPSYCHOTIC USE IN LONG-TERM CARE FACILITIES – 2025 UPDATE

Written by Eric McCaw, RPh, BCGP, Consultant Pharmacist

Skilled nursing facilities have faced increasing regulations for antipsychotic therapy over the years. This started in 1987 with **OBRA**, which required psychotropic medications to be prescribed only for specific medical conditions, with gradual dose reductions (GDRs) and behavioral interventions. In 2005, studies linked antipsychotics to increased mortality in elderly dementia patients, resulting in the FDA issuing black box warnings for these medications. By 2012, CMS launched the National Partnership to Improve Dementia Care, an initiative designed to reduce off-label prescribing. Also, CMS began to publicly report antipsychotic rates, creating pressure on facilities to reduce antipsychotics.

The 2016–2017 **"Mega Rule"** went further by redefining the category of psychotropic medications, expanding documentation requirements for GDRs and non-drug interventions, and introducing the 14-day limit for PRN psychotropic orders. These combined efforts have produced national results: antipsychotic use among long-stay residents declined from 23.9% in 2011 to about 16.98% (adjusted) in 2025. This decline represents real progress, although CMS believes there is more to be done. In 2025, new regulatory changes have been implemented that facilities must understand and follow.

Why Avoid Antipsychotics in Long-Term Care?
Antipsychotics are high-risk medications for older adults with well documented adverse effects. These medications can cause sedation, dizziness, and impaired coordination, which increase fall risk and fractures. They may also worsen confusion, leading to functional decline and greater dependence on staff. Cardiovascular and infectious risks are also increased, with elevated rates of stroke, heart attack, pneumonia, and premature death. In addition, antipsychotics are known to cause extrapyramidal symptoms such as tremors and rigidity which further impair mobility. Also, metabolic effects like weight gain, hyperglycemia, and lipid abnormalities add to the side effect burden.

Because of these risks, FDA requires a black box warning for antipsychotics about increased mortality in elderly patients with dementia related psychosis. It is best practice to reserve antipsychotic prescribing for when other options have not been successful and the patient's symptoms pose an immediate danger or cause severe distress.

Updated Quality Measure: Long-Stay Antipsychotic Use
CMS tracks antipsychotic use through the Nursing Home Care Compare rating system. In the past, this measure used only on MDS reporting and excluded residents with the diagnoses of schizophrenia, Tourette's disorder, and Huntington's disease. However, CMS reports some of the excluded diagnoses have been inappropriately overused to lower reported rates.

Beginning October 29, 2025, CMS will revise the quality measure. The new calculation will combine Medicare and Medicaid claims data with MDS reporting and validate exclusion diagnoses against claims. As a result, the national prevalence of long-stay residents receiving antipsychotics will shift from 14.64% to 16.98%, not because of increased prescribing, but because of more accurate data capture. This change could affect the quality star ratings of facilities going forward.

Revised Surveyor Guidance: F605 and F757
CMS updated guidance to surveyors with changes to how antipsychotic prescribing will be evaluated during the survey process. Under the new guidance, **F605** now covers all psychotropic and antipsychotic medications, and surveyors are instructed to determine whether these drugs are being used for legitimate clinical reasons, rather than for staff convenience or as chemical restraints. Residents must be informed of the risks and have the right to accept or decline therapy. **F757** now applies only to non-psychotropic medications, while **F758**, which previously covered unnecessary psychotropics, has been eliminated and merged into **F605**.

ABSOLUTE PHARMACY

Continued on next page...

When evaluating an antipsychotic order, surveyors will expect to see the following documentation:

- Documented valid, evidence-based diagnosis to support antipsychotic use, along with clear identification of the specific behaviors or symptoms being treated. Vague terms such as “agitated” or “restless” should be avoided.
- The resident’s target behaviors present a danger to themselves or others, or cause significant distress. It is best to explicitly document this – not just imply it.
- Non-pharmacologic interventions were attempted without success, before the medication was ordered. Non-pharm interventions should still continue after AP therapy begins.
- Other treatments or medications are contraindicated or have failed for the targeted condition and symptoms.
- Informed consent from the resident or representative obtained before initiation or dose increases
- Ongoing monitoring of effectiveness / side effects
- Appropriate GDR attempts, or reasons GDR contraindicated

The 14-Day Rule

Since the Mega Rule of 2017, PRN antipsychotic orders may not exceed 14 days. If the order is to continue after 14 days, the physician must re-evaluate the resident in person, document the clinical rationale, and issue a new 14-day order. This prevents the indefinite continuation of PRN antipsychotics without reassessment.

Practical Strategies for Compliance

Develop a documentation safety net. When a new antipsychotic order is initiated or increased, a designated facility staff member should ensure documentation is in place for this order including all the items listed above, and also ensuring 14-day stop dates are in place for PRN antipsychotics. eMAR Antipsychotic report could be routinely generated to look for new orders to start this process.

Ensure appropriate diagnosis is consistent throughout the medical record for each antipsychotic order. Physician notes, the MDS, eMAR entries, and the order itself should align with the same diagnosis. For example, if the physician has properly documented schizophrenia, the order in the eMAR should not read “Risperidone 4mg po QD for behaviors.” Citations have resulted from these discrepancies.

Be wary of extremely low dose antipsychotic orders. For example, Seroquel 12.5mg po HS . These orders often are being used for sedation rather than an approved psychiatric condition where the therapeutic doses would be much higher. Although it is possible low dose orders could be appropriate, they are often opportunities to find safer alternatives. These can often be easily discontinued.

Conclusion

Antipsychotic regulations for skilled nursing facilities have steadily increased in recent years. The goal is to ensure residents receive the safest, most appropriate care possible. The 2025 updates emphasize that antipsychotics should never be a default solution, but rather a last resort after other strategies have failed. Facilities that approach the use of these medications with diligence and thorough documentation are best positioned to remain compliant and while protecting the well-being of their residents.

References

- *CMS – QSO-25-20-NH: Updates to Nursing Home Quality Measures and Guidance on Antipsychotic Use; https://www.cms.gov/files/document/qso-25-20-nh.pdf*
- *CMS – QSO-25-14-NH: Clarification of Guidance Related to Unnecessary Medications; https://www.cms.gov/files/document/qso-25-14-nh.pdf*
- *CMS – State Operations Manual, Appendix PP: Guidance to Surveyors for Long-Term Care Facilities; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf*

About the Author

Outside of work, Eric loves to spend time outdoors including hiking, running, backpacking, gardening, and photography. He enjoys traveling with his wife and 2 children.

Eric McCaw, RPh, BCGP is a Consultant Pharmacist. Eric graduated from The Ohio State University. He began working at Absolute Pharmacy as an in-house Operations Pharmacist in 2006. In 2010, he transitioned to consulting and has enjoyed working with many facility staff members throughout Ohio while striving to improve the lives of residents.

Why do cemeteries have fences?
Because everyone's dying to get in.

How do you fix a broken pumpkin?
With a pumpkin patch!