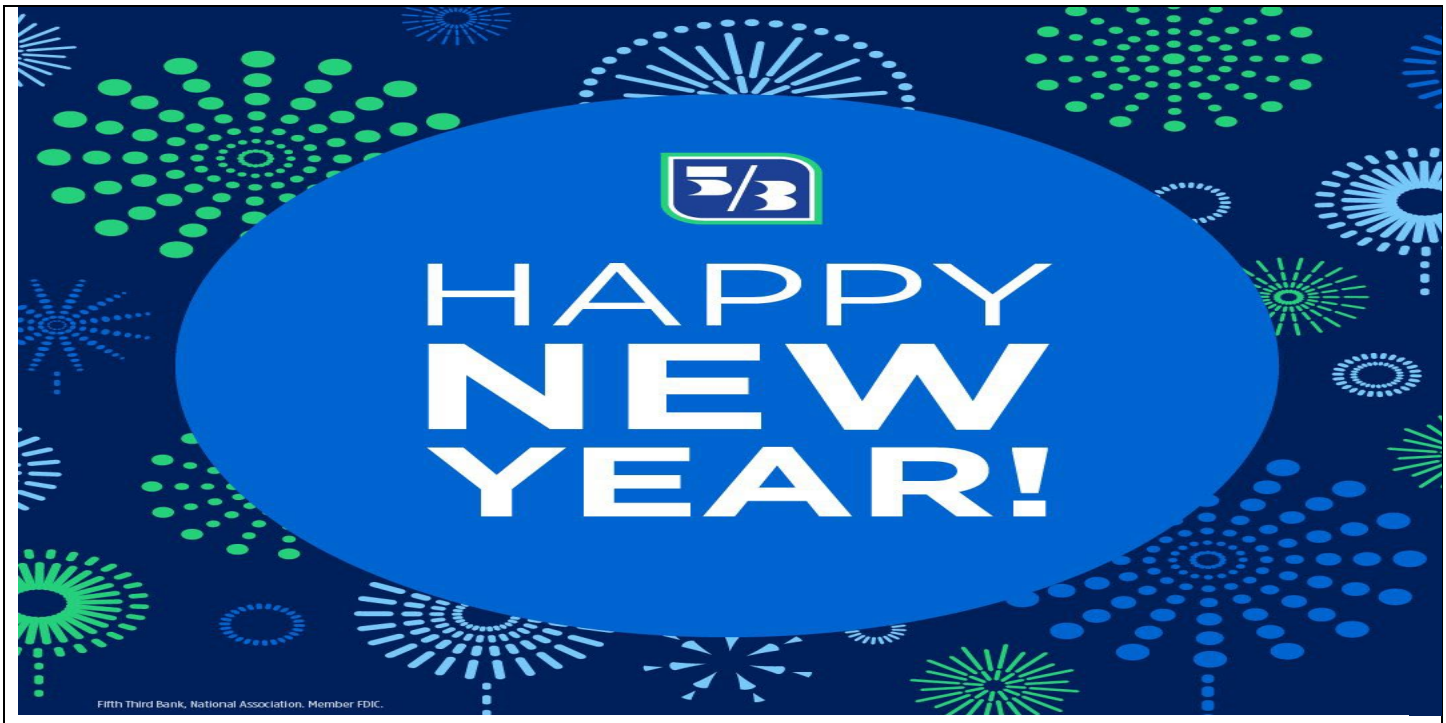
PADONA UPDATES 01/12/2026



HAPPY NEW YEAR! WELCOME 2026!

PADONA is excited to start a new year with all of you – our appreciated members, business partners and friends! We hope you were able to end 2025 with a fond look back at good memories with great friends at a work experience that was positive. We also hope that you started 2026 with the anticipation of even better things to come!

Thank you for allowing PADONA to continue to support you with education and information! We start the first newsletter of the year with a reminder that we have education webinars scheduled for 2026, and more are being added weekly and there is still time to get the great rate for the early bird annual conference registration!

REGISTRATION IS OPEN!
PADONA's 38th Annual Conference
Tuesday, March 24 – Friday, March 27, 2026
The Hotel Hershey • Hershey, Pennsylvania

Early Bird registration discounts are available through January 15, 2026!

As we start a new year, PADONA wishes each of you a healthy, safe and happy year and one that is professionally connected to YOUR nurse leader professional organization – PADONA!

THANK YOU FOR THE OPPORTUNITY TO SERVE AND SUPPORT YOU!

PADONA HOSTED EDUCATION WEBINARS

- **The Non-Negotiable Role of the Infection Preventionist in Long Term Care**
  Date: January 13, 2026
  Time: 11:30 am until 12:30 pm
  Educator: JoAnn Adkins of the PA Patient Safety Authority
  Registration Fee: $35 for members and $50 for non-members
- **Trauma Informed Care In The Nursing Home**
  Date: February 3, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Dr. Kathleen Weissberg, OTD, OTR/L, CMDCP, CDP, CFPS, CGCP, TIE, National Director of Education, Select Rehabilitation
  Registration Fee: $35 for members and $50 for non-members
- **GDR Completion: What Is Required**
  Date: March 5, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Edward Faulkner, Vice President Vital Healthcare Solutions
  Registration Fee: $35 for members and $50 for non-members
- **Documentation Support Required for External Audits**
  Date: April 14, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Stephanie Kessler, Partner, RKL
  Registration Fee: $35 for members and $50 for non-members

******Registration for all webinars closes at 9 am on the day of the webinar.**

******All PADONA hosted education is recorded for purchase at a low cost from the website.**

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Mark your calendars and plan to attend the annual PADONA Infection Preventionist Boot Camp
May 19 and 20, 2026 – 4 hours each morning with a break
Provided by IPRO – the PA QIO
More information to come!

PADONA ANNUAL CONFERENCE

REGISTRATION IS OPEN!
PADONA's 38th Annual Conference
Tuesday, March 24 – Friday, March 27, 2026
The Hotel Hershey • Hershey, Pennsylvania
We are thrilled to announce that registration is now open for PADONA's 38th Annual Conference! Join us this spring for four days of education, networking, and celebration at the beautiful Hotel Hershey.
Our full conference schedule will be released in the coming weeks, but don't wait—Early Bird registration discounts are available through January 15, 2026!
👉 Register online: padona.com/convention
Or contact: LuAnn White – luann@padona.com

Hotel Information
PADONA's discounted room block at The Hotel Hershey is now available.
📞 Call 855-729-3108 and request the PA Directors of Nursing Association 2026 block
🏷️ Room Rate: $299/night + 11% tax
🗓️ Room block closes: Thursday, March 5, 2026
(After this date, rates may increase and room availability is not guaranteed.)
📌 Online Reservations Link: https://www.thehotelhershey.com/gr/LQQU8HAIAE/
Important Notes for Online Booking
• You must use the link to receive the conference rate
• Copy/paste the link into a new browser window
• The link does not work in Internet Explorer
• Government-issued devices may block access—try a personal device if needed

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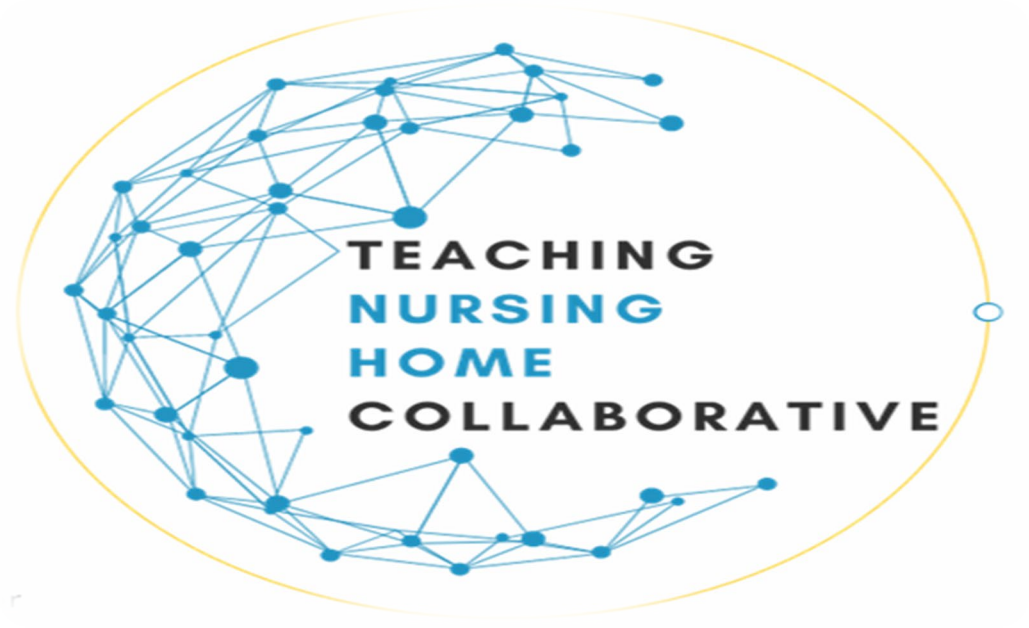
Why Attend in 2026?
✓ Mid-day kickoff on Tuesday—more flexibility for travel
✓ Hear the latest from regulatory leaders and industry experts
✓ Expand your network and share best practices with peers
✓ Dedicated time with vendors showcasing innovative solutions
✓ More free time for connection and collaboration
🎉 And don't miss our Thursday evening party featuring The Roustabouts, playing favorite hits from the 60s through today!

We can't wait to gather again in *The Sweetest Place on Earth!*
See you in Hershey this spring!

PADONA is a proud partner of the Teaching Nursing Home Collaborative



PADONA is proud to partner with the PA Department of Health Bureau of Epidemiology for education

Mid-Atlantic CMS QIN-QIO (Region 2)

QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Introducing the CMS QIN-QIO for the Mid-Atlantic Region

As the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network–Quality Improvement Organization (QIN-QIO) for the Mid-Atlantic region, Delaware, District of Columbia, Maryland, **Pennsylvania,** Virginia, and West Virginia, the collaborative team of IPRO, Healthcentric Advisors, and Qlarant is committed to delivering localized, high-impact support to healthcare providers.

With over 40 years of experience improving care for Medicare beneficiaries, this team offers tailored technical assistance, data-driven insights, and clinical expertise to help providers achieve meaningful, sustainable improvements.

Select hospitals, nursing homes, and outpatient clinical practices have been identified by CMS to participate in the 13th Scope of Work (SOW), a five-year quality improvement initiative which focuses on advancing healthcare quality and outcomes in CMS' priority areas, including:

- **Chronic disease management** and **preventive care** (e.g., hypertension, diabetes, kidney disease, adult immunizations)
- **Patient safety** and **harm reduction** (e.g., infections, adverse drug events, falls, pressure injuries)
- **Behavioral health access and quality** (e.g., depression, suicide prevention, substance use)
- **Care coordination** to reduce avoidable hospital and emergency department utilization
- **Infrastructure resilience** (e.g., workforce development, emergency preparedness, cybersecurity, drug shortage, supply chain)
- **Health IT** integration and optimization

Proud to partner with the Mid-Atlantic QIN-QIO Team on this CMS-funded initiative. Providers who receive an invitation are encouraged to join and take advantage of this opportunity to improve care and performance.

To learn more about the QIO, visit their **website** or contact the team at **QIN-QIOR2@ipro.org.**

Leadership Snippets

Great Leaders Boost Motivation and Avoid Quiet Quitting

The phrase quiet quitting has been cast as a generational rebellion, a disengagement crisis, and a leadership failure, all rolled into one. The narrative suggests that half of your workforce has decided to coast, collecting a paycheck while doing the bare minimum.

According to new global research fewer than 2% fit into the definition of quiet quitting, that is, employees who lack motivation to go above and beyond but still plan to stay with their company. That finding challenges the viral narrative, suggesting that what's happening inside organizations is more nuanced than a mass withdrawal of effort.

So, quiet quitting wasn't the crisis we thought it was, but leaders still face the challenge of unmotivated employees. This data suggests that leaders ought to focus on strengthening the conditions that inspire people to keep showing up with purpose, rather than on rooting out disengaged employees.

1. Listen like a scientist, not a detective

Leaders can approach disengagement as something to diagnose and fix, but employees can sense when conversations are driven by suspicion instead of curiosity. This means asking open-ended questions, such as "Do you feel like you're thriving? Why or why not?" and listening without defensiveness. When employees feel psychologically safe enough to share what's behind their behavior, leaders can address root causes instead of reacting to surface-level symptoms. That sense of safety is what enables employees to sustain high performance over time.

2. Focus on the 52% who are engaged and committed

Here's an overlooked insight: While fewer than 2% of employees are quiet quitting, more than half (52%) are both motivated and committed, which is the sweet spot for engagement. These are the employees carrying organizations forward, yet they often receive the least attention. Leaders need not wait for performance reviews to celebrate these employees. Recognize them and tie appreciation to future potential. Share something along the lines of, "Here's the impact you've made, and here's what's next."

3. Redefine retention: Don't fear turnover, design for flow

Even if employees are performing well, fear-based retention can limit their growth and engagement. Internal mobility programs, mentorship, and career-pathing initiatives can help employees find roles that are more fulfilling and energizing.

Leaders can explore this by asking questions like:

- "What keeps you here, and what would make your work even more energizing?"
- "Which parts of your role feel meaningful, and which feel stagnant?"
- "If you could design your next step here, what would it look like?"

4. Design for energy, not endurance

Organizations ask employees to deliver more while giving them less to work with. High-performing teams outside of business, like firefighting crews or surgical units, understand that performance is more about balancing focus with recovery. Leaders can apply the same principle by building systems for sustainable energy, such as redistributing workloads, encouraging rest, and rewarding behaviors that support long-term resilience. When energy drives performance, employees' motivation naturally rises.

Excerpted from Fast Company Blog

Compliance Communications

Neglect Found at Minnesota Nursing Home After Resident Injured in Lift Incident

The Minnesota Department of Health (MDH) substantiated a finding of neglect after investigating an allegation under the Minnesota Reporting of Maltreatment of Vulnerable Adults Act. The investigation was concluded on December 11, 2025.

The allegation involved a resident who was injured during a transfer using a full-body mechanical Hoyer lift. According to the investigation, two staff members failed to properly secure the lift sling before initiating the transfer. As a result, the resident fell from the sling and sustained a femur fracture requiring surgical repair and hospitalization.

MDH determined that neglect was substantiated and that the two staff members involved were individually responsible for the maltreatment. Video footage reviewed during the investigation showed that the sling loop was not properly connected to the hook of the Hoyer lift spreader bar prior to moving the resident. During the transfer, the sling loop detached from the hook, causing the resident to fall to the floor from a suspended height of approximately three to four feet.

Following the fall, the resident was transferred to the emergency department, where the femur fracture was identified. The resident required surgical intervention and hospitalization as a result of the injury.

Compliance Requirements:

1) Review policies and procedures related to transfers and use mechanical lifts to ensure they include the item for ensuring slings are secure before using the lift.
2) Review these policies and procedures with all team members who transfer residents to ensure they are aware of the safety requirements prior to transferring the residents using the mechanical lift.
3) Ensure team members using mechanical lifts for resident transfers have been educated and competency evaluated prior to using the lifts including all aspects of lift use for transfers that includes sling attachment.
4) Complete routine and periodic audits of mechanical lift transfers to ensure compliance with all aspects of safe mechanical lift use and resident transfer.
5) Review audit results at the QAPI committee meetings.

CMS Considers Advance Care Planning Quality Measure for Nursing Homes

Nursing homes could soon be measured on their ability to capture advance care planning documents for their residents. The Centers for Medicare & Medicaid Services (CMS) released its 2025 list of measures under consideration. Among 24 new or updated metrics considered for a range of Medicare programs, just one would directly affect skilled nursing: Advance Care Planning.

It would measure the percentage of residents 18 and older who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EMR) by the time of discharge. Potentially, it would apply across a range of settings and programs, including the skilled nursing Quality Reporting Program (QRP) and the Value Based Purchasing (VBP) Program.

A CMS announcement (2025 Measures Under Consideration List Now Available | The Measures Management System) about the measures being considered said advance care planning was one several to align with the MAHA initiative, which emphasizes healthcare priorities such as chronic illness, disease prevention, nutrition, physical fitness and wellness.

Advance care planning is a “critical tool” for ensuring that residents’ values, preferences and wishes are communicated to the entire care team. Proactive advance care planning helps prevent unnecessary hospitalizations and reduces the risk of transfer-related trauma.

Experts say advance care plans, regulated under F-578 in nursing homes, should be used to inform an overall care plan, which is developed within the resident’s first two days in a facility. But previous research has shown that advance care directives are often not established (Predictors of advance directives among nursing home residents with dementia - ScienceDirect) for nursing home residents, or not closely followed (JAMDA).

Selection to the QM measures could change that, especially if documentation of conversations or form completion is tied to a payment through SNF incentive programs.

Given CMS’s emphasis on wellness, resident rights, and value-based care, advance care planning is a strong candidate for consideration in the CMS SNF PPS FY2027 Proposed Rule for future inclusion in SNF QRP and SNF VBP. SNFs that proactively strengthen Advance Care Planning workflows, documentation and interdisciplinary coordination will be better positioned if and when this measure moves from consideration to requirement.

In addition to several new measures, CMS said it also is reviewing some measures (2025 MUC List Overview) already in play for long-term care to consider how they might also be used across other healthcare settings. Those include the discharge function score and the percentage of patients on an antipsychotic medication.
CMS said it would accept comments (PRMR Measures | Partnership for Quality Measurement) on all of the possible measures through January 6.

CMS Changes Antipsychotic Medication Quality Measure in 2026 Using Hybrid Data

As of January 2026, the Centers for Medicare & Medicaid Services (CMS) will add a new method for capturing antipsychotic medication use among long-stay residents in skilled nursing facilities.

In addition to MDS-based data from section N, CMS is now using claims data to identify antipsychotic use. Because of this expanded data set, some facilities may notice an increase in their long-stay antipsychotic quality measure.

For instance, if a medication like prochlorperazine — commonly ordered for nausea — is omitted from the MDS due to a lack of awareness that it is classified as a first-generation antipsychotic, it will now be captured for the quality measure through Part D claims.

To avoid such discrepancies, MDS nurses should verify the classification of all medications, especially those coded high risk. Inaccurate or inconsistent documentation can lead to citations and quality measure performance issues. This shift to claims-based tracking highlights the need for strong interdisciplinary collaboration. To support facilities, medical directors, prescribers and consultant pharmacists should evaluate prescribing protocols for antipsychotics. Focus should be placed on accurate diagnoses, documenting non-pharmacological interventions, and applying gradual dose reduction strategies when appropriate.

CMS will now use a combination of both claims and MDS to verify whether the resident received antipsychotic meds (if the resident did not receive an antipsychotic medication during the MDS look-back but a Medicare/Medicaid or Pharmacy claim shows that antipsychotic medications were ordered for the resident, the QM will trigger --even if they never received an antipsychotic mediation). For example, the doctor ordered a PRN antipsychotic medication for a resident. The pharmacy filled the prescription and billed it. The resident never needed or was administered a dose-the measure will still trigger for the quality measures. CMS will also be using claims to do a double validation of a diagnosis of schizophrenia or Tourette's Syndrome or Huntington's Disease. If one of these exclusionary diagnoses was coded on the MDS. If the diagnosis is not on the claim but is on the MDS, the resident would NOT be excluded from the Quality Measure. Review the new hybrid Long Stay Antipsychotic measure in the updated Quality Measures manual.

From Reactive to Proactive: A Better Approach to PDPM Accuracy

Skilled nursing facilities work incredibly hard to deliver high-quality care, yet many still lose out on reimbursement opportunities simply because the right information is not captured at the right time. Diagnoses are documented but not coded accurately; orders are placed, but they aren't captured; hospital records listing comorbidities that could increase PDPM accuracy are available but are overlooked.

These missed details add up quickly, and most facilities don't realize that until after the assessment has been submitted. Skilled nursing teams have adapted impressively to the Patient Driven Payment Model, but one of the ongoing struggles is the tendency to review PDPM information only after the MDS has been completed.

Even highly skilled teams face recurring issues that make reimbursement accuracy difficult. The most common challenge is incomplete diagnosis capture. Important conditions such as pulmonary issues, neurological diagnoses, swallowing problems, infections and NTA-related comorbidities often appear in nursing notes, therapy evaluations, hospital paperwork or physician documentation but never make it onto the MDS assessment. When these items are overlooked, the facility is paid for a level of care that does not reflect the residents' true clinical picture.

Another challenge is the delay between documentation and review. Many facilities rely on end-of-assessment checks or end-of-month audits to find missing or inconsistent items. By that point, corrections may no longer be permitted. Even when late entries are possible, they often place unnecessary pressure on teams and increase the risk of discrepancies and audits.

Cross-departmental inconsistencies are also a major liability. If therapy documents one set of conditions, nursing documents another, and the MDS reflects something different, the facility appears vulnerable during audits. CMS reviewers expect the record to tell one clear story. Any misalignment raises concerns.

To reduce preventable errors, facilities benefit from bringing PDPM oversight into real time. A good PDPM tool does not wait for the MDS to be closed before identifying missing information. Instead, it supports staff by monitoring resident data as it is entered. If a diagnosis appears in documentation but has not yet been added to the active problem list or included in Section I of the assessment, a real-time tool prompts the user to review it while they are working. If a progress note mentions shortness of breath, Section J should reflect it; if a mechanically altered diet is checked off in Section K, that's an indicator that a resident may have dysphagia. Having a system that alerts the user in real time ensures nothing from the EMR gets missed on the MDS.

Documentation consistency is central to PDPM success. When clinical teams, therapy, nursing, and MDS staff all document conditions that align, the record is stronger and easier to defend. Real-time PDPM support helps achieve this alignment. By surfacing items that need attention and identifying areas where documentation may not be fully supportive, facilities can ensure that the MDS accurately reflects the resident's condition.

This does more than improve reimbursement. It reduces confusion, supports compliance, and helps facilities feel more confident during audits. When everything is documented clearly and consistently, reviewers can easily understand the resident's clinical situation. When facilities discover errors early, they preserve reimbursement that might otherwise be lost. Many teams report significant improvements simply by capturing diagnoses and comorbidities that were already present in documentation but had not been coded. Early identification prevents financial surprises and reduces last-minute corrections that strain staff. Facilities that incorporate proactive oversight into their daily workflow are better positioned to protect revenue, reduce discrepancies, and support stronger documentation practices.

Long-Term Care Pharmacy Crisis Could Affect 80% of Nursing Home Residents

An imminent long-term care pharmacy crisis could affect more than 80% of nursing home residents by 2026, with about 84% of pharmacies planning to reduce services or stop serving certain facilities or regions.

About 78% of long-term care pharmacies expect to lay off staff as well, with layoffs already underway, according to a survey conducted by the American Society of Consultant Pharmacists (ASCP) and Senior Care Pharmacy Coalition (SCPC).

The survey respondents represent nearly 20% of closed-door long-term care pharmacies nationwide, serving about 800,000 patients, 300,000 of whom are in rural areas, according to a release issued December 2025 by the ASCP and SCPC. The impact of pharmacy changes is expected to be most severe in rural areas.

Pharmacy companies have been forced to make such drastic moves as reimbursement for brand name drugs is expected to sharply decrease due to changes in Part D drug pricing under the Inflation Reduction Act. The changes undermine the financial viability of long-term care pharmacies, which rely on Part D for 75% of their revenue, the associations stated.

“We are witnessing the collapse of America’s long-term care pharmacy infrastructure in real time, led by small, independent [long-term care] pharmacies throughout the country,” Alan Rosenbloom, president and CEO of SCPC, said in a statement.

The associations point to a legislative solution – the Preserving Patient Access to Long-Term Care Pharmacies Act – which would create a stopgap in the face of reimbursement decreases. A temporary supply fee would be charged to stabilize long-term pharmacy reimbursement, if those drugs are subject to negotiated Medicare prices.

The associations urged Congress and the administration to act quickly, warning that a lack of intervention would leave millions of older adults without access to critical medications.

“Rural America will be hit hardest,” said Chad Worz, CEO of ASCP. “Nearly half of the [long-term care] pharmacies surveyed serve rural communities — areas already struggling with health care access. When these pharmacies reduce services or can no longer survive serving rural nursing homes, where will those homes and their patients turn?”

The association explained that long-term care pharmacies provide legally required, specialized medication management services that can’t be replaced by standard retail pharmacies. Closures of long-term care pharmacies could leave nursing homes without access to essential pharmacy services and in turn lead to nursing home closures and increased hospitalizations.

“These aren’t projections—these are decisions LTC pharmacies are making right now because small and mid-size LTC pharmacies cannot survive under the current reimbursement structure. When these pharmacies close, there is no one to replace them,” said Rosenbloom.

While Rosenbloom drew particular attention to the plight of small and mid-size pharmacies, an industry giant – Omnicare – is dealing with its own significant challenges. Omnicare, a subsidiary of CVS Health (NYSE: CVS), entered into Chapter 11 bankruptcy proceedings in September 2025.

CMS Decision on Skin Substitute Coverage Creates Wound Care Confusion

Federal regulators created fresh confusion around a controversial subset of wound care products after a 10-day period during which they issued and then withdrew new Medicare coverage guidance.

In mid-December, the Centers for Medicare & Medicaid Service (CMS) said each of its Medicare Administrative Contractors would use new local determinations to dictate coverage of skin substitutes when used to treat diabetic foot and venous leg ulcers. The agency issued a detailed press release — now unavailable online — explaining a three-tiered system that would fully cover just 18 branded products as of January 1.

But the agency then withdrew those local coverage determinations in a December 24 announcement (Final Local Coverage Determinations (LCDs) for Certain Skin Substitutes Withdrawn | CMS), setting off a year-end quest for clarification from wound specialists, wound care product makers and patients alike.

Some providers had cheered the initial news, believing it might allow them to bill full price for some skin substitute grafts and cellular and tissue-based products whose efficacy had been demonstrated through clinical testing. Others viewed the narrowing of the list as removing viable and helpful products from the patient care ecosystem. Skin substitutes have proliferated in years. Despite their usefulness in treating hard-to-heal ulcers, they had come under attack after several high-profile fraud cases.

The tradeoff for having fewer approved, higher-price products is that all products are now subject to a $127 per square centimeter rate set under the 2026 Medicare Physician Fee Schedule.

MACs will not have a skin substitute LCD in effect, and none of them have explicit coverage determinations about specific products. This is good in that none of the products will be ruled out automatically. It may be bad that the MACs (and especially the Medicare Advantage plans) have less specific guidance and may continue to limit usage through individual claim denials and audits.

Providers should continue preparing for stricter documentation expectations, evidence-based product selection, and the financial impact of the new reimbursement model after the December 24 announcement.

Local coverage determinations came into play as CMS grappled with skyrocketing costs and fraud charges involving such products, many of which had not been backed by scientific research. The administration paused earlier determinations, which allowed providers to submit new evidence regarding efficacy.

Wound care specialists have been critical of the low, flat-rate payments now in effect, saying it will undercut innovation in the field and limit access in skilled nursing facilities, physician's offices and beyond. Some have encouraged CMS (Safeguarding access, fiscal responsibility and innovation: a comprehensive reimbursement framework for CAMPs to preserve the Medicare Trust Fund | Journal of Wound Care) to adopt an alternative framework.

Discharge Medication Lists 30 Days After Discharge

I spent years as a staff pharmacist in a closed-door long-term care pharmacy. We served multiple buildings, pushing 35,000 pills out the door every day. I personally verified around 600 scripts daily. I saw the medication lists. I knew they were long. But I never saw where they landed.

Then I bought a home care agency. Now I'm on the other side of the discharge, meeting families in their living rooms. I finally see what happens after your residents go home. What I'm seeing should concern you.

Last month, a family called us after their mother was discharged from a skilled nursing facility. She'd been admitted after a fall, stayed six weeks for rehab, and came home with a discharge summary and a bag of medications. When I sat down with the daughter, she pulled out a plastic grocery bag. Inside: 23 prescription bottles. Some were from the SNF's pharmacy — the current regimen. Some were from her mother's old pharmacy, filled months ago. Some she couldn't identify at all. Two different proton pump inhibitors. Three laxatives. A muscle relaxer that was supposed to be short-term during rehab, but the old pharmacy had given it two refills.

The discharge medication reconciliation form listed 17 medications. The bag had 23 bottles. The daughter had no idea which ones her mother was actually supposed to take, and no one had told her to throw the old ones away. This isn't unusual. This is most of my intake appointments.

Why is this your problem in long term care? You might think once the resident leaves, it's no longer your concern. But consider what happens next. That confused daughter calls her mother's primary care physician. The PCP looks at the mess of medications and asks where she was discharged from. Your facility's name comes up. The PCP forms an opinion about your discharge process.

Or the resident gets readmitted within 30 days. Maybe she fell because the PCP renewed the muscle relaxer that was supposed to stop. Maybe she's delirious because the family found an old bottle of oxybutynin in the medicine cabinet and restarted it, not knowing your consultant pharmacist had discontinued it for cognitive effects. Either way, it's a readmission tied to your facility. Or the daughter tells her friends, her church group, her coworkers: "Mom came home on all these medications, and we had no idea what we were doing." She's not blaming your facility — she's describing her reality. But your name is attached to the discharge.

Your quality metrics, your referral relationships and your community reputation all ride on what happens after discharge. The transition doesn't end when the resident leaves your building. It ends when the family feels confident managing care at home.

Inside your facility, the system works. The consultant pharmacist reviews the chart. Nursing administers the meds. The eMAR tracks everything. Someone is accountable at every step. The moment that resident crosses the threshold into home, all of that disappears.

The daughter becomes the pharmacist, the nurse and the medication reconciliation system. She's working from a discharge summary she doesn't fully understand, managing bottles from multiple pharmacies, and trying to figure out why her mother seems more confused at home than she did in your facility.

Here's what I see repeatedly: Short-term PRNs become long-term prescriptions Your team gave Ativan PRN for anxiety during a difficult transition appropriately, with CMS-required frequency limits and supply. Then the resident goes home asking for more Ativan, sees her PCP, and the doctor spots "Ativan PRN for anxiety" on the discharge med list. Without context, he writes a new script. Now she's on a standing benzo indefinitely. Your careful, compliant prescribing just became someone else's long-term problem.

Discontinued medications resurface: Your consultant pharmacist stopped the oxybutynin because of cognitive effects — the right call. But the old bottle is still in the medicine cabinet at home. The family restarts it because “she was on that before.” They don’t know it was stopped for a reason.

Timing gets lost: The careful spacing your nurses maintained — this one in the morning, that one at bedtime, don’t take these two together — becomes “take all your pills” once a day.

Cognitive decline gets locked in: A resident who was foggy in your facility — maybe from the UTI, maybe from the medications, maybe from the unfamiliar environment — goes home still foggy. The family assumes this is just how she is now. No one questions it. Six months later, she’s in memory care with a dementia diagnosis that might have been reversible.

None of this reflects the quality of care you provided. But all of it reflects on you.

Four changes you can make: These aren’t expensive. They don’t require new software or additional FTEs. They require adjusting your discharge workflow.

1. Create a one-page medication summary.

Not the comprehensive reconciliation form with every medication ever prescribed. A single page in plain language: Here’s what she’s taking now, here’s what was stopped and why, here’s what’s new. Large font. No abbreviations. Hand it to the family member, not just the resident.

2. Flag short-term medications as short-term.

Your discharge paperwork lists what the resident is taking. It doesn’t always explain what was meant to stop. If a PRN benzo was appropriate for transition anxiety but shouldn’t continue long-term, say so explicitly — in the discharge summary the PCP will actually read. “Ativan PRN” was used short-term for transition anxiety. Recommend discontinuing. Do not renew.” Five extra seconds of documentation prevents the PCP from reflexively re-prescribing.

3. Make a day seven phone call.

Five minutes. “Are you having any trouble with the medications? Any questions about what to give when?” This single call would catch half the problems I see. Your discharge planner or a staff nurse can do this. Build it into the workflow, not as a nice-to-have.

4. Give families specific warning signs.

Not “call if you have concerns.” Specific, observable guidance: “If she’s sleeping more during the day than she did here, that’s worth a call to the doctor. If she seems more confused than when she left, that’s not normal. If she stops eating, don’t wait.” Families don’t know what a medication is used for. Tell them.

Your facility is one stop on a longer journey. The work your team does inside the building matters, but it only matters if it survives the transition home. Right now, too much of it doesn’t.

I left long-term care because I wanted to see what happened next. What I found was a gap that affects your outcomes, your reputation, and your relationships with referral sources – even though you never see it. You can close that gap. It starts with discharge.

(The writer is a PharmD, CDP, and owner of Options Home Care, a pharmacist-owned non-medical home care agency with locations in Greensboro and Burlington, North Carolina. He previously worked as a staff pharmacist in closed-door LTC pharmacy.)

Wide Range of TEAM Readiness, Some Skilled Nursing Providers Poised to Capitalize

With the Transforming Episode Accountability Model (TEAM) launching in January, the level of readiness varies greatly among skilled nursing providers, as well as hospitals mandated to take part in the initiative. Some nursing home providers are in the position of educating hospitals about the program, giving these SNF operators a chance to stand out as likely collaborators for the initiative.

But other organizations have been slow to mobilize due to other SNF industry pressures and because TEAM's impact felt initially distant. While some post-acute providers are actively analyzing data to prove their worth to hospital systems, others are only beginning to interpret their metrics or haven't started at all.

At any rate, leaders with an eye on TEAM expect the program to take off, with more diagnoses likely to be added after its first year. TEAM is considered the most significant mandatory bundled payment model to date, which aims to cover all costs associated with a 30-day episode of care, including a skilled nursing stay, but hospitals are in charge. Hospitals may need to be educated.

SNF operators need to prove themselves around performance metrics expected by TEAM. If an operator is used to participating in an ACO or with managed care organizations via value-based care contracts, the TEAM model is an "organic, inherent way" to continue taking on risk and deepening relationships with nearby hospital systems.

These organizations are used to managing length of stay and containing costs and finding strategies to help reduce readmissions within the first 30 days, Thorpe said. And so, a history of taking on risk and managing is preparation for TEAM all on its own, as well as a way to get in the door with hospital systems that must participate in the model.

The diagnosis related groups (DRGs), the five major surgical conditions the model focuses on: lower extremity joint replacement, coronary artery bypass graft, major bowel procedure, surgical hip or femur fracture treatment, and spinal fusion. It may be helpful for SNFs to share their metrics regarding these diagnoses.

In terms of risk in the TEAM model, most hospital systems are participating in the Tier One track. This means they're eligible for financial upside related to the financial and quality outcomes of the 30-day episodes of care but do not face financial risks for underperformance. But their risk, and the scope of the model overall, might change as the program rolls out in subsequent years.

Besides surgical diagnoses, TEAM might see comorbid conditions added before long, like congestive heart failure; it would be a way for CMS to hold care settings responsible for chronic disease management outcomes. Providers are being warned against a passive "wait and see" approach from operators during the first year without downside risk; implementing technology, care pathways and hospital partnerships takes many months.

Regarding the Aidin poll, about 65% of respondents were confident to some degree that their staff would be ready to meet TEAM's requirements by January 1, 2026. About 9% said they weren't confident quite yet, and 8% said they were just getting started with readiness, and 5% said they weren't focused on the model yet. This is out of 66 total respondents. The remaining 14% said they were not on the initial TEAM list.

About 64% told the Aidin poll that data and analytics will be most critical for improving tracking and comparing post-acute partner performance; this includes metrics like readmissions, length of stay and referral response times. Providing transparent, actionable insights to clinicians and case managers at the point of decision was a close second in terms of using data and analytics for TEAM prep, at 28% of respondents. This was followed by monitoring episode costs and financial risk exposure in real time, which 5.5% of respondents chose as an area in which data and analytics will help them. Only 3% of respondents said data and analytics will help with standardizing care pathways and reducing unwarranted variation with TEAM prep.

Care pathways, specifically integrating SNF and home health services, offers a seamless post-acute continuum, along with opportunities tied to specific episode types. Post-operative orthopedic patients make up the highest volume of episodes under TEAM, and so a focus on care pathways for this episode could give operators an edge.

PADONA Posts Position Openings to Website

PADONA can assist with your recruitment efforts. As a PADONA member, one of your benefits is that PADONA will post your ads for open positions on our website without cost. If you need to post a staffing ad for a leadership position, please send the written ad to Sophie Campbell at scampbell@padona.com and it will be posted on the PADONA website. The PADONA website is where Pennsylvania nurses and nurse leaders go to look for available positions. We are here to help you fill those needed positions.

Federal Investigations Ongoing Following Two Explosions at Bristol Health & Rehab Center

The nursing home is affiliated with Saber Healthcare Group. Saber leadership hopes to gain access to the building in the coming days to survey the damage, discover what can and cannot be salvaged and determine how best to move forward, Saber's Chief of Government Affairs Zach Shamberg said.

"Until we are allowed to enter, it will be difficult to make a determination on the future of the building itself," said Shamberg. "What we do know is that there is certainly a need for long-term care beds in this part of southeast Pennsylvania, so we hope there will be an opportunity to continue providing care in this area."

The National Transportation Safety Board (NTSB) is focusing its investigation on various details regarding the explosions and fire, including the natural gas service line and soil samples around the facility. Federal officials are also interviewing witnesses, first responders and utility workers as part of their investigation, which Shamberg said could take weeks or even months.

In the aftermath of the incident, Shamberg said the "immediate finger-pointing" was surprising and largely focused on Bristol staff and leadership. "These men and women should be praised for their quick-thinking, decisive action and relentless focus on protecting their residents. More and more stories are emerging of caregivers refusing to leave their resident's bedside, even as flames and smoke engulfed the area," said Shamberg.

John Cordisco, an attorney with Cordisco & Saile, alleges in a PhillyBurbs report that workers at the Philadelphia Electric Company (PECO) were on site for a gas leak in the boiler room two hours before the explosions. A strong gas odor was noted by people on the first floor of the building, according to Cordisco, but they were told PECO was handling the issue and were not instructed to evacuate.

PECO's guidelines call for immediate evacuation if gas odor is detected; fire officials said no 911 calls reporting a gas smell were made before the explosion, according to the report. Cordisco said establishing a timeline and response will be critical for accountability, potential lawsuits and preventing similar tragedies in the future.

Shamberg said Saber is cooperating with federal investigators and awaiting the results of that investigation, in response to reports of the PECO timeline.

As for Bristol's residents, Shamberg said Saber staff helped with transfers to nearby hospitals and nursing homes. Nearly all of the 20 individuals injured in the fire have been discharged from local hospitals to nearby facilities, but there are still residents and staff who have experienced significant injuries, he said.

A nurse, Muthoni Nduthu, 52, and a female nursing home resident at Bristol were killed. "It was our goal to send our residents to the most appropriate care setting as safely and as quickly as possible – not to mention the closest setting we could find," Shamberg said of transfers following the incident. "There are other Saber-affiliated facilities in the area, as well as other nursing homes where providers were more than willing to step up and support."

Saber is also working with residents and their families to return and replace any items they may have lost in the fire; this endeavor will involve state and federal offices, as well as insurance companies. In the meantime, Saber plans to review its procedures to ensure the efficiency of its emergency response, just as the company would after any incident.

Pennsylvania Lawmakers Push Bipartisan Bill to Address Senior Living Workforce

Senate Bill 116 (Senate Bill 116 Information; 2025-2026 Regular Session - The Official Website of the Pennsylvania General Assembly) would allow high school juniors and seniors to earn graduation credit by working or volunteering in licensed care settings, including assisted living communities, personal care homes and nursing homes. The Pennsylvania Senate Education Committee unanimously passed the bill out of committee.

Supporters said that the legislation also is a way to expose high school students to potential career paths in the senior living and care industry. “This bill could show students what a career in long-term care looks like, encouraging them to consider it as they prepare to enter the workforce,” Sen. Dave Argall (R-29), bill author, said in a statement (Argall Bill to Address Caregiver Shortages Advances - Pennsylvania Senate Republicans).

From December 2019 to December 2022, the US Department of Labor reported that residential care communities and nursing facilities in the Keystone State lost 14% of their workforce. “The Pennsylvania Assisted Living Association (PALA) strongly supports this legislation, as it offers students valuable hands-on experience in licensed care settings, while helping our communities cultivate the next generation of senior living professionals,” PALA Executive Director Susan Saxinger stated. “While this initiative alone won’t solve the workforce shortage, it is an important step in inspiring young people to explore careers in personal care and assisted living.”

LeadingAge Pennsylvania (LAPA) Legislative Director Austin Cawley similarly said that the bill is a “significant step toward strengthening Pennsylvania’s long-term care workforce pipeline, as it helps introduce young people to rewarding careers in aging services while supporting providers who are in urgent need of staff.” The Pennsylvania Health Care Association (PHCA), the state affiliate of the American Health Care Association / National Center for Assisted Living, called the bill a “proactive step” toward alleviating the state’s chronic long-term care workforce shortages.

“By incentivizing high school students to explore careers in healthcare through practical experience, the legislation creates a crucial pipeline of future caregivers,” PHCA President and CEO Michael Jacobs stated. “This early exposure not only helps students gain valuable skills and determine their career path, but also immediately augments the current workforce with enthusiastic, entry-level help, setting the foundation for a more sustainable and robust long-term care system in Pennsylvania.”

Argall also introduced two other bills earlier this year to address issues with the long-term care workforce, with the support of the state’s senior living groups.

SB 114 (Senate Bill 114 Information; 2025-2026 Regular Session - The Official Website of the Pennsylvania General Assembly) and SB 115 (Senate Bill 115 Information; 2025-2026 Regular Session - The Official Website of the Pennsylvania General Assembly) address pathways to long-term care certification and the availability of employee training courses.

SB 115 would allow individuals seeking employment as direct care staff members in assisted living and personal care homes to demonstrate competency through a skills-based exam in lieu of a high school diploma or general educational development test. The bill passed the Senate in May and is now in the House.

SB 114 would enhance the availability of nurse aide training courses across the commonwealth. The bill would allow students nurses and graduate nurses to immediately take the certified nurse aide exam upon completion of relevant coursework within their nursing program. The bill passed the Senate in September and is now in the House.

Transforming Nursing Home Care through the 4Ms of Age-Friendly Health Systems

Join the PA Long-Term Care Learning Network's weekly webinars in Q1 2026 to learn practical ways you can embed the Age-Friendly 4Ms framework in your daily work!

Webinars occur <u>every Thursday at 2-3PM ET</u> starting January 22!

If you do NOT already receive the Learning Network webinar invites, email Stacie at bonenberger@jhf.org to join the invite list

WEBINAR SCHEDULE:

4MS AND THE TEAM
January 29- February 5

4MS AND MANAGING CLINICAL CONDITIONS
February 12 - February 19

4MS AND QAPI
February 26- March 5

4MS AND CULTURE
March 12- March 19

Gather Your Team!

- At least one team member should attend each session
- Webinar recordings will be available online
- Webinars will review Age-Friendly Health System recognition process; LTC RISE Partners will help nursing homes apply

Messiah University CNA Training Program Classes Announced

Messiah University is pleased to announce six new dates for the Nurse Aid Training program and a new website with online application.

- March 3 - March 31, 2026
- May 19 - June 17, 2026
- September 1 - September 29, 2026
- October 27 - November 24, 2026

Below is information for your existing and potential employees in need of Nurse Aid Training. Applications are currently being accepted for all six dates.

The **Nurse Training Program website** includes direct links to all required application documents along with the **APPLY NOW** button at the bottom of the page. You will upload all required documents and submit your application instantly and electronically (no paper applications or materials will be accepted).

Once your completed application has been submitted, the materials will be reviewed by the course instructor, Mahogany Blackston, for accuracy and completeness. Mahogany will email you if additional information is needed. Please note you are not officially admitted into the program until you receive a confirmation of acceptance email from Mahogany.

After you have reviewed the updated website, if you have further questions, please contact bridgecenter@messiah.edu or mblackston@messiah.edu

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HACC, Central Pennsylvania's Community College

Nursing Home Administrator Program – Spring 2026

Approved by the PA State Board of Examiners of Nursing Home Administrators

Offered in-person and via Zoom – Fridays 8 a.m. to 4:30 p.m. for 16 weeks

HACC's spring 2026 120-hour, PA NHA Board-approved program begins on Friday, Feb. 6, 2026, through Friday, June 5, 2026. Classes meet from 8 a.m. until 4:30 p.m. with a one-hour lunch break, at the HACC Lancaster Campus AND all sessions are also held via Zoom for those who may not be able to attend in-person. Classes are held each Friday for a total of 16 weeks. (HACC also offers an optional two-day review course at the conclusion of the 120-hour program (Friday & Saturday, June 12 and 13, 2026).

You can register for individual modules ($175 each) or one of two cost-savings module bundles (Modules 1-16 ($2,579) OR Modules 1-16 plus the optional review course ($2,954)) here.

For more information, please contact Emanda Reiner at 717-221-1377 or elreiner@hacc.edu or Susan Biggs at 717-221-1348 or sebiggs@hacc.edu.

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Mid-Atlantic CMS QIN-QIO (Region 2) | QIN–QIO Quality Innovation Network - Quality Improvement Organizations CENTERS FOR MEDICARE & MEDICAID SERVICES QUALITY IMPROVEMENT & INNOVATION GROUP

The Mid-Atlantic Quality Connection

October 2025

What's an IP3?

IP3 stands for Infection Prevention for Infection Preventionists by Infection Preventionists. It is a special program of the Mid-Atlantic CMS QIN-QIO (Region 2), developed to provide essential support to nursing home staff charged with overseeing infection prevention within their facilities.

IP3 is for You if...

- You are a new infection preventionist.
- You are a seasoned infection preventionist who would like some assistance with regulations.
- You would like to connect with experienced IPs to discuss hot topics like enhanced barrier precautions, understanding vaccine recommendations, developing an antibiotic stewardship program, and more.

We Meet You Where You Are

Wherever you are in your IP journey, the Mid-Atlantic CMS QIN-QIO IP3 Group is here to help meet your needs for education, information and peer support. Join our weekly scheduled virtual office hours, or jump into a conversation whenever the you have the time by logging into our dedicated, professionally moderated Facebook page.

Learn More

Email Infection Preventionist **Melanie Ronda, MSN, RN, LTC-CIP, CPHQ,** Director, Healthcare Quality Improvement, at mronda@ipro.org, or **schedule a one-on-one conversation** with your local Quality Improvement Advisor to learn more.

The Mid-Atlantic CMS QIN-QIO (Region 2) works to ensure high-quality, safe health care in Pennsylvania, Virginia, West Virginia, Delaware, Maryland, and the District of Columbia.

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PADONA is on LinkedIn! Follow us at:
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PADONA is an approved Directed Inservice Training Provider!!

We offer a Discounted fee with our Directed In-services and all education for providers with at least one PADONA member!

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