PADONA UPDATES April 15, 2024

BREAKING NEWS

PADONA IS LAUNCHING A MEMBERS ONLY PAGE ON THE WEBSITE!

PADONA is proud to announce that starting TODAY you have the opportunity to be part of another strategic initiative that is a member benefit from PADONA!

The members only page of the PADONA website is specifically designed to assist you – our valued members – to access resources quickly and easily. Items that have been previously sent in the daily email updates, education tools, audit tools, manuals, federal and state information and updates and many other items will be available to you on the members only page.

Anyone can access the PADONA website….BUT ONLY PADONA MEMBERS CAN ACCESS THE MEMBERS ONLY PAGE!

How can you access the members only page of the PADONA website?

1) **Go to www.PADONA.com**
2) **The add to the end of that URL – membersonly (no space)**
3) **When you get to the page asking for a password – use p@don@!**
4) **The password is the same for all members**
5) **You will not be asked for another password**
6) **Please do not share this password – this is a members only benefit**

PADONA will be constantly updating the members only page as items are updated, changed and revised. It is a work in progress.

We hope this members only page of the website assists you in your roles and meets your need for information and education!

THANK YOU FOR THE OPPORTUNITY TO SERVE AND SUPPORT YOU!

PADONA HOSTED EDUCATION WEBINARS

- **Legionella – Prevention, Recognition and Management in Long Term Care**.
  Date: April 18, 2024,
  Time: 11:30 am until 12:30 pm
  Educator: Dr Kristina Zwolenik of the Pennsylvania Department of Health Bureau of Epidemiology.
  Topic: Addressing the preventative steps from water management and treatment through the recognition of signs and symptoms and management of residents who have been diagnosed.
  Registration Fee: no registration fee for this webinar education based on the partnership between PADONA and the PA DOH Bureau of Epidemiology. (Registration is required).
  There will be both nursing and nursing home administrator continuing education hours for this education provided by the PA DOH through PA TRAIN
- **Ready for Enhanced Barrier Precautions? Let Live Data Analytics Guide You**
  Date: April 25, 2024
  Time: 11:30 am until 12:30 pm
  Educator: Cheryl Scalzo, RN infection preventionist with RealTime Medical Systems
  Topic: Break down the new guidance on the use of EBPs and discuss policies and procedures facilities can implement, that include education to facility staff, residents, and families and how care teams can leverage the data already found in their resident EHRs to help identify when EBPs are needed.
  Registration Fee: $35 for members and $50 for non-members
- **Sepsis in the Long-Term Care Setting – Prevention, Recognition and Treatment**
  Date: May 1, 2024
  Time: 11:30 am until 12:30 pm
  Educator: Carolyn Pandolfo, RN Infection Preventionist with Project FirstLine
  Topic: identification and treatment of sepsis in the geriatric resident
  Registration Fee: no registration fee for this webinar education based on the partnership between PADONA and the PA DOH Bureau of Epidemiology. (Registration is required).
  There will be both nursing and nursing home administrator continuing education hours for this education provided by the PA DOH through PA TRAIN
- **Preventing, Identifying and Managing C-Diff in the Long-Term Care Setting**
  Date: May 21, 2024
  Time: 11:30 am until 12:30 pm
  Educator: Dr. David Nace, Associate Professor of Geriatric Medicine at the University of Pittsburgh and Clinical Chief of Geriatric Medicine, and Chief of Medical Affairs for UPMC Senior Communities.
  Topic: Focus on C-Diff in the long-term care resident to prevent it, identify it, know when to isolate and treat to maintain resident and staff safety from illness.
  Registration Fee: $35 members and $50 non-members

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

- **Infection Preventionist leadership boot camp – June 4 and 5, 2024**
  - **In collaboration with the Quality Insights Organization**
  - **Education and network for the infection preventionist to know what to do and when and how often to maintain compliance, be prepared, manage outbreaks and provide guidance.**
  - **More information to come in the next PADONA Updates**

PADONA Education Recordings

If you have been unable to attend PADONA hosted webinars but want the education, information, AND Nursing Continuing Professional Development continuing education hours –

PADONA EDUCATION RECORDINGS PROVIDE NURSING CONTINUING PROFESSIONAL DEVELOPMENT CONTINUING EDUCATION HOURS!

PADONA also provides the following education:

- DON Education and Mentoring: This education is a series of educational sessions to assist the new DON with the areas critical to being effective in the role of DON. It is also a great refresher for the experienced DON as well as for the ADONs.
  - Education sessions are scheduled weekly for 90 minutes sessions
  - Education is virtual eliminating travel time for the DON and costs to the provider
  - Sessions can be menu selected from the list of topics for the experienced DON
  - Mentoring through discussion and addressing facility specific situations are included

- Directed In-Service Education: PADONA is an approved provider of directed in-service education by the Pennsylvania Department of Health
  - Fees are reasonable
  - Recordings are completed for those staff unable to attend

- Nursing specific or Interdisciplinary team education
  - Root cause analysis
  - Medical record documentation
  - Medicaid Case Mix Index
  - Care Planning
  - Regulatory compliance

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NOTE: When you register for a PADONA webinar or course you will always receive a receipt from PADONA. This demonstrates that PADONA has received payment and that you are registered. If you have not received your receipt within a few hours of payment – please reach out to LuAnn White, PADONA Administrative Assistant at luann@padona.com to check.

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INFECTION PREVENTIONIST BOOTCAMP

June 4 and 5, 2024 – 4 hours each day in the morning

Educator is QIO Infection Preventionist Jennifer Brown, RN

Provided in collaboration between PADONA and the QIO (Quality Insights Organization)

Registration Fee: $80

Following the Bootcamp, 3 additional monitoring and mentoring sessions will be scheduled with registered attendees and Jennifer Brown, RN

Check the Thursday Education Email Updates for information and registration form

PADONA is a proud partner of the teaching Nursing Home Collaborative

The Collaborative is a dynamic and evolving network of nursing homes, schools of nursing, and advocates dedicated to advancing excellence in nursing home care through education and workforce support.

Website: **www.patnhc.org**

Email: **info@patnhc.org**

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PADONA is a proud partner of the AMI RISE DON Resiliency program in the Southwest, North Central and Northeast regions

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MARK YOUR CALENDARS! TWO PADONA EDUCATION EVENTS HAVE BEEN SCHEDULED!!

PADONA ANNUAL SUMMER SYMPOSIUM ON QUALITY

JULY 10 AND 11, 2024

VIRTUAL EDUCATION

2 DAYS OF EDUCATION PROVIDED BY INDUSTRY EXPERTS ON RESIDENT QUALITY OF CARE ARES INCLUDING:

- **PREVENTION OF READMISSIONS**
- **RESPIRATORY CARE**
- **FALLS PREVENTION AND MANAGEMENT**
- **AND MANY OTHERS!**

PADONA ANNUAL LEADERSHIP DEVELOPMENT COURSE

SEPTEMBER 24 – 27, 2024

VIRTUAL EDUCATION

OPPORTUNITY TO COMPLETE THE DON CERTIFICATION EXAM AT THE

Leadership Snippets

Leadership and Performance Feedback

Leadership is never an easy role to have. But when the task of performance feedback is introduced to the leader – new or experienced – there is a layer of anxiety and concern that often accompanies the task. Performance feedback isn't just the annual performance review/evaluation, it is the feedback that is provided throughout the year leading up to the performance review/evaluation. Performance feedback provided consistently and continuously reduces the anxiety of the annual review/evaluation and eliminates surprises during the annual.

When managing others, feedback needs to be immediate and constructive.

The goal is to build people up and improve performance – shame is *never* a motivator.

When giving feedback, consider factors that affect how your message is understood. Think about the following anytime you're about to provide feedback:

1. **Clarity Matters**: Define your objective clearly and frame your response supportively.
2. **Choose Words Wisely**: Tailor your vocabulary, use relatable examples, and adapt for language barriers.
3. **Delivery Mode**: Decide between casual encounters, formal conversations, or technology-based methods.
4. **Finesse in Delivery**: Maintain a relaxed tone, adjust volume, and align body language with your words.
5. **Timing**: Provide feedback promptly after events, consider one-on-one sessions, and reflect on organizational context.
6. **Know Your Audience**: Understand preferences, emotional readiness, and remember that sometimes silence speaks volumes.

Remember, effective feedback isn't just about *what* you say – it's about *how* you say it.

(Excerpted from ACHIEVE BLOG)

Compliance Communications

Alleged DNR Error Death Is Concern for Nursing Homes

The death of a Connecticut nursing home resident in September was the result of mistakenly communicating the roommate's do-not-resuscitate order.

A negligence lawsuit was filed against The Reservoir nursing home in West Hartford, CT, its acting nurse supervisor and the nursing home's operator — Harborside Connecticut Limited Partnership by the resident's family.

Resident was found unresponsive on September 4 and staff were allegedly told to not perform CPR, according to the lawsuit. Staff did call 911. When facility leadership could not provide DNR documentation, the first responders performed CPR, unsuccessfully.

Allegedly, the DNR that was eventually provided applied not to the deceased resident, but to her roommate. Lawyers representing the plaintiff expressed being puzzled at the apparent lack of protocols or failure to follow existing protocols indicated by the events alleged in the lawsuit.

The Centers for Medicare & Medicaid Services has implemented "ample guidance" governing how facilities should create protocols for DNRs and administering CPR. The Connecticut Department of Health issued Harborside a $10,000 citation for the incident.

Compliance Considerations:

1) Review policies and procedures related to CPR and DNR status and how residents are identified as to their wishes/choice when CPR or life saving measures are needed.
2) Review these policies and procedures with the staff in all departments regularly so they are aware and what their roles are when they find a resident unresponsive.
3) Ensure CPR/DNR status is readily identifiable and supervisory staff are aware of where that information can be found in an emergent situation.
4) Ensure CPR/DNR status is reviewed and updated with the resident/resident representative routinely.
5) Routinely audit medical records to ensure the CPR/DNR status is included in the location as stated in the protocol/policy and procedure and that it has been reviewed and updated per policy.
6) Consider conducting drills in the facility to ensure all staff are aware of their roles when a resident is found unresponsive and the CPR/DNR status can be readily and quickly located in the medical record per policy.

IMPORTANT NEWS – FROM CMS TO LONG TERM CARE NURSES

PADONA Members,

Contractors of CMS support a Health IT Work Group (HITWG) to better understand health data exchange across the spectrum of care.

CMS, or contractors of CMS, would like to hear current realities and have a candid discussion about enabling timely data exchange with long-term and post-acute care (LTPAC) providers, vendors and patients/consumers. CMS, or contractors of CMS, seek to hear from all interested parties across the spectrum of care to convey their current experiences exchanging data. CMS, or contractors of CMS, and health information technology (IT) subject matter experts will facilitate a dynamic dialogue about best practices and barriers that healthcare stakeholders experience during care transitions with LTPAC settings. Please let us know if you and your organization would be interested in engaging in this discussion to help CMS better understand and prioritize requirements for easing the process of data exchange across multiple care settings.

Please contact Michele Galioto, DNP, RN, CNS via email (michele.galioto@pocp.com) if you're interested in discussing data exchange successes and challenges in your work setting, including data to support transitions of care, care planning, documenting standardized assessments, quality reporting and more.

Nightingale Awards of PA Scholarship Applications Are Now OPEN!

Nightingale Awards of Pennsylvania was established in 1989 to support and recognize excellence in nursing. Our primary mission is to encourage the future of nursing by providing educational scholarships for all degree levels.

Are you a nursing student - or do you know one - who needs some extra money for school? Apply for a Nightingale Awards of PA scholarship!

Scholarships will be awarded in the following eight categories:

~ Diploma

~ Licensed Practical Nursing (LPN)

~ Associate Degree (ADN)

~ Bachelor of Science in Nursing (BSN)

~ Bachelor of Science in Nursing Completion

~ Advanced Degree - Masters (includes CNS, CNM, CRNA, CRNP, etc.)

~ Advanced Degree - Doctoral (includes DNP, DNS, EdD, etc.)

~ PhD

Application Deadline:

April 15, 2023

Enhanced Barrier Precautions Added to Infection Prevention and Control Guidance

Nursing homes must begin to use enhanced barrier precautions (EBP) to prevent broader transmission of multidrug-resistant organisms (MDROs) and to help protect residents with chronic wounds and indwelling devices as stated the Centers for Medicare & Medicaid (CMS) in their recent memo that was effective April 1. The guidance was issued to providers and state survey agencies and is no longer a recommendation.

The new standards correlate CMS regulations with Centers for Disease Prevention and Control (CDC) guidance issued in 2022 (Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) | HAI | CDC). The enhanced barrier precautions require the use of gloves and the donning and doffing of gowns in six high-contact activities, but the requirements are less stringent than existing contact precautions.

CMS in its guidance acknowledged that some nursing homes have been hesitant to use the CDC enhanced barrier precaution guidance because it could have limited the activities in which residents with colonized multidrug-resistant organisms could participate. Instead, some nursing homes have used the precautions only with patients that have an active infection.

CMS said more than 50% of nursing home residents may be colonized with an MDRO. Examples of the organisms targeted by CDC include:

- Pan-resistant organisms
- Carbapenemase-producing carbapenem-resistant *Enterobacterales*,
- Carbapenemase-producing carbapenem-resistant *Pseudomonas* spp.,
- Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*, and
- *Candida auris.*

The new CMS memo includes the use of EBP during high-contact care for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, “in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. We note that facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents,” the agency said in a memo (QSO-24-08-NH (cms.gov). “Residents are not restricted to their rooms or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident’s stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.”

Enhanced barrier precautions should be used when dressing, bathing, transferring, providing hygiene, changing linens, changing briefs and assisting with toileting. They’re also required for patients using a central line, urinary catheter, feeding tube or tracheostomy/ventilator or with any skin opening requiring a dressing.

The memo said the precautions would not necessarily be needed when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Facilities also have discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC.

The new guidance is being incorporated under the F880 Infection Prevention and Control regulation requirements.

CMS announced it would enact Enhanced Barrier Protection requirements (Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) | HAI | CDC) for nursing homes where residents have active multidrug resistant organisms infections or are known carriers. The new rules were developed in line with existing CDC guidance for other provider types. Nursing home leaders have raised concerns that the more routine use of gloves and gowns, even around residents not actively infected, would take away from a nursing facility's homelike feel, increase costs and take up more valuable staff time.

Questions have been asked by providers during the CMS Open Door Forum regarding the cost of implementing EBP such as: "Has anybody done any kind of study to see what the increased cost is going to be for gowns and gloves because of this, and how it is going to affect the psyche of our residents that we are now going to be having to wear gowns and gloves all the time in the rooms?" Additional questions on the Open Door Forum questioned the difference between common area transfers and transfers in therapy treatment space where one does not require EBP and the other does.

Others questioned how and when they should determine whether to use EBPs, and MS representatives said those evaluations should be done on an "ongoing basis. That would be whenever the resident is admitted; whenever they go out to the hospital, they are readmitted and returned to the facility; if they have a change in condition; if they have a new wound that may change their status as far as needing to use EBP; a change in the indwelling catheter or indwelling medical device," the CMS representative said. "All of those things would necessitate the facility to re-evaluate the resident to determine whether or not EBP are appropriate."

While the regulations require EBPs for residents with organisms targeted by the CDC, the new CMS regulations leave facilities to decide how they will approach patients with other, "epidemiologically important" MDROs, such as MRSA. One caller noted that CDC websites provided as resources by CMS give nursing home staff "no real way to discern" when to incorporate the use of additional personal protective equipment.

Despite any lingering questions about the regulations Evan Shulman from CMS said providers should be in compliance immediately. "There is no grace period," he said. "We know that the enhanced precautions have been out for quite some time from the CDC. We also find in our guidance that we try to give facilities as much flexibility as possible to be creative in how to identify residents that require precautions. We will continue to evaluate it as it progresses, but there is nothing stated in our guidance about any grace period, and we think that providers should be able to adopt this.

Career Ladders and Lattices' Provide Opportunities for CNAs

Providers could assist certified nursing assistants (CNAs) to advance their careers as a method of retention, according to an article (No Fear of Heights: Ladders and Lattices for CNAs - Caring for the Ages) in Caring for the Ages, a publication of AMDA–The Society for Post-Acute and Long-Term Care Medicine (Embracing a New Identity: AMDA Announces Name Change | AMDA (paltc.org).

"One promising concept involves career ladders and lattices," wrote Joanne Kaldy, senior contributor. "As a CNA, ladders enable you to pursue opportunities to move 'up the ladder' into other positions, such as licensed practical nurse (LPN), registered nurse (RN), or administrator. Alternatively, the career lattice is attractive if you want to continue working as a nurse assistant but want opportunities to expand."

Quality Care Health Foundations (QCHF) CNA UpSkilling Program (CUSP (cahf.org) is "designed to provide CNAs with the chance to advance through recognized levels of achievement based on their completed micro-certification modules and work experience."

Those micro-certifications could be earned by new workers every six months, each one providing them with a certified skill in areas such as dementia care, behavioral health or soft skills like workplace leadership. Those certifications would be transferable between participating employers in California, and each one would come with an incremental wage increase. On e key aspect of the program is that when new CNAs are hired but they have previous experience, they come into the new facility at the level at which they left the previous facility.

Lori Porter CEO and co-founder of National Association of Health Care Assistants (NAHCA) noted that additional options exist for expanding a CNA's career options. She said that after about eight months on the job as a CNA, she was offered the opportunity to get certified as a medication technician.

According to Porter, NAHCA is "building a career lattice" with nine specialty certifications to give CNAs a pathway to advancement. The specialties include, among others, infection prevention/control, incontinence care and restorative care.

"This isn't designed to replace nurses handling these specialties," Porter said. "Instead, CNAs with these certifications can support the nurses and other team members in their efforts. This kind of expertise is invaluable, particularly as nurse shortages continue to plague many organizations."

CNAs can bring "ladders and lattices" to their employers' attention by speaking with administrators, directors of nursing and other employees about the possibilities, and even asking about things such as tuition assistance, mentorships and career pathways. When interviewing for a new job, candidates should ask upfront about opportunities for career growth.

CMS is Shifting The Infection Prevention and Control Focus to Sepsis

Quality experts at the Centers for Medicare & Medicaid Services (CMS) will be taking a closer look at sepsis rates in nursing homes while continuing broader efforts to improve infection control, CMS leaders stated Tuesday April 9 at the CMS Quality Conference.

"When we're looking at readmissions and talking to our QIN-QIOs, the most common reason for readmission is typically related to sepsis," said Colleen Frey, director of the CMS Division of Community and Population Health, referring to regional quality improvement groups that work with nursing homes.

Quality Improvement Organizations are already able to support nursing homes looking for additional resources, Frey said. But CMS also is working with the Centers for Disease Control and Prevention (CDC) and the Sepsis Alliance to develop more education on best practices for preventing, recognizing and treating sepsis, Frey said.

"In the nursing home, what we really want to focus is on making sure that the staff is well-trained on the identification of early sepsis before it becomes really dramatic," she said. "As you know, sepsis is kind of a runaway train if you don't stop it early." She also said nursing homes that work with family members to explain sepsis — a bloodstream infection caused by bacteria — might also see results, given that family members involved in care or visiting frequently might be first to notice changes in a patient's conditions.

Another way of lowering sepsis rates, which are already tracked by CMS, would be to do a better job of preventing other, more localized infections, such as UTIs, Frey said.

While CMS has not added a sepsis metric to its expanding value-based payment plans, research and efforts at this early stage could inform later initiatives or incentives. The CMS focus may not be wholly self-initiated. The Health and Human Services (HHS) Office of Inspector General (OIG) is expected to issue audit findings this year on potentially preventable hospitalizations of Medicare-eligible skilled nursing residents, including those who needed acute care for UTIs, sepsis and four other conditions.

Prior OIG work identified that skilled nursing facilities "often did not provide UTI prevention and detection services in accordance with its residents' care plans, increasing the residents' risk for infection and hospitalization."

The March 20 QSO Memo from CMS regarding implementation of Enhanced Barrier Precautions (EBP) was intended to "give a very clear and concise guidance" to be used by both surveyors and nursing home frontline staff. The rules went into effect April 1, and left nursing homes some discretion as to where and when to use additional PPE for residents with multidrug-resistant organisms (MDROs) not targeted by the CDC.

"We honed in on, who is this for, how will this impact the nursing home, how do we keep the 'home' in nursing home?" she said. "We still need to realize; this is their home where they live."

New Resident Safety Measures Possible as CMS Review Harm Risk in Nursing Homes

The Centers for Medicare & Medicaid Services (CMS) is acutely focused on resident harm and will introduce new measures addressing resident safety later this year, agency leaders said at the CMS Quality Conference last week.

Dora Hughes, MD, acting chief medical officer and acting director of the CMS Center for Clinical Standards and Quality, said conversations with providers and new insights about the challenges they face will help inform additional resident safety-related conditions of participation, value-based payment measures or other tools that could be tweaked to prevent harm.

“We have been very strategic in leveraging our different levels of resources, our authority, our programs, truly coming together to really think through how we can elevate the importance of patient safety,” Hughes said. “How can we do more, do better? This is truly a CMS priority, and our priority is certainly a [Centers for Disease Control and Prevention] priority and an overarching administration priority, and you will continue to hear more from us across the federal government on patient safety.” Agency officials are working with other Health and Human Services branches and meeting internally to develop a 10-point resident safety strategy to be introduced later in 2024.

That ongoing work includes a reevaluation of what harm is, a list that could evolve from the 29 “never events” (Never Events | PSNet (ahrq.gov) envisioned by the National Quality Forum in 2021, said Michelle Schreiber, MD, CMS Deputy Director for Quality & Value and Group Director for the Quality Measurement and Value-Based Incentives Group. “There are other new harms to consider, such as diagnostic excellence … EMR error, cybersecurity, or the future harm that may come from poorly designed artificial intelligence,” she explained. “Second, we’re very committed to ensuring that patients, caregivers and their voices are heard throughout patient safety.”

For instance, Schreiber said, CMS could encourage or require more communication about patient safety events, including use of the CANDOR method to address errors head-on (Communication and Optimal Resolution (CANDOR) | Agency for Healthcare Research and Quality (ahrq.gov). Other changes could be to require services in additional languages, a resident’s rights issue that has already begun to surface in some nursing home regulations.

Schreiber said the agency has already adopted “a suite of new patient safety measures and will be introducing more this year.” She also noted those measures will play an increasing role in the agency’s value-based program.

CMS now has 27 pay-for-performance payment programs for specific settings or provider types, including a set of skilled nursing metrics that is expanding after years of facilities being judged by their hospital readmission data alone.

“We use these programs to drive accountability. We link payment to them, and we use them most importantly in our public reporting and our Care Compare sites so that the public can actually see this data and it can help them make informed decisions,” Schreiber said.

In nursing homes in particular, CMS previously instructed surveyors to get back to the basics on some core issues — including resident mobility, weight loss, pressure ulcers and use of antipsychotic medications — that increased during the pandemic. “We may never get to zero harm but making it our goal is extremely important so that everybody is doing what they can to minimize harm,” Schreiber said. “We can do this by making safety data transparent and promoting high-reliability techniques.”

Behavioral Concerns — Not Financial Issues — Noted With Unplanned SNF Discharges Per OIG

The Office of Inspector General (OIG) noted that nursing homes most often initiated an unplanned discharge due to resident behavior that endangered the resident or others in the facility, which is an appropriate discharge rationale. But some providers are not fully documenting facility-initiated discharges, undermining residents' rights to appeal or plan for a move, the Health and Human Services Office of Inspector General said in a companion report. The information in the OIG report was first reported on in 2021.

Providers have been scrutinized for the use of facility-initiated discharges, which consumer advocates tend to portray as heartless decisions made for financial reasons. But the OIG report found, a resident's failure to pay was a documented factor in just 26% of 126 sample cases; most residents (62%) were asked to leave the facility because of physically or verbally "aggressive" behaviors or because the facility could not keep the resident safe from wandering, elopement, suicide, self-harm or harming others.

Slightly more than 93% of residents discharged due to behavior concerns had a mental health disorder, compared to 70% of residents who were discharged for other appropriate reasons. Report authors acknowledged nursing homes' "challenges" in admitting and caring for residents with mental health disorders, especially as the need for this level of care increases.

The rationale for the OIG report and fact finding was to determine if residents with behavioral health concerns were receiving appropriate care and services. Questions from the report findings included whether the needs of the referrals with mental health or behavioral health concerns were discussed during the referral and admission process and accurate assessments for staff, resources and capacity to provide care addressed before the actual admission. Admission of residents with mental and behavioral health needs can be traumatic and unsafe for the resident, other residents and the staff.

Identifying the correct type of discharge is not only important for compliance, but it also triggers additional support that could help residents better navigate the change. That extra help may be especially important among affected residents with behavioral health challenges. A third OIG report made public last week, shows how challenging increasing behavioral health resources are for nursing home residents, especially those on Medicaid and Medicare. An analysis of providers in 20 US counties found fewer than five active mental health providers for every 1,000 enrollees. Medicare Advantage averaged 4.7 providers per 1,000 enrollees, while Medicare fee-for-service has 2.9 providers and Medicaid had 3.1 providers. Some counties had not even a single provider per 1,000 enrollees.

OIG noted that almost all nursing homes included in the review tried some different interventions prior to discharging residents due to dangerous behaviors. Most used one or two interventions, but nursing homes documented no interventions for six facility-initiated discharges in the review. The most common interventions nursing homes implemented were medication changes and counseling.

For example, one nursing home documented medicating a resident for agitation and pain to decrease aggressive behavior. Several nursing homes noted that the residents, following aggressive behavior, received counseling such as education and guidance on appropriate behavior, healthy conflict resolution, or positive coping skills. Nursing homes also counseled residents who violated smoking policy. Less common responses were redirection or new activities or monitoring, such as one-on-one staff supervision or by checking residents every 15 minutes. Even less frequently used tools were room changes, temporary hospital transfers, and the use of wearable bracelets for residents known to elope.

CMS requires nursing homes to provide written notice to residents of facility-initiated discharges 30 days prior and include information and resources the resident can use to help with a move or an appeal.

In all but about 15% of cases reviewed, nursing homes discharged residents for allowable reasons — failure to pay among them. In this sample, debts ranged from $716 to $173,000, with a median of $8,960. And most nursing homes, OIG said, provided residents “with a reasonable and appropriate notice,” which is what CMS requires when a nursing home initiates a discharge for failure to pay. Nursing homes documented notifying residents of changes in payment status and/or attempted to collect payments in three-quarters of these discharges, sometime setting up payment plans or helping them apply for Medicaid coverage.

But providers frequently did not complete the notice and documentation requirements, regardless of their reason for discharge. For instance, the OIG found that nursing homes failed to give a complete written notice to more than three-quarters of discharged residents. Most commonly, nursing homes did not provide full information about the appeals process or the state entity to contact for an appeal.

Also notable: Nearly half of the nursing homes that provided notices to residents did not provide notices to an ombudsman, which the report said undermines the CMS goal of providing protections to residents.

OIG recommended that CMS develop a facility-initiated discharge template that could be easily shared with all nursing homes, giving staff an easy way to share all needed information with residents and advocates. OIG also recommended CMS use existing systems to record facility-initiated discharges and bring more transparency to the issue.

Vacant Nursing Home Beds Are on the Rise in Pennsylvania Amid a Reimbursement Crisis

Nursing homes in Pennsylvania face a critical underfunding of Medicaid, with one in four nursing home beds currently offline due to inadequate reimbursement. Survey findings from LeadingAge PA also point toward the continuing workforce shortage, as to why so many beds are not being used. About 48% of facilities in the state have had to decline hospital referrals in the past two to three months, despite having licensed capacity, according to the survey.

That's nearly 25% of beds taken offline due to the workforce shortage and low reimbursement rates, LeadingAge PA President and CEO Garry Pezzano said. The number one cause for reducing capacity was inadequate nursing assistant (CNAs) staffing, followed by insufficient Medicaid reimbursement, and then a low number of licensed practical nurses (LPNs).

In Pennsylvania, the senior population, or those age 65 and older, exceeds 2.2 million people; nearly 70% of the senior population relies on Medicaid for their long-term care. State reimbursement rates are a critical factor when considering access to nursing home services.

One provider in Allegheny County said they had to shut down a sister community that was almost entirely Medicaid, after years of losses, as a result of lower Medicare Advantage rates. The facility could no longer subsidize the subpar Medicaid funding, with MA paying less than traditional Fee-for-Service (FFS) Medicare.

"Our staffing challenges are too severe to consider bringing beds back online. Increased funds are needed to retain the staff we have and to be able to recruit for the beds already online," one provider in Adams County said as part of the survey.

An overwhelming 93% of providers in the state would increase wages for new hires and existing staff if Medicaid funding were raised, LeadingAge PA reported. About 67% of respondents said they were unable to bring beds back online in the last year. Of the 32.6% that were able to bring beds back, the number one reason was the ability to hire more staff after a pay rate increase.

"The world of nonprofit skilled nursing centers is becoming a thing of the past due to decreased reimbursement, increased regulations and staffing issues," another provider in Montgomery County said in the survey.

Currently, just under 80% of providers are using agency staff to fill nursing positions at all levels.

The association is advocating for a $70 million increase in Medicaid for nursing homes as part of the 2024-25 state budget, along with at least $8.9 million for the state's Living Independence for the Elderly (LIFE) program, which offers home and community-based services

16 Strategies for Integrating CNAs Into Care Planning and IDT Meetings - From CNAs

Certified nursing assistants (CNAs) are uniquely positioned to contribute to care planning and interdisciplinary care team (IDT) meetings, where important decisions about residents' care needs and changes to their care plans are discussed. CNAs possess an understanding of residents' needs and preferences, including their favorite meals, music, TV shows, activities, level of comfort with the current care plan, conditions. In 2016, the Centers for Medicare & Medicaid Services (CMS) began requiring the integration of CNAs into IDT meetings and resident care planning.

In ongoing research with CNAs, directors of CNAs, directors of nursing, social workers, nursing home surveyors, ombudsmen and physicians, the challenges nursing homes face in integrating CNAs are complex. This includes coordination issues among CNAs across different shifts, not having suitable times for IDT meetings that accommodate CNAs' schedules, a failure of administrators/executives in acknowledging CNAs' value, insufficient training for CNAs on care planning, and staffing shortages. Further, members of the IDT also struggle with knowing what questions to ask CNAs and how to leverage their expertise into decision-making during care planning. Addressing these issues is crucial for the seamless integration of CNAs into care planning and IDT meetings and the overall improvement of resident care.

Cultivating a culture of CNA recognition and empowerment:

1. Have administrators spend time on the floor with residents and CNAs to better understand their contributions.
2. Make leadership more approachable and present in the building through open-door policies for all employees.
3. Educate CNAs on the care planning process.
4. Allow CNAs to write in care plans and be involved in electronic documentation, providing them a sense of leadership.
5. Create a Director of CNAs or lead CNA role via new hire or promotion.
6. Incentivize CNAs' active participation in IDT meetings by providing opportunities for professional growth and/or raises.

Navigating challenges with scheduling IDT meetings:

1. Conduct polls and surveys among CNAs using free tools like Qualtrics or Google Forms to identify their preferred meeting times for IDT meetings.
2. Explore the effectiveness of scheduling meetings at times like 3-3:30 p.m. to accommodate both first- and second-shift CNAs.
3. Ensure the CNA responsible for the specific resident being discussed in the care planning and IDT meetings attends and actively participates in meetings.
4. Provide CNAs with access to the care plan before meetings for review and to provide input.
5. Ensure another staff member can fulfill CNA duties when they are in the IDT meeting.
6. Utilize communication tools such as communication cards or daily logs to ensure real-time information is shared among IDT members and tracked effectively.

Soliciting information from CNAs during IDT meetings using the following questions:

1. Did anything occur in the previous month related to the resident's treatment or rehabilitation plan that you would like to share?
2. What is and what is not working well in the care plan?
3. What are the preferences of the resident that are currently not taken into account?
4. Your thoughts on the proposed goals of care and implementation strategy in the care plan?

House Bill Requests $1.6 B Program to Increase Nursing Home Workforce

The Nursing Home Workforce Support and Expansion Act, introduced by Representative Steven Horsford (D-NV), would provide workforce grants to states, US territories and tribal governments based on their population of seniors and people with disabilities — targeting pay, benefits, education and retention improvements for nursing home workers. The aim of the bill is to increase the workforce in nursing homes with $400 million over each of the next four years.

In announcing the bill (Horsford Introduces Legislation to Improve Nursing Home Care for Nevada Seniors | Congressman Steven Horsford (house.gov), Horsford acknowledged the difficulties that providers face retaining workers. Most directly, the proposed legislation would address this by providing wage subsidies to help keep nursing home wages competitive with other healthcare sectors and competing industries. To supplement that, the grants also would fund student loan and tuition assistance, guarantee affordable childcare and subsidize transportation costs for workers. All of these measures would be required of any government entity that accepts grant funding.

Additionally, those government bodies would have the discretion (untitled (house.gov) to use grant funding to create emergency funds for nursing homes, subsidize paid leave for care workers and provide resources like interview clothes and legal assistance to lower the barriers of entry into the long-term care workforce.

The bill defines who qualifies as an "eligible individual" to receive funding from the proposed grants — such as certified nurse aides, licensed practical nurses, social workers, and anyone in training for certification in those roles. "Long-term care workers face low wages and challenging work conditions," Horsford said. "I've seen the difference that high-quality care can make…. This legislation will invest in our care workers in nursing homes across the country so they can retain their skilled workers, while also expanding the workforce by attracting new individuals to the field."

The proposed legislation comes as long-term care providers are awaiting the impending arrival of a first-ever national nursing home staffing mandate and an already-existing staffing shortage during which nearly a quarter million nursing home workers left the sector between 2020 and 2023. Providers and policymakers who are critics of the staffing rule from the Centers for Medicare & Medicaid Services (CMS) have frequently called it an unfunded mandate and a clumsy, one-size-fits-all approach to improving care. Forecasts of the total cost for providers to implement the rule have varied, with CMS initially estimating around $4 billion and leading provider group the American Health Care Association (AHCA) estimating a roughly 70% higher at $6.8 billion.

While the Nevada congressman's proposed legislation would make up for only a portion of that suggested price tag — a total of $1.6 billion spread between fiscal years 2025-2028 — top critics of the mandate have united behind the bill.

"The Nursing Home Workforce Support and Expansion Act exemplifies the support that the long term and post-acute care profession needs as we continue to face a caregiver shortage," said Clif Porter, senior vice president of government relations at AHCA. "We thank Representative Horsford for his innovative and thoughtful approach to building policy that directly addresses the challenges of attracting and retaining passionate workers for the sector."

Katie Smith Sloan, president and CEO of nonprofit association LeadingAge, shared that sentiment. "Without staff, there is no care," she said. "This bill … will get us one step closer to an America that values older adults and those who serve them."

The SEIU, which represents many unionized long-term care workers, also supports the bill.

New Bill of Rights for People With Alzheimer's Disease

Voices of Alzheimer's, (Voices of Alzheimer's (voicesofad.com) a nonprofit organization, recently created a bill of rights (Bill of Rights — Voices of Alzheimer's (voicesofad.com) for people living with Alzheimer's disease.

Jim Taylor, president and CEO of the organization, said his group will reexamine the document every year to make changes if necessary.

Some of the clauses in the 10-point bill of rights include the right to have prompt diagnosis and treatment, the right to be treated with dignity and respect, the right to annual cognitive screenings, and the right to affordable Medicare and other payer coverage to cover fees.

It's not the first time that a bill of rights for Alzheimer's disease was created. Taylor said the team found documents that were more than a decade old, which also included a bill of rights for people with dementia.

"Because of all the tremendous developments in screening for blood biomarkers and in disease modifying therapies, this is a totally new landscape," he said in an interview with Being Patient (There's a New Bill of Rights for People With Alzheimer's | Being Patient).

In addition to rights for older adults with Alzheimer's, one point on the list applies to younger people diagnosed with the disease or mild cognitive impairment. These adults may not have been included in the traditional population of people with Alzheimer's disease.

"We really needed to issue a new document, one that we consider a living document," Taylor added. "We're not going to put it in the ground and leave it. We hope every year to reexamine it and to re-publicize it, but also to make the changes that are important, given the advances that have occurred and whether or not that makes us rethink some of the way that our verbiage is written."

Over time, Taylor hopes that the bill of rights will make it into the hands of lawmakers so they can better understand what people with dementia and Alzheimer's deal with on a daily basis. Some of the challenges in Taylor's experience include getting prompt access to care, being able to participate in clinical trials (Addressing Diversity in Alzheimer's Clinical Trials | AAIC 2021) and being able to afford breakthrough treatments. His wife was first diagnosed with mild cognitive impairment and later Alzheimer's disease.

Pennsylvania
Nursing Home Administrator
Online Program

Philadelphia College of Osteopathic Medicine
PA-State Approved 120 Hour Nursing Home Administrators Online Program

Take your skills and knowledge of older adults a step further through PCOM's 120 Hour Nursing Home Administrators online program. This Pennsylvania State Board of Examiners of Nursing Home Administrators-approved program is designed to provide the knowledge for those interested in pursuing a career in the long- term care administration field. The faculty of PCOM NHA program are leaders in long-term care who will share their experiences in the clinical and managerial aspects of skilled nursing care.

This 120-hour program is offered completely online and runs from **August 27 – December 17, 2024**. Each week, participants will complete online course requirements asynchronously with an option to engage in live interactive webinars each Tuesday. For those unable to attend the Tuesday webinar, on-demand recorded sessions will be made available.

For more detailed information or to register, please follow this link:
https://conted.pcom.edu/public-catalog/products/303

If you have any questions, please reach out to **Tinach@pcom.edu**

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 posting a staffing ad, 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.

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