2027 Annual PADONA Conference

March 30 – April 2

THANK YOU TO ALL WHO ATTENDED THE PADONA 38TH ANNUAL CONFERENCE IN HERSHEY DURING THE WEEK OF MARCH 24 – MARCH 27!

WE HOPE IT WAS AS MEMORABLE FOR YOU AS IT WAS FOR PADONA!

IF YOU WERE A RETURNING CONFERENCE ATTENDEE – THANK YOU AND WE ARE SO HAPPY YOU HAVE MADE THIS YOUR ANNUAL CONFERENCE!

IF YOU WERE NEW TO THE CONFERENCE – THANK YOU AND WE HOPE IT WAS MORE THAN WHAT YOU EXPECTED AND THAT WE HAVE MADE YOU BELIEVERS AND YOU WILL KEEP COMING BACK!

MARK YOUR CALENDARS – THE SCHEDULE IS SET FOR THE 2027 ANNUAL CONFERENCE (LISTED ABOVE) AND WE WANT TO SEE YOU THERE!!!

THANK YOU FOR THE OPPORTUNITY TO SERVE AND SUPPORT YOU!

PADONA HOSTED EDUCATION WEBINARS

- **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
- **Need to Know: F658 Schizophrenia Diagnosis, Antipsychotic Medication Quality Measure Changes and Falls With Major Injuries**
  Date: April 28. 2026
  Time: 11:30 am until 12:30 pm
  Educator: Tammy Coleman, RN, RAC-CTA, CNDLTC, Vice President of Business Development and Consulting, Affinity Health Services
  Registration Fee: $35 for members and $50 for non-members
- **Whose decision Is It? Healthcare Decisions and Who Has the Decision-Making Power**
  Date: May 14, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Mark Mattioli, Healthcare Attorney with Post & Schell
  Registration Fee: $35 for members and $50 for non-members
- **Antibiotic Stewardship**
  Date: June 2, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Denise Cutting, RN, MSN, MHS, CNL, CIC, Infection Prevention Advisor with Patient Safety Authority
  Registration Fee: $35 for members and $50 for non-members
- **Documentation Support for the MDS**
  Date: June 9, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Heather McGowan, RN, BSN, RAC-CT, Director of Clinical Reimbursement, CHR Consulting Services
  Registration Fee: $35 for members and $50 for non-members
- **Wound Care Infections**
  Date: June 23, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Merewyn Sheeran, BS, RN, CIC, LTC-CIP, Infection Preventionist | PA Project Firstline
  Registration Fee: $35 for members and $50 for non-members
- **HAI Reporting requirements in Pennsylvania**
  Date: July 7, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Amanda Bennett, MPH, MLS**, CIC, Infection Prevention Advisor, Patient safety Authority**
  Registration Fee: $35 for members and $50 for non-members
- **Internal Controls for Nursing Home Pharmacy OIG Work Plan Item and Opioid Deprescribing**
  Date: August 11, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Ana Sidor, PharmD, BCGP, FASCP, Director of Clinical Services Brockie PhramaTech
  Registration Fee: $35 for members and $50 for non-members
- **Enhanced barrier Precautions Reviewed**
  Date: August 18, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Monica Magee, BSN, RN, CIC, Infection Prevention Advisor, Patient safety Authority
  Registration Fee: $35 for members and $50 for non-members
- **Leadership in Healthcare**
  Date: September 1, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Tammy Dunmyre, RN, RAC-CT, Nurse Consultant, Lewis Litigation Services
  Registration Fee: $35 for members and $50 for non-members

- **Effective Grievance Management – Distinguishing Between Grievances and Concerns**
  Date: September 22, 2026
  Time: 11:30 am until 12:30 pm
  Educator: Lori Ammon, MA, LSW, NHA, PCHA, CHC, Compliance Manager, AQORD Compliance Collaborative
  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

8:30 am – 12:30 pm

8.0 Nursing Continuing Professional Development Contact Hours

Eduator is: Melanie Ronda, MSN, RN, LTC-CIP, CPHQ

Director, Healthcare Quality Improvement, Health Systems Leader, Infection Preventionist

IPRO – the PA QIO

Registration is open now!

Plan to schedule team members to attend the

PADONA Annual Skin and Wound Care Course

August 4, 2026

8 am – 12:30 pm

4.0 Nursing Continuing Professional Development Contact Hours

Eduator is: Angela Huffman, RN, WCC, CHC

Compliance Specialist Ascension Living

Registration is open now!

Share the information and plan to attend the annual

PADONA SUMMER SYMPOSIUM

July 21 and 22, 2026 – 3.5 hours each morning with planned break

8:30 am until 11:45 am

6.0 Nursing Continuing Professional Development Contact Hours

July 21 – Ready Every Day: Turning Compliance into Habit, Not Hustle

Session 1: The Story Behind the Tags: What Deficiencies are Telling Us

Session 2: From Reaction to Readiness – Don't Just Fix It – Prevent It!

Educators are: Danielle Martin, Compliance Manager and Kerry Weaver, Compliance specialist with AQORD

July 22- Assisting Domestic Violence Victims in the Nursing Home

Session 1: Recognition, Reporting, Response

Session 2: Managing Emotions and Assisting the Victim

Educator is Mae Reale from the Domestic Violence Coalition

Registration will be available soon!

PADONA ANNUAL LEADERSHIP DEVELOPMENT COURSE

September 29 – October 2, 2026

Virtual Education

Full day education with scheduled breaks

25.0 Nursing Continuing Professional Development Contact Hours

25.0 Administrator CE Hours will be applied for through NAB

Prerequisite for the DON certification exam (CND

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

TView as Webpage

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.

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 every Thursday at 2-3PM ET 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

Leadership Snippets

Why 'just being yourself' threatens safety

Tomas Chamorro-Premuzic illustrates in a forthcoming book, *Don't Be Yourself: Why Authenticity is Overrated and What to Do Instead,* it has become fashionable to tell leaders—and others—to "just be yourself" or to "bring your whole self to work." The idea is seductive: after all, who wouldn't want to work in a place where they can express themselves freely, without external pressures or obligation to align their behavior to a corporate norm, and perhaps even celebrated for expressing their unedited and unfiltered self? But here lies a dangerous misconception. In fact, your "authentic" or "whole" self also includes the undesirable, unprofessional, and dark side dimensions of your character. As a comprehensive review of this topic highlights, "self-expressions may be experienced and perceived as authentic, and yet reduce one's influence if they irritate, anger, or overwhelm others." In that sense, you are better off bringing your *best* self to work; save the rest for your family, with whom we sympathize for having no escape! Psychological safety is not built through unfiltered self-expression; instead, it tends to require the opposite. Leaders who want to build safe environments for learning and innovation must resist the temptation to bring their "whole self" to work. Rather, they must make an effort to cultivate and express the best possible version of their professional self*,* namely the self that is devoted to the greater good, to developing others, and to working hard to achieve meaningful goals.

In any of these cases, "bringing your whole self" may feel liberating for the leader, but it comes at the expense of the team's ability to contribute without fear. Psychological safety demands that leaders filter, regulate, and elevate their behavior: an aspiration that is quite distinct from unedited authenticity.

Consider four ways in which "whole self" leadership can obstruct safety:

1. **Unfiltered emotions**: A leader who vents every frustration, irritation, or passing mood risks creating a volatile climate. Teams end up tiptoeing around the leader's emotions instead of focusing on the work.
2. **Biases and prejudices**: Everyone harbors biases, but airing them under the guise of authenticity is toxic. Expressing stereotypes or discriminatory views (however sincerely held) undermines trust and risks excluding essential voices.
3. **Brutal honesty taken too far**: Sharing your every thought or judgment may feel authentic, but it can humiliate others. Safety requires candor, yes, but also tact, empathy, and timing. There must be some limits to unfiltered honesty. "If someone shows you a picture of their newborn child, you don't tell them, 'that's an ugly baby.'"
4. **Self-centeredness**: Leaders who insist on prioritizing their own needs, quirks, or values above the team's mission confuse the purpose of leadership. Leadership is about enabling others, not indulging oneself. Indeed, with power comes responsibility, and with great power comes great responsibility. T

WHY OTHERS, TOO, SHOULD BRING THEIR BEST, NOT THEIR WHOLE, SELVES

The same principle applies to employees who are not formal leaders. While leaders carry heavier responsibility, every team member contributes to the climate. A workplace cannot function if "being yourself" means failing to consider how one's actions affect others.

Imagine a software engineer who insists on interrupting colleagues because "that's just how I am." Or a salesperson who justifies aggressive, competitive behavior as "authentic." Or someone who loves cracking jokes that make some people laugh but are offensive or hurtful to others. At some point, the right to be fully oneself collides with the obligation to create space for others. Teams thrive not because everyone is indulging their idiosyncrasies, but because members align around a shared mission and adapt their behavior to make collective work possible.

Compliance Communication

Maryland Attorney General Announces Settlement over Substandard Nursing Home Care

On March 19, 2026, Maryland Attorney General Anthony G. Brown announced a $250,000 settlement with the owners of a nursing home in Oakland, Maryland, resolving allegations that they violated the Maryland False Health Claims Act by providing substandard care to hundreds of residents.

The settlement involves both current and former owners and includes a monitoring agreement in which the Office of the Attorney General will oversee the facility for three years. This marks the fifth nursing home case resolved in the past two years by the Medicaid Fraud and Vulnerable Victims Unit (MFVVU) and is part of an ongoing effort to improve conditions at the state's roughly 230 nursing homes.

The facility came to the office's attention in 2024 after two residents died. The investigative team gathered extensive evidence on day-to-day operations and conducted a "strike force" visit. During this unannounced visit, a large group of investigators—including members from MFVVU, DHS Adult Protective Services, and the Department of Aging State Long-term Care Ombudsman—conducted a comprehensive review of operations.

The investigation found:

- Failure to satisfy state regulations regarding registered nurse staffing on 17 percent of shifts;
- Failure to meet bedside care staff-to-resident ratio regulations on 25 percent of shifts;
- Eleven patients suffering serious injury due to falls and other preventable events;
- Several serious regulatory violations compromising patient care, including improper nutrition and feeding; and
- Frequent resident complaints about long call-bell response times.

The investigation revealed that Medicaid recipients were receiving care so substandard that taxpayers, who fund the program, were being defrauded. To ensure improvement, MFVVU required the monitoring agreement in addition to the monetary settlement. Paid for by the facility, the agreement allows the state to monitor all relevant aspects of operations through outside audits and unfettered access to corporate documents, medical files, and staff. If problems continue, the facility must make improvements or face renewed legal exposure.

Compliance Requirements:

1) Ensure there are policies and procedures regarding resident care and they meet the federal and state regulatory requirements and standards of practice.
2) Ensure the policies and procedures related to resident care are regularly reviewed with the team members in staff meetings to ensure awareness and understanding.
3) Provide on-going and regular team member education and competency training to ensure resident care is being delivered at a level of quality and per standards of practice as well as being compliant with regulatory requirements.
4) Routinely and regularly audit resident care delivery to ensure the care provided adheres to the policies and procedures.
5) Discuss care delivery with residents to ensure they agree that care is at a level of quality that is acceptable.

Navigating Antipsychotic Expectations Amid New Pressure on CMS

The federal oversight agency of the OIG in March accused nursing homes of inappropriately diagnosing residents with schizophrenia to “mask” the misuse of antipsychotic drugs and “artificially inflate” their star ratings — just days after another agency said it was reviewing whether to continue its strict policy limiting the use of such drugs.

The nation’s Medicare agency should do more to prevent antipsychotic use among skilled nursing residents and keep more attention on their possible risks, the Department of Health and Human Services Office of Inspector General stated in two companion publications. The report maintains pressure on CMS.
The dual reports on antipsychotic use and schizophrenia diagnosing were based on 40 nursing home audits conducted between 2018 and 2021, before a 2022 schizophrenia coding change to the MDS and before the Centers for Medicare & Medicaid Services (CMS) launched schizophrenia audits in 2023. CMS also updated surveyor guidance on antipsychotic medications last April to strengthen medical director responsibilities and to ensure clinical teams adhere to consistent standards of care, including new psychiatric diagnoses and prescribing antipsychotics.

In its reports, the OIG said medical directors made inappropriate schizophrenia diagnoses to “justify prescribing antipsychotic drugs,” used those diagnoses to “skirt Medicare safeguards intended to protect residents” and “compromised residents’ care” by inappropriately diagnosing schizophrenia.
LeadingAge on Thursday called the OIG’s findings “inexcusable” and agreed that false diagnoses should never be applied. But Jodi Eyigor, vice president of health policy, also called on CMS to focus “policies, practices and metrics on better distinguishing between appropriate and inappropriate use of antipsychotic medications and then target resources to stop the practice.”

“False diagnoses should not be applied to avoid quality measure implications, and quality measures should not discourage necessary care,” she added in an emailed statement. “Rather than making sweeping generalizations — that all antipsychotic usage is bad — and continuing to patch up an ineffective fix (i.e., such as implementing audits based on an influx of new diagnoses that result from a blunt-object quality measure), we need to solve the real problem.”

The OIG did not provide any examples of appropriate antipsychotic use in its reports. Instead, it urged CMS to update and add resources addressing non-drug interventions, dose reductions, and related strategies.
The OIG recommended (Nursing Homes’ Inappropriate Use of Antipsychotic Drugs Poses a Risk to Residents | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services) CMS build on its efforts to reduce inappropriate schizophrenia diagnoses, which it has targeted through the audits.

The report also called for an expanded use of data to monitor diagnoses and target oversight, as well as increased efforts to ensure nursing home residents and families are fully informed when antipsychotics are given. Facilities are already required to obtain consent from the resident or a family member when starting or increasing an antipsychotic medication, which should list a reason.

CMS did not concur with the OIG recommendations, saying that its approach to oversight is “constantly evolving.” The agency acknowledged less than two weeks ago that it was “actively reviewing the antipsychotic [quality] measure with the goal of supporting clinically indicated use while continuing to discourage inappropriate prescribing.”

Congress had called on the agency to distinguish between inappropriate and appropriate prescribing of antipsychotics, and providers cheered the news that regulators might soften their stance on medications that many providers and families want to help their residents manage distressing neuropsychiatric symptoms. While providers and pharmacists had cheered the idea of CMS even considering the idea of relaxing its quality measure to make room for more acceptable antipsychotic uses, some experts said the new OIG reports are an important reminder that little has changed yet. Providers have been held increasingly accountable for antipsychotic use since a major reduction campaign launched in 2012 — even though the sector has lowered rates significantly overall.

It is recommended providers attempt non-pharmacological interventions prior to seeking medications. Documentation of what has been tried and why it failed is an important component. Audit for behavior documentation, and that it is up to date and accurate, and remember that some individuals will need antipsychotic medications because they suffer from neuropsychiatric symptoms. NPS includes things like agitation, depression, wandering and several other symptoms. Antipsychotic medication can help alleviate those symptoms."

But the OIG took a much harsher view of the medications, which carry Black Box warnings. It found facilities prescribed antipsychotics to residents with dementia to "manage their behavior for the benefit of staff, despite FDA's warning that these drugs may increase the risk of death. Even though antipsychotic drugs pose risks to residents' health, nursing homes did not take required steps to help protect residents who were given these drugs," the report said. "Medical directors failed to prevent inappropriate use of antipsychotic drugs. Nursing home pharmacists failed to identify medical concerns and did not recommend dose reductions."

Still, CMS said its survey process was working to identify outliers. And one provider organization said less than 1% of nursing homes have had their quality ratings affected by a schizophrenia or dementia care-related audit.

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.

CMS Leader Talks Risk-Based Surveys, Staffing Campaign, Survey Hot Spots

The Centers for Medicare and Medicaid Services (CMS) is set to roll out risk-based surveys on a broader basis, with final criteria expected to be released in a matter of months. Inspectors still could flag targeted operators for a full survey, depending on what they find. That's according to Evan Shulman, director of the division of nursing homes for CMS.

About 10% of skilled nursing facilities in the U.S. would qualify for the risk-based survey, and that criteria for that survey will be released mid to late summer, according to Shulman. These surveys are more targeted instead of a full, standard recertification survey. Qualifying nursing homes likely would have five-star ratings and not have failed schizophrenia audits, for example.

Elopements represented the number one citation "hot spot," he added, with misuse of lift equipment being number 2 and choking being number 3.

Certified nurse aides (CNAs) are included in the staffing campaign using CMP dollars, streamlining the process to get more people to fill this role. The campaign also will focus on nursing homes that are struggling the most to hire workers, such as facilities with high staffing shortages and rural areas. The campaign is up to $40,000 for loan repayment for a four-year nursing program isn't going to go very far, while the two-year program is facing a long waiting list due to a shortage of teachers.

CMS may be using more AI too, Shulman said, while also discussing proper use of AI by the nursing home as use rapidly evolves in the sector. The warning was issued that if a provider uses multiple AI vendors you run the risk of HIPAA breaches or security breaches.

The OIG report released on earlier in March found widespread misuse of antipsychotic drugs, especially among residents with dementia, while also suggesting these medications were often used to control resident behavior. The report shows that there are still a lot of bad actors out there, Schulman said.
This quality measure could make it difficult for placement for those individuals who need an antipsychotic for their neuropsychiatric symptoms, to keep them safe because of their agitation and aggression.
Adversarial relationships between surveyors and facility leaders were discussed by Shulman, who said there is a mediation resource of sorts that can be used by both operators and surveyors.

‘Good News’ as CMS Doubles Spending on Nursing Home Staffing Campaign

Providers welcomed the “good news” that the budget for a Centers for Medicare & Medicaid Services (CMS) nursing home staffing campaign has more than doubled to reach $200 million. The campaign was originally set to devote $75 million to nurse training and recruitment for the long-term care sector and is set to begin in earnest this summer.

Centers for Medicare & Medicaid Services Administrator Mehmet OZ noted that a related collaboration with states had led to the near tripling of the designated spending. “Every governor, all 50, engaged us to contribute money so all of us can train more nurses designed for nursing home staffing, especially in rural areas,” Oz said. “And it’s gonna work. We’ll launch it over the summer.” In addition to announcing the new $200 million allotment, Oz said the agency has “people who are donating money to help cover some of the overhead, so all the money goes to training nurses.”

Nursing homes are competing with hospitals, home health agencies and other providers for a limited pool of highly skilled professionals. For nursing homes to be able to recruit and retain the registered nurses residents depend on, initiatives like [CMS’] expanded financial incentives program are critically important. Nursing homes will require tens of thousands of additional registered nurses in the coming years to meet rising demographics and higher needs among residents.

The staffing campaign was first announced as part of a now-defunct federal nursing home staffing rule. It has been said to include financial incentives to recruit registered nurses and licensed practical nurses, including up to $40,000 in tuition reimbursement and/or a $10,000 stipend in return for working three years in a qualifying nursing home or state inspection agency. In addition, CMS has also said it will invest in online and other tools that help promote and streamline CNA recruitment.

While it survived the rule’s repeal, the program’s launch has been delayed multiple times since 2023. A new notice of funding opportunity needed to identify groups that can allocate grant funding was launched last month (https://www.grants.gov/search-results-detail/361025#xd_co_f=MmVlOGE2NzctYWQzNS00Yzc3LTk4ZmYtMGIyM2FhNDY2Nzg3~) . Applications are due March 27, 2026, with the earliest possible start to the program expected to be July 1, 2026.
The program will be funded by the federal government and through the state use of civil monetary penalties, which are collected from nursing homes cited for lapses in care. Oz last year encouraged governors to tap the CMP funds they hold for the nursing home staffing program to supplement the previously announced CMS budget line.

Providers warmed to that news, given that states were holding $485 million in those funds at the end of 2025 — with many states funding five or fewer programs annually to help improve nursing home quality.
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“I saw things as a physician, including the fact that we didn’t have enough nurses, and the nurses we did have were the glue that held the system together,” he said. “When you get more nurses, when you train them, I think this is going to help us address the high burnout rate, while continuing to get nurses involved in treating patients and saving lives.”

US House Responds With Its Own Nursing Home Staffing Bill

A bill to mandate nursing home staffing at levels that exceed even failed federal regulations has been introduced by two House Democrats. Representatives Jan Schakowsky (D-IL) and Lloyd Doggett (D-TX) have stood side-by-side with union officials in advocating for nurse staffing ratios since it was announced more than four years ago.

While the Centers for Medicare & Medicaid Services (CMS) finalized rules in 2024 requiring around-the-clock registered nurse staffing and 3.48 of nursing care per resident per day, they were defeated in two courts and repealed by the current administration before ever going into full effect. Now, Democratic lawmakers in both Houses are looking to get around the argument that felled the staffing rules in court by changing Congressional statutes governing nursing home minimums.

The Schakowsky-Doggett bill, titled the Safe Staffing Saves Lives Act (safe-staffing-saves-lives-act-one-pager.pdf), would boost the mandated minimum to 4.1 hours of direct care per resident per day. That's in line with a study from the early 2000s and far exceeds the benchmark CMS set after conducting a new, in-depth study in 2022. The bill also would prescribe hourly coverage by certified nurse aides, licensed practical nurses and RNs. The CMS rule allowed LPNs to count for some total hours but did not mandate their time. The legislation establishes more stringent penalties, too. While the CMS version left those open to interpretation using a range of penalties already in the agency's wheelhouse, the Safe Staffing bill subjects facilities that do not meet minimum standards to surveys every three months; denial of federal payments for any newly admitted residents; ineligibility for the Skilled Nursing Facility Value-Based Payment Program; and prohibition on transfers or discharges of residents for the purpose of meeting the minimum staffing requirement.

Last month, seven Democratic senators introduced their own rule, which more closely mirrored standards in repealed federal regulations. In addition, a report from Senate Aging Committee Ranking Member Kirsten Gillibrand (D-NY) last week sought to keep the nursing home staffing issue alive, accusing the administration's repeal of "letting nursing homes off the hook."

The House bill includes a waiver provision for 180-day periods, but it would not be available to nursing homes in the Special Focus Facility Program, or any found to have a deficiency that resulted in harm to a resident or "jeopardized the health or safety of its residents."

"Study after study shows that stronger staffing standards lead to better patient outcomes and higher-quality care," Schakowsky said in a press release (Schakowsky, Doggett Unveil Brand New Bill to Establish Mandatory Nursing Home Staffing Standards | Congresswoman Jan Schakowsky) issued Thursday. "It is past time that we act on the evidence, hold facilities accountable, and ensure every resident receives the person-centered care they deserve."

In addition to comments from Doggett, that press release also cited leaders from three major labor unions representing skilled nursing staff. The House bill's cosponsors have each attended multiple union events pressing for the staffing rules, which Schakowsky in 2023 said would be "good for these overburdened workers."

Providers Navigate Opportunity and Exposure of Respiratory Therapy

As many as half of all nursing home residents may benefit from respiratory therapy, given rising complexity and common conditions such as COPD, congestive heart failure and other chronic breathing and swallowing disorders. But the same experts who see the need also see danger for skilled nursing providers, who can get paid extra to provide such services but also face mounting audit and claims denial risks. Providers believe that respiratory therapy in nursing homes is both an opportunity and an exposure.

Late last year, respiratory treatments in the special care high designation are a driver for nursing home of reimbursement but also of denials. Providers frequently fail to capture needed indicators or provide related documentation. This issue will increase as more states convert to Medicaid case mix systems built around the Patient Driven Payment Model (PDPM) meaning states would also begin evaluating the necessity of respiratory care for long-term care patients.

And the Office of Inspector Genera (OIG)l audit of nursing home PDPM coding found one provider erred in 99% of its claim submissions. Now, concern is growing around future OIG and Centers for Medicare & Medicaid Services (CMS) attention on respiratory claims.

Respiratory care strategies that focus on provision and documentation can reduce hospitalization; capture need appropriately and withstand regulatory review. Providers must design a system that works backward to understand what auditors will see when they look at the documentation. Systems should demonstrate clear skilled need and the clinical decision-making process, including oversight by a physician.

Having a standard assessment of respiratory risk is key to identifying need, and providers should also have a trainable way of defining the need for skilled care among their population. They also need an escalation pathway for residents whose conditions are newly exacerbated.

Although a Special Care high designation requires at least 15 minutes a day of daily respiratory therapy and a GG functional score of 14 or higher, Hoak said up to 50% of today's nursing home residents truly need that level of care. Even a daily nebulizer takes an average of 17 minutes to administer, in addition to time to assess, monitor and clean up.

There are major challenges for providers capturing all the steps needed to earn additional reimbursement, including that evaluations are conducted by qualified personnel with a way to capture and preserve their training and credentials. Physician orders are also required and must be specific regarding modality, frequency, duration and scope.

Providers should establish standard education and training programs that support staff across shifts in capturing and providing needed care. Medical necessity must also be established and notable in the documentation.

Surviving Nursing Home Audits in the Age of AI

Nursing home audit success depends on proactive habits. Providers who regularly review their own documentation stay informed about Medicare policies and audit trends and make sure each resident encounter is clearly documented and individualized are on the right track. And the devil's in the details. The smallest gaps, or easy fixes, can trigger audits for treatment decisions, unclear chief complaints or mismatched diagnosis codes can all result in a denied claim.

Proactive habits become more important than ever when automation and AI are added, both of which are rapidly transforming health care billing and auditing of nursing homes, starting with an increase in scrutiny. Providers and payers both use AI tools to increase efficiency – payers use AI to analyze massive volumes of claims data. AI systems look for patterns such as copied notes, overuse of high-level billing codes and vague documentation. If AI flags a claim, it's brought to human auditors which can then lead to external audits.

Overall, data patterns drive audit selections in today's tech-driven world. In addition to coding and cloned notes, reviews are triggered by high-frequency visits and inconsistencies between coding and documentation as well.

Note cloning is a major red flag for auditors, since it suggests a lack of individualized care and can be interpreted as misrepresentation. Irrelevant information in notes was another potential pitfall with audits. Auditors don't like to count the words. They don't like note bloat. That's where you talk about all this irrelevant information, and they're having to weed through it to try to figure out why in the world this doctor or nurse practitioner is seeing this resident again. They want to see your thought process and the evolution of care, because clinical clarity is everything.

And so, providers need to be more explicit and precise in their documentation, clearly stating clinical reasoning and severity – don't assume such things are implied. Strong documentation is a provider's primary defense. If it's clear, if it's concise, you can defend that. Align CPT codes, ICD diagnoses and thorough documentation to defend work and reduce audit risk, while also ensuring appropriate reimbursement.

The auditor typically looks at four criteria: monitoring, evaluating, assessing and treating, and the audit process follows a lifecycle. A trigger leads to a documentation request, followed by a review, determination and then possibly a recoupment of payments. But operators have the right to appeal decisions and a significant percentage of audit findings are overturned when challenged with strong documentation.

Appealing is an important step to take, since simply repaying claims could signal ongoing issues and trigger additional reviews. Fifty to 60% of audit findings are reversed. You can challenge your UPIC and RAC auditors as long as you have solid documentation. Some entities are focused on identifying improper payments while others hone in on detecting fraud, but all aim to ensure that documentation aligns with billing.

Audits usually occur primarily for these two reasons: ensuring quality or ensuring payment accuracy. Coding alone isn't enough, supporting documentation is needed to avoid claim denials, which can happen even if care was appropriate.

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Long-Term Care Infection Prevention Symposia 2026

The Patient Safety Authority is offering four regional **Long-Term Care Infection Prevention Symposia** in 2026. Don't miss these infection prevention (IP) topics, presented by leading experts and specifically focused on the needs of long-term care: building surveillance skills, managing contracted clinical services, water safety management, preventing and managing outbreaks, and conducting risk assessments.

The symposia will be held on four different dates at locations throughout the commonwealth. Registration and conference times, as well as the **agenda**, are the same for all dates and locations.

Registration and Breakfast: 7:30–8 a.m.

Symposia: 8 a.m.–3:30 p.m.

Tuesday, April 14	**RLA Learning and Conference Center** 850 Cranberry Woods Drive Cranberry Township, PA 16066	Register
Thursday, April 16	**The Conference Center at Central Penn College** 600 Valley Road Summerdale, PA 17093	Register
Wednesday, April 22	**Hilton Garden Inn Valley Forge/Oaks** 500 Cresson Boulevard Phoenixville, PA 19460	Register
Monday, May 4	**DoubleTree by Hilton Wilkes-Barre** 600 Wildflower Drive Wilkes-Barre, PA 18702	Register

5.50 continuing education hours will be awarded for completion of this course¡ *Continuing education credits apply to Pennsylvania registered nurses only. (Note: We have applied for nursing home administrator [NHA] credits but are awaiting approval.)*

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.

- 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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PADONA is on LinkedIn! Follow us at:
linkedin.com/company/padona

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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Contact PADONA for your education needs!

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