PADONA /LTCN
Pennsylvania Association of Directors of Nursing Administration

DEDICATED TO SERVICE
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JULY 2018

PADONA ENews

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Dear PADONA Members,

This Fourth of July, we might find ourselves barbecuing, congregating with loved ones and enjoying our precious free time. But, it is also a time to step back and take stock in the deep freedoms we enjoy every day. Although most of us are patriotic all year round, the Fourth of July gives us a chance to truly celebrate our country. We are so blessed to live in a land that affords such freedom and opportunity, and that is protected by the brave men and women of our armed forces. It is a time to remember the foundation upon which our country was built, the courage our founding fathers displayed and a time to appreciate and reflect on the wonderful gift of freedom that we all enjoy on a daily basis. PADONA wishes you and yours a fun-filled and safe Fourth of July holiday!

Our PADONA Board of Directors, staff, and many committee volunteers continue to work diligently in support of our members. A few items that I would like to share:

Our Professional Development Nurse Educator is working to become a Department of Health approved provider of Directed Inservice Training. We plan to begin offering this service to all nursing facilities in need of a Department mandated directed inservice in the very near future. PADONA will be offering a discounted rate for facilities with at least one PADONA member. In addition, contracting through PADONA for your directed inservice will provide RN CEU's for your staff! For further information or to inquire about this service, please contact Becky Flack at bflack@padona.com or me at cmcmullen@padona.com

The PADONA/LeadingAge PA webinar series on the Phase 2 requirements of participation focusing on the revised regulatory requirements and critical element pathways will resume later this month. Webinars are held every other week on Tuesdays from 11AM-12N. Be on the lookout for the next topic and speaker information in the weekly update. The webinars are taped and past webinars can be accessed on the PADONA website.

Don't forget to register for PADONA's LTC Leadership Development Program, being held October 16-19, 2018 at The Holiday Inn Harrisburg – Hershey in Grantville, PA. Session details and registration information can be accessed in our weekly update and through our www.padona.com website. This program is extremely popular and is filling up quickly! The information provided during this 4-day intensive course is relevant to Directors of Nursing, Assistant Directors of Nursing, MDS Coordinators, and other members of the nursing administration team seeking to expand their knowledge of long-term care nursing administration.

This fall, PADONA will begin offering a 2 day program in various parts of the state geared toward new Directors of Nursing, Assistant Directors of Nursing, Nursing Administration, including Shift Supervisors and Unit Managers on the "need to know" aspects of Long-Term Care Administration. Some of the key areas to be covered in this program include: responsibilities of nursing administration, customer service strategies, effective inter-disciplinary communication processes, PA Nursing Scope of Practice, leadership styles, managing difficult employees, review of the Pennsylvania Nursing Facility regulations, overview of the nursing facility survey process, regulatory reporting, and abuse

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and incident investigations. PADONA wants to provide you with resources to help you improve the knowledge and skills of your nursing administration team. Be on the lookout for more information on this program in the coming months!

Our education committee is putting together a webinar series for you, your nursing administration, and your interdisciplinary teams on various risk management topics. The "Mitigate Your Risk" series will begin in September! If you have a risk management topic that you would love to learn more about, please let me know! We intend to include a wide range of risk management topics in the series.

I want to continue to encourage each of you to join our forum on the PADONA website. We added this feature several months ago, at the request of our membership. The forum continues to be very slow in spreading but I am hopeful that we can make it a useful forum to network with each other, seek advice, and give support to one another! The link is: http://padona.com/forum. This is a great venue to post questions to other PADONA members and seek advice and input on issues that arise in your day to day operations. We encourage you to use this free resource provided by PADONA!

As always, please do not hesitate to let us know how PADONA can be of assistance to you. We look forward to several exciting new program offerings over the next several months!

Wishing you all a happy, healthy, and safe July 4 Holiday!

In Your Service,

Candace McMullen

A Deeper Look at Infection Prevention and Control—FTAG 880

Provided by Candace McMullen, RN, NHA, MHA, CLNC, CNDLTC, PADONA Executive Director

FTAG 880 is the third most frequently cited regulation in calendar year 2018, likely because of its broad span of influence in your nursing facility. Infection control practices are relevant to each and every staff person, resident, family member, visitor and practitioner and requires diligent cleaning and disinfecting of supplies, equipment, and the environment. Because infection control is a facility-wide program, it creates a much greater challenge to attaining and maintaining compliance.

FTAG 880 requires nursing facilities to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

The infection prevention and control program must include, at a minimum, both a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment and following accepted national standards, and written standards, policies, and procedures for the program.

FTAG 880 Regulatory Requirements

Your written program must minimally include;

1. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
2. When and to whom possible incidents of communicable disease or infections should be reported;
3. Standard and transmission-based precautions to be followed to prevent spread of infections;
4. When and how isolation should be used for a resident; including but not limited to:
5. The type and duration of the isolation, depending upon the infectious agent or organism involved, and
6. A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
7. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
8. The hand hygiene procedures to be followed by staff involved in direct resident contact.

The regulations also require a system for recording incidents identified under the facility's infection control and prevention program as well as documented corrective actions taken by the facility.

This tag also addresses the handling, storage, processing, and transportation of linens so as to prevent the spread of infection.

And, finally, each facility must conduct an annual review of its IPCP and update their program, as necessary.

Examples of FTAG 880 Non-Compliance

To better assist you in your quality assurance and improvement activities surrounding your infection control program; let's look at some of the challenges experienced by Pennsylvania's nursing facilities, since November 2017, with FTAG 880 compliance.

Glucometer Cleaning

Glucometers used for multiple residents must be cleaned and disinfected between residents according to the manufacturer's policy recommendations. A nursing facility's policy and procedure should address how often and when staff should clean the glucometer along with the acceptable manner in which it must be cleaned for proper disinfection. Citations often involve staff failure to disinfect the glucometer between uses or failure to disinfect utilizing the protocols outlined in the policy or manufacturer's directions. Example citation: During an observation the Licensed Practical Nurse (LPN) obtained a blood glucose reading from Resident and then wiped the glucometer with an alcohol wipe and not a registered disinfectant or germicide wipe.

Wound Dressing Changes

Our skin is a natural barrier to organisms and preventing infection. Residents with impaired skin integrity are at a significantly increased risk of developing infections. Examples of citations involving potential for cross contamination during a dressing change include:

1. The facility Wound Dressing Change policy instructed the nurse to open dressings to be used without touching the dressing, to open as many gauze packets as necessary to perform the treatment and to apply treatment medication as ordered using a cotton tipped applicator, sterile tongue blade or gauze pad. During an observation of a dressing change, the nurse applied a new pair of gloves but then reached into a plastic bag to retrieve tubes of topical medication and zinc oxide and opened packages of gauze. The nurse then applied the topical medication to the tunneling sacral wound initially using a cotton-tipped applicator but then used gloved fingers. When applying zinc oxide around the wound, the nurse also used gloved fingers and then applied the outer dressing. The RN wore the same pair of gloves during this procedure. The nurse failed to exercise proper infection control technique during the dressing change for, which created the potential for cross contamination.

2. During a dressing change, the nurse retrieved dressing supplies from the treatment cart and scissors from her purse. The nurse then placed the supplies on top of the resident's bedside table, and without washing her hands, opened a bottle of normal saline, a package of 4 x 4's, a package of topical medication, a border gauze dressing and retrieved a pen from her pocket and dated the dressing. Next, without washing her hands**,** applied disposable gloves, removed the resident's soiled dressing from the left buttock, and discarded into the resident's wastebasket. She changed gloves without washing her hands, cleansed the area, cut the dressing to size with the scissors that were retrieved from her purse, and applied the border gauze dressing. She rolled the resident onto her left side, changed gloves and then retrieved a package of cleansing wipes from the resident's drawer, removed the resident's urine saturated incontinent brief, and cleaned the resident. The surveyor then observed the nurse “double glove” as she attended to the resident’s right ischium providing the same treatment as she did on the resident's left side. During the observation, the topical medication that she used came in contact with the resident's over the bed table when she moved the dressing supplies. The nurse opened and used dressing supplies obtained from the resident's bedside stand, which contained an open packet holding the dressing and two opened bottles of normal saline. The nurse failed to maintain infection control practices during the dressing change.

3. Another example noted failure to ensure that aseptic (clean) technique was used during a wound care treatment and dressing change. A nurse performing wound care on four different wound areas for the same resident washed his hands between glove changes; however, he did not thoroughly wash his hands for the required 15 seconds and turned off the water faucets with his clean hands prior to drying his hands with a clean paper towel. In addition, after applying clean gloves, the nurse opened the dressing packages, touched bed linen, furniture and prepared tape. Without changing gloves, the nurse applied a prescribed topical ointment to his gloved hand (after contact with the various above noted items) and then proceeded to apply that ointment to the opened wound area on the four different locations. At one point in the observation, the nurse placed soiled saline soaked gauze directly on the clean work surface next to open tubes of topical ointments. Since there were four treatments, the trash with the soiled contaminated dressings and gloves was full and the nurse then used the room trash receptacle to dispose of soiled gloves and dressing. On three occasions, the nurse missed the trash receptacle with the contaminated dressing landing directly on the floor. The floor was not disinfected following the conclusion of the treatment.

4. During observation of a wound care dressing, the nurse placed clean dressings on the resident’s overbed table next to a used napkin and a coffee cup. The nurse did not establish a clean field prior to wound treatment, which created the potential of contamination of the resident's wound care supplies.

5. Facility policy on using gloves indicates that gloves should be discarded in the room as soon as they are contaminated. During an observation of a dressing change, a nurse prepared a resident for a dressing change. She removed the resident’s brief finding stool and subsequently cleaned the stool. The nurse then proceeded

with the dressing change, failing to place a clean field under wound to protect residents bedding during the dressing change. The nurse then removed a multi dose tube tube of Santyl ointment from a clear bag and squeezed some onto the dressing. With the last set of gloves used during the dressing change, the LPN gathered soiled lines, towels and other supplies dropped towels and linens on the floor in the residents restroom retrieved other used supplies and then returned to the restroom picked up soiled lines/towels from the floor holding them with one gloved hand and with the other gloved hand opened the door by turning the handle. The nurse then called for someone to open the door. Another staff member came with a soiled linen hamper and the nurse disposed of contaminated linens. The nurse then returned to the room to obtain the multi dose tube on Santyl ointment, removed gloves came out to the hallway holding the tube in her hand and verbalized that she was done with the procedure. LPN failed to preform hand washing after the last removal of gloves and failed to return to Resident room to sanitize the over bed table that was used during the dressing change.

6. During an observation of a dressing change, a nurse prepared a resident for a dressing change by removing the brief and finding stool in the brief. The nurse loosened the brief, wiping some stool from resident's buttocks then tucking the brief under the resident, leaving the remaining stool on the resident's buttocks, while continuing with the dressing change. The nurse failed to place a clean field under the wound to protect residents bedding. The nurse then applied acetic acid to the wound by pouring solution from the multi dose bottle that was at the bedside. She then applied the new clean dressing near the residue of stool that was left on the resident's lower buttocks area. As the dressing change was complete, the nurse returned the multi dose acetic acid solution bottle to the treatment cart.

Medication Pass

The following examples include deficient practices identified during surveyor observations of medication pass.

1. During an observation of medication pass, the nurse retrieved medication from an automated medication dispensing unit, touched the door knob, typed on a keyboard, retrieved additional medication from a drawer, exited the room touching the door knob, and touched two residents on the way back to the medication cart. The nurse then opened the resident's medication packet, touched the pill cup and retrieved eye drops. She then handed the medication cup to the resident, retrieved a cup of water for him and then applied gloves to instill his eye drops, without washing her hands.

2. In another instance, the nurse was observed passing medications to two residents. She administered several medications to the first resident and then proceeded directly to the medication cart and began pouring and dispensing medications for a second resident without performing hand washing between residents.

3. During an observation of the medication cart contained a container of Procell (protein supplement) powder with the scoop stored in the powder.

4. In the Medication Room, a surveyor noted the following in the medication cart drawers: 2 containers of cereal, a staff drink cup, numerous sugar packets, a large container of sugar, and a staff member's purse. In the medication room, observations noted three staff coats, one drink cup filled with fluid on counter covered with a paper towel, four boxes of copier paper, and numerous miscellaneous items stored under the sink.

5. During an observation of a medication pass, a nurse prepared a resident's medication by pouring pills into a bag to crush. The nurse used a finger to hold pill that he/she did not want to go into the bag. Cups with pills and liquid medication were placed inside one another and then carried to the room. The nurse spilled a

liquid medication on the floor, set the pill down, retrieved paper towels, and wiped up liquid and then continued with administering the oral medications. The nurse then applied gloves to administer eye drops, placing the eye drop storage bag on resident's blanket that she was covering her. The nurse then returned to the medication cart, removed keys from her pocket, charted on the computer and proceeded to remove medications for another resident. The nurse took all medications to the resident room and again spilled water on the floor of the room, set medications down, retrieved a paper towel and wiped up the floor. Medications were then administrated and the nurse returned to the medication cart, failing to perform hand washing during the medication pass, for either resident.

Nebulizer and Oxygen Treatments

In one instance, a facility's Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol policy indicated that after completion of therapy and between uses, the equipment was to be stored in a plastic bag marked with the date and resident's name. During observations on the nursing units, breathing treatment equipment was not stored in plastic bags per facility policy.

In another instance, surveyor observations noted a resident's nasal cannula lying on the floor behind a wheelchair, not bagged or covered, and a second nasal cannula lying on the resident's bed, not bagged or covered. The same resident's nebulizer was sitting on his bedside stand uncovered. Facility policy did not address storage of nebulizer equipment.

Another facility failed to maintain infection control practices in the care of residents receiving oxygen therapy. Observations of the oxygen humidifier bottle revealed that the humidifier bottle was placed on an upside down trash receptacle. The bottom of the trash receptacle was observed covered with various spots of dirt and liquid spills.

Bio-Hazardous Waste

In a recent survey finding, a facility's handling and removal of bio-hazardous waste policy, noted that when residents had an infection and precautions were needed, staff was to contain bio-hazardous waste in specified containers and wear personal protective equipment when handled. Nursing staff documented that droplet precautions were implemented for a resident with confirmed influenza infection; however, a nurse was observed handling bio-hazardous material and transporting the uncontained bio-hazardous waste through an occupied resident dining area before disposing in an undesignated trash receptacle, without wearing personal protective equipment.

In another, a facility failed to maintain proper infection control practices in one of three biohazard rooms and one of two soiled utility rooms. Facility policy titled Hand Hygiene indicated that all care partners are to wash their hands with soap and water when their hands are visibly dirty, contaminated, or soiled. Hand washing is to be done after contact with resident's skin, contact with body fluid secretions or excretions, non-intact skin and wound dressings, and after removing of gloves. During facility tour the biohazard room had waste boxes placed containing biohazard bags placed in front of the hand washing sink making the sink inaccessible to staff entering the room. Additionally, the hand washing sink contained unused red biohazard bags that were placed inside of the hand washing sink bowel. During facility tour, a room with a label on it titled dirty utility and trash room did not contain a hand washing sink inside the room.

Catheter Tubing

Clinical record review revealed that a resident with an indwelling urinary catheter and a history of UTI's, was observed with the catheter tubing and bag touching the floor. Several nursing staff was observed walking into the resident's room but did not remove the urinary drainage bag from the floor.

Infection Control Precautions

The clinical record for a resident revealed a current physician's order for Contact Precautions. Observation noted the respiratory therapist don a gown, gloves and mask before entering room with a pulse oximeter. The pulse oximeter was placed on the resident's bedside table. After performing tracheal suction, the RT placed the probe on resident's finger to get a reading, then placed the pulse oximeter back on the resident ' s bedside table before picking it up, removing her gown, gloves and mask and washing her hands. After leaving the resident's room, she placed the pulse oximeter on the respiratory therapy cart. The RT then picked up the pulse oximeter, entered another resident's room and placed the pulse oximeter on bedside table. The pulse oximeter was not disinfected after being used on a resident on isolation precautions.

A Resident's face sheet showed the resident was readmitted to the facility from the hospital with a physician's order to maintain the resident on contact isolation precautions due to four treatment resistant organisms. Daily observations during the survey revealed no visible evidence that any isolation precautions were in place for the resident.

In another instance, a resident admitted to the facility following an inpatient hospital stay and surgery on his right knee. The resident was receiving intravenous antibiotics for treatment of MRSA and septic arthritis of the right knee. Observation revealed the presence of a sign posted on the door frame to the resident's room which stated Contact Precautions. However, the sign wasn't posted until 24 hours after the resident admission and should have been posted upon admission.

A further example notes a facility failed to consistently implement procedures planned and necessary to maintain contact precautions. During an observation a housekeeper entered a resident room of resident requiring contact precautions for C. Difficile, wearing only gloves. The housekeeper cleaned the resident room, including the bedside tables, beds, sweeping and mopping the floor and cleaning the bathroom. The housekeeper was not observed to wear any protective clothing or equipment, other than the gloves. The surveyor donned personal protective equipment, including a gown and gloves, and entered the same resident room. Prior to exiting the room the surveyor removed the gown and gloves and attempted to discard the protective equipment into the residents' designated trash receptacle for disposal. However, the receptacle was located across the room and behind the seated resident. The trash receptacle could not be accessed without again crossing the resident room without wearing protective equipment.

General Care

The following examples note deficient infection control practices during routine care procedures.

1. A facility's infection control policy indicated that the purpose of their policy was to ensure a sanitary environment. A nursing note revealed that a resident had a nose bleed, and two hours later continued to have bleeding from his nose and was subsequently sent to the hospital. Observations of the same resident's room revealed a day later noted that dried red drainage visibly smeared on the floor by the resident's bed.

2. A resident was assisted by a Nurse Aide while he self-propelled in his wheelchair through his room. After the nurse aide assisted the resident to transfer into bed, she placed the resident's shoes directly on top of his wheelchair seat cushion. The nurse aide then obtained a pair of pressure relief boots off the floor and applied them on the resident's feet.

3. Facility failed to follow a physician's order for a nasal swab for influenza. The clinical record revealed written communication from nursing to the physician regarding the resident having a cough, temperature elevation and complaint of not feeling well, with a resulting physician order for chest X-ray and nasal swab for influenza. Several days later, the Director of Nursing indicated that the facility did not have nasal swabs in stock and that the nasal swab for influenza had not yet been collected.

4. Facility failed to ensure that residents were served meals in a safe and sanitary in the dining room. Observation of dining service revealed that culinary aide walked out of the country kitchen with gloves on. The aide put their left gloved hand into their pocket, and adjusted their apron and pants. The aide then picked up a used serving tray and proceeded back into the kitchen area to begin serving two more residents food without changing their dirty gloves. Further observations conducted of dining service revealed the same employee left the country kitchen area, adjusted their pants, touched the wall several times, and picked up a second used serving tray before proceeding back to the country kitchen. This employee also handled clean plates and put unused utensils away without changing their dirty gloves. Dietary staff should change gloves before serving meals to residents or handling clean utensils and plates after touching other surfaces and their clothing.

5. Observations during one survey noted:

   - The shower room contained two unmarked hair-filled brushes on the back of the sink, two pillows in cases stacked on top of a trash can and multiple bottles of body wash and shampoo stored along the handrails in the shower area.
   - The clean shower room contained multiple trash and soiled linen bags that had been placed on the floor next to three overflowing trash and soiled linen bins. Further observation on a different day of the survey noted multiple bins that contained bags of soiled linens and trash and two housekeeping carts stored along with multiple shower chairs and wheelchairs. The whirlpool tub had two large cardboard boxes with a large cushion stored in it. The whirlpool tub was surrounded by various wheelchairs and equipment which inhibited the access to the tub.
   - The toilet bowl had a cracked cover and a brown substance was noted on the seat and on floor in front of toilet.
   - The shelf over the sink had multiple open bottles of lotion, an open box of face masks and open containers of shaving cream.
   - A shower chair revealed that it was missing PVC pipe.
   - The shower stall had a thick white substance in the drain area.
   - A broom and floor cleaning stick was stored in the right corner of the shower area. A resident's slipper was located on the floor next to the broom.
   - Observation during survey revealed an employee walking in the hallway wearing visibly soiled gloves and carrying a soiled linen bag. The employee then walked into the clean shower room carrying soiled linens.

Strategies for Compliance

Infection Control compliance requires consistent implementation of facility policies and procedures by staff across all departments, performing all tasks. A few strategies to assist your facility with attaining and maintaining compliance might include:

1. A robust education program geared to all employees in all departments that include not only general infection control and prevention strategies, but also the proper practices for the workflow tasks they perform as a routine part of their daily responsibilities.

2. A competency assessment of the high risk workflow tasks that create the biggest opportunity for spread of infection through incorrect staff practices. Select one high risk task per department for completion of competency assessments each month. Include a mini educational training on that task during monthly departmental meetings.

3. Implement an environmental assessment that includes high risk infection control practices that all department directors and administrative staff can complete on an assigned, routine basis by walking throughout the facility observing staff in the performance of their day to day tasks.

4. Clearly written policies and procedures for staff that provide a step by step method for performance on daily tasks.

5. As part of the overall IPCP for surveillance, establish process and outcome surveillance.

Process Surveillance

Process surveillance is the review of practices by staff directly related to resident care. The purpose is to identify whether staff implement and comply with the facility's IPCP policies and procedures. Some areas that facilities may want to consider for process surveillance are the following:

- *Hand hygiene;*
- *Appropriate use of personal protective equipment (e.g., gowns, gloves, facemask);*
- *Injection safety;*
- *Point-of-care testing (e.g., during assisted blood glucose monitoring, prothrombin time meters);*
- *Implementation of infection control practices for resident care such as but not limited to urinary catheter care, wound care, injection/IV care, fecal/urinary incontinence care, skin care, respiratory care, dialysis care, and other invasive treatments;*
- *Managing a blood borne pathogen exposure.*
- *Cleaning and disinfection products and procedures for environmental surfaces and equipment;*
- *Appropriate use of transmission-based precautions; and*
- *Handling, storing, processing, and transporting linens so as to prevent the spread of infection.*

Outcome Surveillance

Another component of a system of identification is outcome surveillance. For example, this addresses the criteria that staff would use to identify and report evidence of a suspected or confirmed HAI or communicable disease. This process consists of collecting/documenting data on individual resident cases and comparing the collected data to standard written definitions (criteria) of infections.

The following are some sources of data that can be utilized in outcome surveillance for infections, antibiotic use and susceptibility: Monitoring a resident(s) with fever or other signs or symptoms suspicious for infection;

- *Laboratory cultures or other diagnostic test results consistent with potential infections to detect clusters, trends, or susceptibility patterns;*
- *Antibiotic orders;*
- *Medication regimen review reports;*
- *Documentation from the clinical record of residents with suspicion of an infection such as physician orders/ progress notes; and/or*
- *Transfer/discharge summaries for new or readmitted residents for infections.*

Utilizing these tools will assist with preventing the spread of infection to/between residents as well as mitigate the identification of non-compliance with FTAG 880.

Pennsylvania's Most Frequently Cited F-TAGS in 2018

Rank	Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
1	F0684	Quality of Care	77	10.30%	12.20%
2	F0656	Develop/Implement Comprehensive Care Plan	69	9.30%	10.90%
3	F0880	Infection Prevention & Control	68	9.20%	10.70%
4	F0812	Food Procurement, Store/Prepare/Serve Sanitary	62	8.30%	9.80%
5	F0689	Free of Accident Hazards/Supervision/Devices	62	8.30%	9.80%
6	F0842	Resident Records - Identifiable Information	50	6.70%	7.90%
7	F0550	Resident Rights/Exercise of Rights	45	6.20%	7.10%
8	F0580	Notify of Changes (Injury/Decline/Room, etc.)	41	5.60%	6.50%
9	F0657	Care Plan Timing and Revision	39	5.30%	6.20%
10	F0761	Label/Store Drugs and Biologicals	35	4.60%	5.50%
11	F0641	Accuracy of Assessments	34	4.70%	5.40%
12	F0578	Request/Refuse/Dscntnue Trmnt;Form Ite Adv Dir	33	4.70%	5.20%
13	F0804	Nutritive Value/Appear, Palatable/Prefer Temp	31	4.00%	4.90%
14	F0695	Respiratory/Tracheostomy Care and Suctioning	31	4.20%	4.90%
15	F0584	Safe/Clean/Comfortable/Homelike Environment	31	3.90%	4.90%
16	F0758	Free from Unnec Psychotropic Meds/PRN Use	30	4.30%	4.70%
17	F0658	Services Provided Meet Professional Standards	29	4.00%	4.60%
18	F0585	Grievances	28	3.70%	4.40%
19	F0655	Baseline Care Plan	27	3.60%	4.30%
20	F0558	Reasonable Accommodations Needs/Preferences	25	3.40%	3.90%

Welcome New Members

- Lynn Manges-Werner - McMurray Hills Manor - Area I
- Monica Marcello - St. Anne's Retirement Community - Area II
- Adam Millis, OD - Millis Eye Associates, LLC - Area III
- Elizabethann Ward - Pembrooke Health and Rehab - Area III

Calendar Updates

- July 17 - Education Committee
- August 7– PADONA Bylaw Meeting
- September 7 - PADONA Board
- December 7 - PADONA Board Meeting

Employment Opportunities

Check out the PADONA website for new job opportunities.

2019 Exhibitors: Sign Up for the PADONA 31st Annual Convention

Exhibitor locations are already booked for 2019!
Convention in Hershey, PA, April 3 through 5, 2019

PADONA / Leadingage PA Joint Webinar Recordings

January 9, 2018
Title: Sufficient Staffing, Competent Staffing, and Facility Assessment
Presenter: Sophie Campbell, Baker Tilly
https://leadingagepa.adobeconnect.com/prtauxgdure6/?launcher=false&fcsContent=true&pbMode=normal

January 23, 2018
Title: Safe and Clean Environment, Beneficiary Notices, Resident Groups, and Personal Funds
Presenters:
Kelly O'Neill, NHA, PHR, CHC
Barbara Stadelberger, RN, NHA, RMC, CHC
https://leadingagepa.adobeconnect.com/pwjzl7dpwpkf/?launcher=false&fcsContent=true&pbMode=normal
https://leadingagepa.adobeconnect.com/p1yosolmwh67/?launcher=false&fcsContent=true&pbMode=normal

February 20, 2018
Title: Freedom from Abuse, Neglect, and Exploitation
Presenter: Paula Sanders, Esquire, Post and Schell Attorneys at Law
https://leadingagepa.adobeconnect.com/po5593kh2axc/?launcher=false&fcsContent=true&pbMode=normal

April 10, 2018
Title: Navigating the New Survey Process--Dietary Regulations
Presenter: Lisa Harkins, RD, LDN, FLIK Lifestyles
https://leadingagepa.adobeconnect.com/pk0341abhwf5/?launcher=false&fcsContent=true&pbMode=normal

May 8, 2018
Title: Accidents F689/Bed Rails F700
Presenters: Suzanne Glisan and Candace McMullen, Homewood Retirement Centers, Inc.
https://attendee.gotowebinar.com/recording/7052241582878871820

May 22, 2018
Title: Quality of Care: Tube Feeding, Dialysis, Bowel/Bladder Incontinence, Urinary Catheters, UTI, Pain Management, Respiratory Therapy, Rehab and Restorative, Positioning, Mobility, and Range of Motion
Presenter: Suzanne Glisan, Homewood Retirement Centers, Inc.
https://attendee.gotowebinar.com/recording/800789003072731655