

## Member Call Summary

July 11, 2025

### Summer Series – Amber McLey, Bartels Lutheran Retirement Community

#### Federal Policy Update

On July 3, after an 8-hour 44-minute floor speech opposing the bill by House Minority Leader Hakim Jeffries (D-NY), the House passed H.R. 1, the One Big Beautiful Bill Act, by a vote of 218 to 214. The bill is expected to result in the loss of health insurance for at least 11.5 million people and reduce federal Medicaid funding by at least \$900 billion over the next 10 years. In Iowa, the decrease in federal spending on Medicaid over the next 10 years is expected to be \$11 billion, according to [KFF](#).

LeadingAge members actively worked to improve and ultimately oppose the massive package, which extends, makes permanent, and creates various tax cuts, which primarily benefit the wealthiest U.S. households, and provides funding for border control and immigration enforcement. The bill's cuts to funding and enrollment access to Medicaid, insurance provided by the Affordable Care Act, and the Supplemental Food Assistance Program brought a wide range of individuals and organizations out in droves over the last several months to oppose the bill's many negative impacts on the federal social safety net.

LeadingAge members reached out to their federal officials more than 8,000 times since December 2024 when it was clear Republican control of the House, Senate and White House would result in the use the budget reconciliation process to enact tax cuts at the expense of peoples' health and welfare needs. LeadingAge held hundreds of visits with congressional offices and wrote, coordinated, and signed onto dozens of letters to House and Senate offices describing the negative impact of potential policies under discussion for inclusion in the bill, including a final plea on July 2 to House members to oppose the bill. The bill's threats to Medicaid were also the focus of LeadingAge's April 2025 Lobby Day, where hundreds of LeadingAge members described the bill's impacts to elected officials and their staff in person.

With passage of the bill, which does include a moratorium on the Center for Medicare and Medicaid Services (CMS)'s mandatory nursing home staffing requirements for nine years and a permanent 12% increase to state allocations of the 9% low income housing tax credit along with a 25% bond financing threshold, there is much work to be done as federal agencies now begin to implement its components and states wrestle with the complicated and cruel ways the bill requires them to carry out the bill.

President Trump [signed the bill](#) into law on July 4. To read more, [click here](#).

## HHS Launches Adult Day Services Workgroups – Members Needed

Iowa Health and Human Services (HHS) is launching two new workgroups focused on creating actionable strategies to support and grow adult day services across the state, and they're seeking passionate providers to join the effort.

The two groups, **Educate and Empower** and **Policy and Partnerships**, will tackle key issues impacting adult day centers:

- **Educate and Empower** will dig into the regulatory landscape and develop creative ways to connect and uplift other adult day providers through education, outreach, and collaboration.
- **Policy and Partnerships** will focus on crafting messaging, identifying advocates, and building strategies to elevate adult day services with policymakers and community stakeholders.

LeadingAge Iowa is looking for members involved in adult day services who are interested in serving on one or both of these workgroups. This is a great opportunity to shape the future of adult day services in Iowa while building relationships with other providers and decision-makers.

If you're interested in participating email [sheibel@leadingageiowa.org](mailto:sheibel@leadingageiowa.org). Please let us know by **Friday, July 11**.

## DIAL Monthly Updates

On Monday, June 30, LeadingAge Iowa met with representatives from the Department of Inspections, Appeals, & Licensing for a regular monthly association update. DIAL provided the following updates:

### Nurse Aide Testing

Credentia will be the second [remote testing platform available](#) to those wishing to complete the written portion of the nurse aide certification testing in a remote setting. DIAL reported that they hope this will be live around July 2. At this time, there are approximately 21 individuals that have registered for the remote testing option with Headmaster but did not have anyone complete the testing as of June 30.

### Assisted Living

Deb Dixon, a long-term program coordinator with the adult services unit has announced she will be retiring as of July 31. The adult services unit will be working to replace this leadership role but did not indicate who would be replacing Deb upon her retirement.

Additionally, the adult services unit reported they have been receiving quite a few phone calls with questions on the changes to the scope of practice. While assisted living

announced that they will not be enforcing the current rules related to tenant evaluations, the scope of practice change originated from the board of nursing and questions on the change should be directed to them. LeadingAge Iowa can also help to answer questions you may have on any of these changes. You can email your questions to [Kellie Van Ree](#), Director of Clinical Services.

There were 26 recertifications completed in June, bringing the average recertification period down to 29.5 months. Finally, the assisted living unit reported that they are continuing to complete the red tape review of the administrative rules. Outside the changes to the scope of practice they do not foresee any substantive changes to the rules in any of the chapters they are reviewing.

#### HHA/Hospice/Hospital

The home health, hospice, and hospital unit within DIAL wanted to remind all home health agencies (HHAs) that the OASIS is now a requirement for all payor types and the payor source must be indicated on the OASIS assessment. Additionally, HHAs should be aware that DIAL will be completing their requirements as directed by the Centers for Medicare & Medicaid Services (CMS) to complete certain HHA recertification visits at the 24.9 month period.

#### LTC

The long-term care (LTC) unit reported that they also received notice that Joe Saddler (Program Coordinator for the northeast region) will be retiring in early July. They are currently working to replace this position and will keep the associations updated.

Nursing home recertification averages are currently at 11.5 months on average with a similar number of outstanding complaints as previous months. The transition from ASPEN software to iQIES for surveys will occur on July 14. The surveyors are currently working through a mock survey as part of the training on the system. During the week of the transition, DIAL will schedule less recertifications and add an additional surveyor to each scheduled recertification to attempt to avoid any extensions on the typical survey length.

#### Misc

DIAL reports that they have received an increasing amount of complaints related to the air conditioning not functioning appropriately in buildings, particularly when the complainant does not believe the provider is attempting to correct the issue. If you are experiencing air conditioning functional programs, DIAL encourages you to communicate the plan to repair the air conditioning system along with steps you're taking to ensure that the residents and staff remain safe, particularly on some of the hot days that Iowa has experienced recently.

The healthcare associated infection (HAI) team reported that there are a growing number of cases of Candida auris (C. auris) in the state for 2025. To date, 35 cases of clinically identified resistant C. auris has been identified (meaning the person has

clinical manifestations of a C. auris infection) along with more than 90 screening cases. Hospitals reported to the HAI team that at times they are experiencing difficulty with placement of individuals infected with resistant C. auris. The HAI team has been working on education related to this topic to ensure nursing homes are adequately equipped to meet the residents needs. If you receive a referral for a possible admission that has tested positive for C. auris and have questions you can reach out to the [HAI team](#) or [Kellie Van Ree](#), Director of Clinical Services.

Additionally, there are also several measles cases reported in the state. All healthcare providers should be encouraging staff and residents to be up to date on their measles vaccination and if there is any question about an individual's vaccination status, a measles titer can be completed. If you administer vaccines to residents and staff, you are able to use the [Iowa Immunization Registry Information System \(IRIS\)](#) to verify an individual's vaccination status. While this is not required in the regulations, this could be a part of the infection prevention and control program (ICPC) as outlined in the federal regulations.

### **OSHA Issues Proposed Rule Revising the Respiratory Protection Program Requirements**

On July 1, 2025, the Occupational Safety and Health Administration (OSHA) filed a [proposed rule in the Federal Register which seeks to revise the Respiratory Protection Program](#). Currently, the Respiratory Protection Program requires that employers complete medical evaluations and fit testing when employees are required to wear filtering facepiece respirators (FFR) or loose-fitting powered air-purifying respirators (PAPR). In the proposed rule, OSHA is seeking to remove the requirement for employers to complete the medical evaluation component of the respiratory protection program and is seeking feedback on all components of the program. OSHA indicated in the proposed rule, that the health effects are lacking and insufficient to establish that medical evaluations meaningfully reduce material impairment caused by wearing a FFR or loose fitting PAPR.

Comments are due to <https://www.regulations.gov/document/OSHA-2025-0006-0013> no later than 10:59 p.m. CT on September 2, 2025.

### **OSHA Issues Proposed Rule to Remove COVID-19 Recordkeeping Requirements**

On July 1, 2025, The Occupational Safety and Health Administration (OSHA) filed a proposed rule in the Federal Register related to the [Occupational Exposure to COVID-19 in Healthcare Settings](#). The proposed rule seeks to remove the remaining requirements of the OSHA Emergency Temporary Standard (ETS) issued in June 2021. While the majority of the ETS were not finalized in formal rulemaking, except for the requirements to maintain a log of and report COVID-19 hospitalizations and fatalities among staff. OSHA notes in the proposed rule that they are currently not enforcing the

rule despite the text remaining in the Code of Federal Regulations (CFR) and therefore seek to remove the requirements.

You may submit written comments on the proposed rule electronically at <https://www.regulations.gov/document/OSHA-2020-0004-2542> by 10:59 p.m. CT on September 2, 2025.

### **Post Fall Physical Assessments**

Nursing home regulations direct providers to “ascertain if there were injuries following a fall and provide treatment as necessary.” However, the guidelines don’t provide recommendations or best practices for the frequency or duration of follow-up assessments, which leaves providers wondering what the best practice is and what should staff assess for.

#### Root Cause:

When a fall occurs, providers should do their best to attempt to determine (or assist the tenant/patient depending on the level of care in determining) why the fall occurred or the root cause. This helps drive new fall interventions that can prevent similar falls from possibly occurring. If you’re unable to identify a root cause, you may consider implementing new interventions that would reduce the resident’s risk for injury. Typically, a post fall investigation into the possible contributing factors is completed once with a follow up to ensure that the implemented intervention is appropriate. For example, following a fall, you determined that Resident #1 stood up unassisted and attempted to walk to the bathroom which led to a fall. During investigation, it was determined that last assisted to the resident in the bathroom three hours prior and the resident was incontinent of urine at the time of the fall. Even if the resident is unable to tell you they needed to go to the bathroom, a reasonable assumption given the circumstances could be that the resident may have been attempting to go to the toilet and appropriate interventions could be assisting the resident to use the bathroom every two hours. During follow up review of the intervention it was determined that the resident still attempted to walk unassisted despite staff compliance with the toileting plan and fall intervention which means that the intervention may not have been appropriate and should be reevaluated to determine if the intervention is still necessary or if something different should be implemented.

#### Physical Assessments:

Additionally, nurses should assess the resident/patient to determine if an injury is apparent. Neurological assessments may also be indicated and are based on your individual policy. Some providers require that neurological assessments should be

completed for all unwitnessed falls, which leaves your nurses sometimes scrambling to complete them without any clear signs of head trauma while others just complete neurological assessments if there is an indication or belief that the resident hit their head. This is nursing home and survey/deficiency specific as it may have been a plan of correction to a previous finding of noncompliance. There isn't anything in guidance that states neurological assessments after each fall or unwitnessed falls are required. It is the standard of practice that if you have suspicion of a resident hitting their head, you complete neurological assessments.

According to references cited below, a resident should be assessed for physical injuries prior to moving them from the location of the fall because if the resident sustained an injury, moving them may cause further physical injury, such as a cervical or spinal injury. If a significant injury is suspected based on clinical assessment findings, the resident should not be moved, and the nurse should follow the procedures for transferring the resident/patient to a higher level of care for evaluation (such as to an ER). Allow the emergency medical personnel to complete splinting or bracing of potential injury areas prior to moving the resident/patient and then assisting the resident onto a cot for transport.

The nurse assessing the resident/patient following a fall should assess:

- Vital signs include the resident's pulse, blood pressure, respiratory rate, oxygen saturation. Some providers include orthostatic blood pressure and pulses to determine if orthostatic hypotension (when the blood pressure decreases as someone changes elevation) was a contributing factor to the fall. Vital sign abnormalities could indicate a potential injury as well as a possible indication of an underlying infection that could have contributed to the fall.
- Cognition or a change in consciousness as an indication that the resident/patient may have suffered a head injury.
- Muscle strength, sensation, and range of motion which could be indicators of possible injuries including sprains, strains, or fractures.
- Deformities could be an indication of a physical injury such as external rotation of a leg or one leg is longer than the other in a possible hip fracture.
- Skin integrity such as abrasions, skin tears, or bruises.

#### Frequency:

The resource documents referenced below vary in the recommendations of the frequency of follow-up assessments. Injuries from a fall may not always present immediately upon the incident such as a head injury that may take hours for the residents to display a change in consciousness. It is important for nurses to complete

some type of follow-up assessment after the fall to ensure that any possible injuries are identified and treated as soon as possible.

The recommendations include anywhere from every four hours to every shift and for durations extending to 24 – 48 hours post fall. Some providers may extend this out to a 72 hour period, just to be on the safe side. Additionally, follow-up assessments may vary based on any suspected injuries. If a resident has signs that they hit their head during the fall, neurological assessments should be completed more frequently than general physical assessments without signs of head trauma. Whatever your policy is, ensure that your nurses have a clear process of completing the follow-up assessments including where and how they are documented for consistency.

#### Notification of State Survey Agency:

Some providers are required to notify the state survey agency of specific incidents. Staff should have knowledge of the specific requirements to report to the survey agency along with the method for expedited reporting. Iowa rules are outlined below:

Nursing Homes – 481-50.7(1) requires that accidents causing major injury be reported to the department within 24 hours or the next business day. Major injury is defined as resulting in death, requiring admission to a higher level of care for treatment, other than for observation, or requiring consultation with the attending physician or designee who determines on a major injury determination form that the injury is a major injury. Residents who are independently ambulatory are not included in this requirement, so far as the nursing home did not culpability in the fall.

Assisted Living – 481-67.4(1) Similar to the nursing home, assisted living programs must report accidents that result in major injury with major injury being defined the same as the nursing home rules above.

#### Policy & Procedure:

Finally, all steps in the fall process must be included in your policy and procedure. This includes pre-fall preparation such as completing a fall risk assessment, identifying preventative interventions to when a fall occurs and what the expectations are of your staff to monitor the individual ongoing for possible injuries or a change in condition. Whether the resident sustains an injury or not, ensure that the resident/patient's responsible party and physician are notified timely of the incident and include findings from the assessment.

#### References:

Chapter 50 – [Health Care Facilities Administration](#)



Chapter 67 – [General Provisions for Elder Group Homes, Assisted Living Programs, and Adult Day Services](#)

AAPACN – [Post-Fall Assessments](#)

AHRQ – Falls Management Program: A Quality Improvement Initiative for Nursing Facilities – [Chapter 1](#).

Preventing Falls in Hospitals – [Tool 3N: Postfall Assessment, Clinical Review](#)

Veteran's Administration – [Falls Policy Overview](#)

CMS – [Appendix PP for Nursing Homes](#)

### **New Member Resources Available**

The [High Risk Medication](#) policy template can be used by members as a guide to care planning and monitoring the use of high risk medications outlined in the Resident Assessment Instrument (RAI) manual.

The latest webcast on long and short stay quality measures is now available on our [YouTube Channel](#) and includes strategies for developing an improvement plan. Tell us what you think about this new member benefit by completing this [survey](#)!

The [June Resource Library](#) is also now available and includes new resources developed by LAI staff along with popular articles and links to available forms.

### **PBJ Policy and FAQ Documents Updated**

The [Payroll Based Journal \(PBJ\) Policy](#) and [FAQ documents](#) were recently updated (dated June 2025) and include the following clarifications:

1. *If the employee takes less than a 30-minute meal break, is the full 30 minutes still deducted?* Yes, even if the employee takes less than a minute break, the PBJ rules require that a 30-minute break is deducted for each eight-hour shift worked. If the provider were audited, the audit would be compliant if the PBJ report showed a 30-minute break, despite the payroll records indicated a shorter break.
2. *Can nurse consultant hours be reported?* Only if the nurse consultant is on-site and available to provide direct care to the resident. If the nurse consultant is assisting with survey preparation or chart reviews, the hours cannot be reported.
3. *Can remote hours be reported?* No.
4. *If a provider can prove that an RN was onsite for 8 consecutive hours but the PBJ report includes only 7.5 hours (due to the meal break policy), would the nursing home be in non-compliance?* No, if the nursing home can provide evidence that the RN was onsite for 8 consecutive hours they should not receive a deficiency.



5. *What should nursing homes do if they have an RN waiver but wanted it to remain above a one-star?* The nursing home should contact CMS to verify that an RN waiver is present. The RN waiver would be verified, and the nursing home can remain above a one star as long as the RN is onsite for a minimum of 40 hours per week.
6. *What if a person's salary is based on more than 40 hours per week? Is there a cap that can be reported?* The hours can be reported if the person receives some type of bonus that is directly correlated to the hours worked and is distinguishable from other payments. No, there is not a cap to the number of additional hours, but you must have evidence such as the person's contract of what the person is being paid for (minus other applicable rules such as removal of the 30-minute meal break period).
7. *If a provider fails a PBJ audit and would like to appeal the decision, is there a way for them to do so?* Yes, instructions on requesting a reconsideration are included in the audit results letter. However, there are some reasons when a provider fails an audit where no reconsideration would be available. For example, if an audit reveals that a nursing home grouped contract employees under one ID instead of creating unique IDs for each employee, the failure caused a significant variance because turnover cannot be calculated accurately. In this case, the results letter would not contain reconsideration instructions.
8. *The understanding is that a "significant variance between the hours reported and verified" would trigger a failed PBJ audit. Is that correct? Are there other conditions that would trigger a PBJ audit failure?* Yes, a significant variance between the hours that were reported in PBJ and the hours that were verifiable back to payroll would result in an audit failure. A significant variance could also occur if a facility did not complete all MDS discharge assessments timely, resulting in an inaccurate census calculation. In addition, a failure to respond to an audit request or to submit all required documentation would trigger a failed PBJ audit.
9. *Can you clarify that all communication regarding the audit and appeal is through the auditors and not directly from CMS?* The audit request and all subsequent communication regarding the audit would come directly from the current audit contractor and not from CMS. This includes the final results letter and, if reconsideration is requested, the results of that request. Note that all reconsiderations are sent to CMS for review and final decision, however, the final decision would be communicated by the audit contractor.

Additionally, the PBJ LTC Policy Manual included the following additional change:

- In no case should a single employee ID or system ID include more than 22.5 hours for a single day entered (as this is in compliance with working 24 hours minus the meal break policy).

## **Upcoming Events**

### **Regional Networking Meeting** (in-person)

July 15 from 1-3 p.m.

Location: Friendship Haven, Fort Dodge

*Sponsored by: AlixaRX & Assured Partners*

### **CAA Virtual Program** (virtual)

July 17 from 11 a.m.-3 p.m.