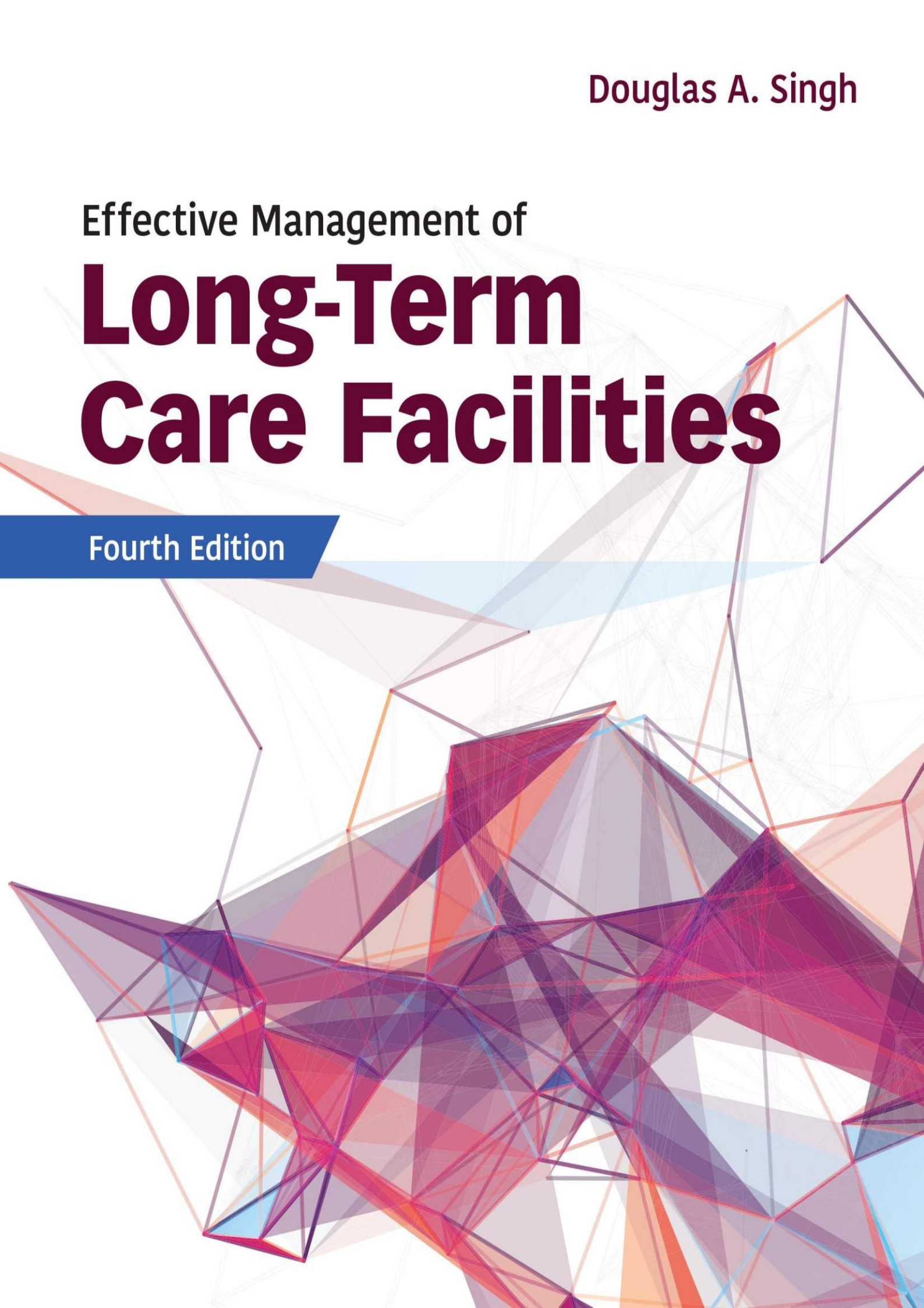


Douglas A. Singh

Effective Management of

Long-Term Care Facilities

Fourth Edition



Effective Management of Long-Term Care Facilities

FOURTH EDITION

Effective Management of Long-Term Care Facilities

FOURTH EDITION

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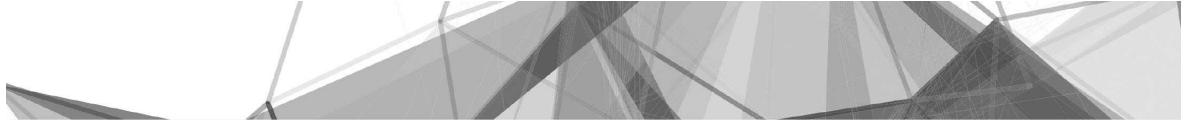
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I continue to dedicate this book to all those who serve the noble profession of long-term care as caregivers or leaders in the field and to the educators who are preparing the next generation of these caregivers and leaders.



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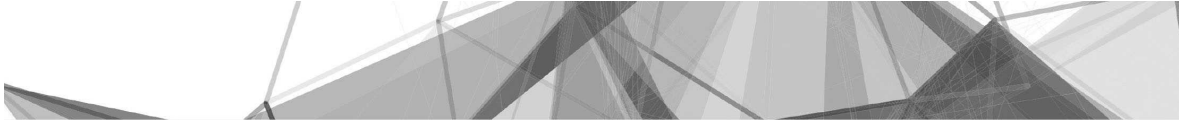
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New to This Edition

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Every effort has been made to bring this fourth edition up to date with current materials, research findings, regulatory standards, reimbursement systems, and contemporary management practices. Tables and figures have been updated with the latest available data. Numerous exhibits have been added to summarize the main federal regulations—with cross-referenced F-Tags—that govern the delivery of the various services that skilled care nursing facilities must comply with. The theme of person-centered (resident-centered) care is interwoven throughout the text.

Chapter 4 Aging and Long-Term Care is new to this edition. This chapter has been added to consolidate in one place the various perspectives on aging and age-related issues associated with long-term care delivery. Hence, the book has 19 chapters. To keep the reading load within reason, certain nonessentials and materials that did not add value were deleted throughout the book, but without compromising quality.

Note: All chapter references herein are for this fourth edition.

Following is a list of the main revisions to aid in transitioning from the third edition:

- **Chapter 1 Overview of Long-Term Care**
 - New section on current mindsets and vocabulary
 - Association between age, gender, multimorbidity, and ADL/IADL limitations
 - Moved to Chapter 4: Aging and HIV/AIDS
- **Chapter 2 Long-Term Care Policy: Past, Present, and Future**
 - Impact of 1915(c) waivers and the Money Follows the Person program
 - Introduction to Medicare's value-based purchasing program. Details are covered in Chapter 7.
 - Introduction to the Quality Assurance Performance Improvement (QAPI) program and the role of quality improvement organizations. Details on QAPI are covered in Chapters 6 and 19.
 - Future implications of financing, program innovations, lifestyles, national wealth, and workforce planning for long-term care policy
- **Chapter 3 The Long-Term Care Profession**
 - Two main components of home health services: clinically oriented care and human services
 - Decline in utilization of Intermediate Care Facilities for Individuals with Intellectual Disabilities
 - New section: Facilitating technology
- **Chapter 4 (New) Aging and Long-Term Care**
 - Health status of racial and ethnic minorities
 - Moved from Chapter 9: Understanding aging; theories of aging; ageism and infantilization; diversity; and cultural accommodations
 - Moved from Chapter 10: Mental and cognitive disorders
 - Moved from Chapter 1: Aging and HIV/AIDS
 - New section: Aging Among the Veterans
 - New section: End-of-Life Issues
 - New short case: Why Too Few Minorities?
- **Chapter 5 Legal Environment**
 - Exhibit 5-2 (New): Federal regulations and F-Tags pertaining to resident rights
 - Exhibit 5-3 (New): Federal regulations and F-Tags pertaining to abuse, neglect, and exploitation
- **Chapter 6 Regulation and Enforcement**

- Revised Exhibit 6-1: Requirements of Participation and F-Tags for Nursing Homes (summary of all nursing home regulations)
- The current survey process, QAPI, quality assessment and assurance (QAA) review, and role of the Certification and Survey Provider Enhanced Reporting System (CASPER)
- New section: Achieving Continuous Compliance
- **Chapter 7 Financing and Reimbursement**
 - Table 7-1 (New): National Daily Median Costs of Long-Term Care Services, 2019
 - Medicare reimbursement under the Patient Driven Payment Model
 - How facilities have fared under the value-based purchasing program
 - Managed care contracts under Medicare Advantage and Institutional Special Needs Plans (I-SNPs)
 - Current examples of prosecutions under the False Claims Act
- **Chapter 8 Organization, Environment, and Culture Change**
 - Clinical outcomes and cost-effectiveness of homelike models
 - Updates on creating environments for residents with dementia
- **Chapter 9 Social Services, Admission, and Discharge**
 - Moved to Chapter 4: Sections on Knowledge of Aging and the Elderly and Diversity and Cultural Competence
 - New Section: Regulations governing transfers and discharges
 - New Section: Regulations pertaining to grievances
- **Chapter 10 Medical Care, Nursing, and Rehabilitation**
 - Exhibit 10-1 (New): Federal regulations and F-Tags pertaining to physician services
 - Role of nurse practitioners and physician assistants in the delivery of medical care
 - Role of evidence-based practices in medical care
 - Exhibit 10-2 (New): Federal regulations and F-Tags pertaining to nursing services and nurse aide training
 - Exhibit 10-3 (New): Federal regulations and F-Tags pertaining to resident assessment and care planning
 - Exhibit 10-4 (New): Federal regulations and F-Tags pertaining to infection prevention and control
 - New section: The Case of COVID-19
 - New section: Antibiotic Stewardship
 - Moved to Chapter 4: Section on Mental and Cognitive Disorders
 - Exhibit 10-6 (New): Federal regulations and F-Tags pertaining to pharmacy services
 - Calculation of medication error rate
- **Chapter 11 Recreation and Activities**
 - Exhibit 11-1 (New): Federal regulations and F-Tags pertaining to activities
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 - New section: Cognitive Stimulation
 - Updates on activities for residents with dementia
- **Chapter 12 Dietary Services**
 - Exhibit 12-1 (New): Federal regulations and F-Tags for dietary services
 - New section: Subcutaneous Infusion
 - Table 12-1 (New): Cost-Benefit Analysis for Decentralized Food Service
- **Chapter 13 Plant and Environmental Services**
 - Relevant F-Tags are referenced
 - Introduction to annual facility assessment (F838)

- Table 13-1 (New): Minimum Testing and Servicing Requirements for Emergency Systems
- Table 13-2 (New): Cost-Benefit Analysis for Installing Security Surveillance Equipment
- **Chapter 14 Administrative and Information Systems**
 - Relevant F-Tags are referenced
- **Chapter 15 Effective Governance, Leadership, and Management**
 - Behaviors most characteristic of highly rated leadership in nursing homes
- **Chapter 16 Effective Human Resource Management**
 - Correlations between staffing and survey deficiencies
 - Tables 16-1 and 16-2 (New): Staffing levels recommended by the Centers for Medicare and Medicaid Services
 - The issues of presenteeism versus absenteeism
 - Updates on medical exams and mandatory vaccinations
- **Chapter 17 Effective Marketing Management**
 - Key customers and the implications of Medicare's Hospital Readmissions Reduction Program for nursing home marketing
 - New Section: Assessment and Creation of Value
 - Implications of mass-market approach, regulatory constraints, and Medicaid
 - New section on online channels for promoting the facility
- **Chapter 18 Effective Financial Management**
 - Updated Exhibits 18-4 (Labor Hour Report) and 18-5 (Labor Cost Report)
- **Chapter 19 Effective Quality and Productivity Management**
 - New Section: The QAPI Program
 - Exhibit 19-1 (New): Federal regulations and F-Tags pertaining to quality assurance and improvement



Preface

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This *Fourth Edition* marks 18 years in furnishing comprehensive knowledge to prepare the next generation of long-term care administrators. It also puts into the hands of practicing administrators, corporate officers, and governing board members an in-depth reference source. From its inception, this book has been included in the list of recommended resources to prepare for the national nursing home administrator licensure exam administered by the National Association of Long-Term Care Administrator Boards (NAB). *Note: The American College of Health Care Administrators (ACHCA) no longer offers the certification exam for which this book was also recommended.*

This is the only book on the market that covers in one volume (1) what long-term care is and why it is an integral part of the larger health care delivery system; (2) the legal and regulatory parameters, and payment constraints within which long-term care facilities must be managed; (3) details on each of the main functional departments that administrators must understand and oversee (after all, how can someone effectively manage a nursing facility without having a detailed understanding of what services it provides, how those services are provided, and what regulations govern their delivery?); (4) effective governance and leadership, management of human resources, marketing, financial management, and quality and productivity, much of which is quite unique to nursing home administration and must be learned within that context; and, finally, (5) case studies to simulate situations that the administrator is likely to encounter in actual practice. Like no other book, it also furnishes easy-to-understand summaries of the federal regulations referenced by their F-Tags.

Within the institutional long-term care continuum, similar skills are employed to effectively manage different types of operations. If a person can learn how to manage a skilled nursing facility, he or she can easily make the transition into managing other, less complex and less challenging, environments such as assisted living facilities or residential facilities.

Organization of This Book

The book is logically organized into five main parts. Each part covers chapters associated with a major theme. The five major themes begin with an introduction to long-term care; past, current, and future policy; components of the profession; and understanding the dimensions of aging (Part I). The next three chapters progress to an explanation of legal, regulatory, and financing requisites (Part II). The seven chapters in organization and delivery of services come next (Part III); the last five chapters cover governance and leadership, human resource, marketing, finance, and quality improvement (Part IV). The book concludes with case studies (Part V) that call for the application of knowledge and skills learned in previous chapters.

Tools To Enhance Learning

- What You Will Learn summaries at the beginning of each chapter.
- Figures, tables, and exhibits to illustrate discussions in the text.
- List of terminology (highlighted in the text) at the end of each chapter.
- For Further Thought assignments at the end of each chapter.
- Short cases at the end of most chapters.
- Short lists of internet resources at the end of chapters for further learning.
- A Glossary is furnished as an easy reference to technical terms encountered in the text.

For Instructors

Please contact your Jones & Bartlett Learning account representative to get access to the complete Instructor's Manual, slides in PowerPoint format, Test Bank, and Excel materials.

Douglas A. Singh

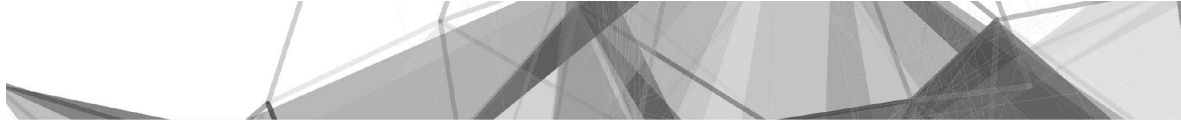
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Acknowledgments

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Several experts in long-term care either contributed cases written specifically for this book or provided valuable assistance in developing cases. Where appropriate, their names and affiliations appear with their contributions.



List of Abbreviations

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A

AARP	Formerly known as the American Association of Retired Persons
ACA	Affordable Care Act (2010)
ACHCA	American College of Health Care Administrators
ACO	Accountable care organization
ADA	Americans with Disabilities Act; American Dietetic Association
ADEA	Age Discrimination in Employment Act (1967)
ADL	Activities of daily living
ADN	Associate degree in nursing
ADON	Assistant director of nursing
AFC	Adult foster care home
AHCA	American Health Care Association
AHIMA	American Health Information Management Association
AIDS	Acquired immunodeficiency syndrome
AIT	Administrator-in-training
ALF	Assisted Living Facility
AMDA	American Medical Directors Association
ASHA	American Speech-Language-Hearing Association

B

BBA	Balanced Budget Act of 1997
BSN	Bachelor of science degree in nursing
BSW	Bachelor's degree in social work

C

CASPER	Certification and Survey Provider Enhanced Reporting System
CBO	Congressional Budget Office
CCRC	Continuing care retirement community
CDC	Centers for Disease Control and Prevention
CDM	Certified dietary manager
CEO	Chief executive officer
CFO	Chief financial officer
CMS	Centers for Medicare & Medicaid Services
CNA	Certified nursing assistant
CON	Certificate of need

COTA	Certified occupational therapy assistant
COVID-19	Coronavirus Disease 2019
CQI	Continuous quality improvement
CSA	Controlled Substances Act (1970)
CTRS	Certified therapeutic recreation specialist

D

DD	Developmentally disabled
DHHS	U.S. Department of Health and Human Services
DME	Durable medical equipment
DNR	Do-not-resuscitate (order)
DO	Doctor of osteopathic medicine
DON	Director of nursing
DPT	Doctor of physical therapy
DRI	Dietary Reference Intake
DTR	Dietetic Technician, Registered

E

EEOC	Equal Employment Opportunity Commission
EHR	Electronic health record
EPA	U.S. Environmental Protection Agency

F

FCA	False Claims Act (1863)
FDA	U.S. Food and Drug Administration
FICA	Federal Insurance Contributions Act
FIFO	First-in first-out
FLSA	Fair Labor Standards Act
FMLA	Family and Medical Leave Act (1993)
FUTA	Federal Unemployment Tax Act

G

GAAP	Generally accepted accounting principles
GPO	Group purchasing organization

H

HCBS	Home and Community Based Services
HHA	Home health agency
HI	Hospital Insurance (Part A of Medicare)
HIPAA	Health Insurance Portability and Accountability Act (1996)
HIV	Human immunodeficiency virus
HMO	Health maintenance organization
HUD	U.S. Department of Housing and Urban Development

I

IADL	Instrumental activities of daily living
ICF/IID	Intermediate care facility for individuals with intellectual disabilities
ID	Intellectual disability
IDD	Intellectually/developmentally disabled
IOM	Institute of Medicine
IPC	Infection prevention and control
IRF	Inpatient rehabilitation facility
IRS	Internal Revenue Service
IS	Information systems
IT	Information technology

L

LAN	Local area network
LPN	Licensed practical nurse
LSC	<i>Life Safety Code</i> ®
LTC	Long-term care
LTCH	Long-term care hospital
LVN	Licensed vocational nurse

M

MA	Medicare Advantage
MBO	Management by objectives
MCO	Managed care organization
MD	Doctor of medicine
MDS	Minimum data set
MFP	Money Follows the Person (Program)
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSBT	Multisensory behavior therapy
MSE	Multisensory environment
MSS	Multisensory stimulation
MSW	Master's degree in social work

N

NAB	National Association of Long-Term Care Administrator Boards
NBCOT	National Board for Certification in Occupational Therapy
NCCAP	National Certification Council for Activity Professionals
NCTRC	National Council for Therapeutic Recreation Certification
NF	Nursing facility (referring to a federal certification category)
NFPA	National Fire Protection Association
NHA	Nursing home administrator
NLRA	National Labor Relations Act (1935)
NLRB	National Labor Relations Board
NP	Nurse practitioner

NPP	Nonphysician practitioner
NTA	Nontherapy ancillaries

O

OAA	Old Age Assistance
OBRA-87	Omnibus Budget Reconciliation Act of 1987
OSHA	Occupational Safety and Health Administration
OT	Occupational therapist or occupational therapy
OTR	Occupational Therapist, Registered

P

P&L	Profit and loss statement(Income statement)
PA	Physician assistant
PACE	Program of All-Inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review
PDSA	Plan, do, study, act (cycle)
PHI	Personal health information
PM	Preventive maintenance
POA	Power of attorney
POC	Plan of correction
PPD	Per patient day
PPE	personal protective equipment
PPS	Prospective payment system
PRD	Per resident day
PT	Physical therapist or physical therapy
PTA	Physical therapy assistant

Q

QAA	Quality assurance and assessment
QAPI	Quality assurance/performance improvement
QIS	Quality Indicator Survey
QoL	Quality of life

R

RAI	Resident Assessment Instrument
RC/AL	Residential care/assisted living (administrator's license)
RD	Registered dietitian
RHIA	Registered health information administrator
RHIT	Registered health information technician
RN	Registered nurse

S

SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2

SLP	Speech/language pathologist
SMI	Supplementary Medical Insurance (Part B of Medicare)
SMWT	Self-managed work team
SNF	Skilled nursing facility (referring to a federal certification category)
SPs	Standard precautions
SSI	Supplemental Security Income

T

TB	Tuberculosis
TCU	Transitional care unit
TPN	Total parenteral nutrition

U

USDA	U.S. Department of Agriculture

V

VHA	Veterans Health Administration
VRE	Vancomycin-resistant <i>enterococci</i>

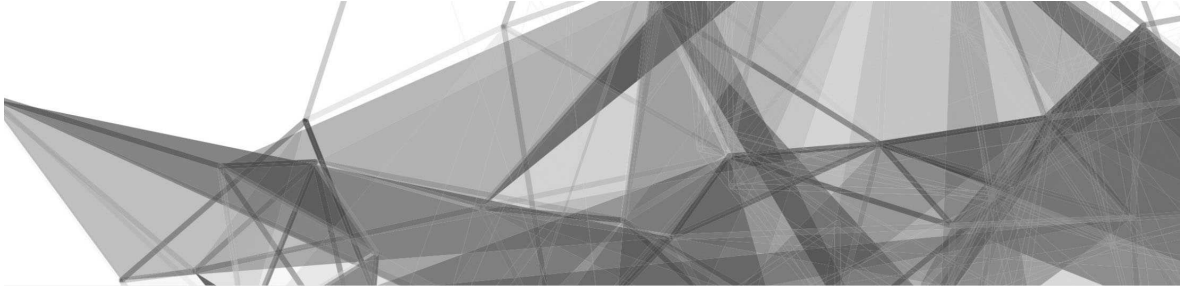


About the Author

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Dr. Douglas Singh retired from teaching graduate and undergraduate courses in health care delivery, policy, finance, and management in the School of Business and Economics and in the Department of Political Science at Indiana University–South Bend. He has authored/coauthored five books and has been published in several peer-reviewed journals.

He spent more than 15 years as a licensed long-term care administrator in four states. He also held the positions of regional manager, vice president, and consultant and supervised both skilled nursing care and independent living operations. His doctoral work at the School of Public Health, University of South Carolina, broke new ground in understanding nursing home performance on certification surveys, for which he was awarded the Long-Term Care Research award in 1995 by the Foundation of the American College of Health Care Administrators.



PART I

Introduction to Long-Term Care

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[Chapter 1 Overview of Long-Term Care](#)

[Chapter 2 Long-Term Care Policy: Past, Present, and Future](#)

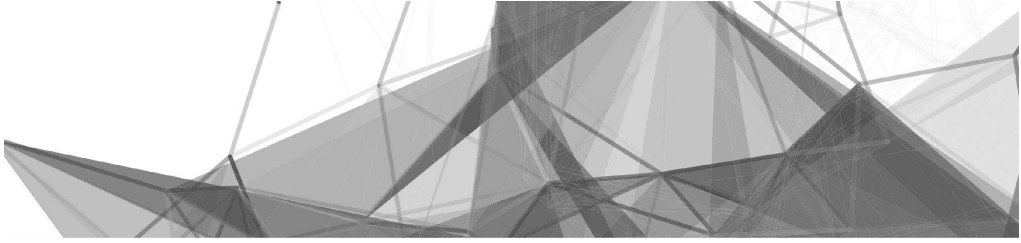
[Chapter 3 The Long-Term Care Profession](#)

[Chapter 4 Aging and Long-Term Care](#)

As a major component of the health care delivery system, long-term care (LTC) has received much attention in both developed and developing countries. LTC is closely associated with disabilities emanating from chronic conditions that are mostly related to human aging. Developed countries have seen a steep rise in chronic conditions, and the trend will continue. Thanks to better sanitation, nutrition, and medical care, longevity is also increasing in developing countries. A rise in chronic conditions and functional limitations is an unfortunate adjunct of longevity. Moreover, the social environment in developing countries is changing. Both men and women have been drawn into the workforce to improve their standards of living, which leaves little time to address the needs of elderly parents and relatives. Hence, demand for LTC services is growing in the developing world as well.

A broad understanding of LTC as a distinct segment of the health care delivery system, LTC clients and services, policy perspectives, and industry perspectives lay the foundation for managing any LTC organization. The four chapters in this section address these areas:

- [Chapter 1](#) explains what LTC is, why it is needed, what type of health care and social services constitute LTC, who needs LTC, and how LTC should interface with the broader health care system.
- [Chapter 2](#) focuses on policy as the driving force behind the evolution of LTC services. Financing, quality, and access to community-based services have shaped some of the recent developments. The future remains challenging and requires a number of policy initiatives to address lingering issues.
- [Chapter 3](#) furnishes details of the LTC industry, which is necessary for the efficient delivery of services. The chapter covers community-based and institutional providers, insurers, LTC professionals, case management agencies, LTC pharmacies, and various categories of LTC technology.
- [Chapter 4](#) addresses aging and the theories that undergird the delivery of person-centered care. The issues associated with stereotyping, cognitive function, and HIV/AIDS are discussed. The chapter addresses diversity and cultural accommodation. It concludes with the handling of death and dying.



CHAPTER 1

Overview of Long-Term Care

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WHAT YOU WILL LEARN

- Appropriate vocabulary is used to complement changing mindsets in the delivery of long-term care.
- Physical and/or mental deficits that limit a person's ability to do regular daily tasks create the need for long-term care. Continuity of care after hospitalization may also suggest a need for long-term care.
- Long-term care is complex. It is founded on 10 main dimensions that can also be viewed as fundamental principles that should guide the delivery of long-term care.
- Not all seniors need long-term care. However, chronic ailments, comorbidity, disability, and dependency are progressive steps indicating the need for long-term care.
- The three broad sectors through which long-term care is delivered are informal care, home- and community-based care, and institutional care.
- Non-long-term care services must complement long-term care to meet a person's total care needs.

Introduction

Long-term care (LTC) is associated with physical and/or mental deficits that limit a person's ability to do regular daily tasks that most humans take for granted. There can be numerous causes for functional limitations. Examples include complications arising from prolonged heart disease, onset of partial or full paralysis after a severe stroke, severe head injury from a motorcycle or industrial accident, loss of physical capacity by a young adult from a crippling disease such as multiple sclerosis, a child born with severe autism, or gradual loss of memory in an aged person. LTC services are needed mostly by senior citizens, generally referred to as the elderly in health care literature—people older than 65 years—hence, most LTC services have been designed with seniors in mind.

LTC is a broad and complex system. Diverse LTC services—sometimes referred to as long-term services and supports (LTSS)—are provided in a variety of community-based settings. Also, family members and surrogates provide most of the care that is unseen to outsiders and generally unpaid. Nursing homes and other LTC institutions play a critical role in delivering advanced levels of LTC services that cannot be provided effectively and efficiently in community or home settings. Moving to a nursing home often results from various losses, multiple and complex illnesses, impaired functioning, fewer social relationships, and a poorer quality of life than the general elderly population (Rinnan et al., [2018](#)). In 2016, 65,600 LTC providers served approximately 8.3 million people in the United States (Harris-Kojetin et al., [2019](#)). Americans receive LTC from a variety of formal sources, such as adult day care centers, home health agencies, hospices, nursing homes, and residential care communities.

Mindsets and Vocabulary

In a general sense, those who receive medical services are referred to as “patients” in hospitals, doctors’, dentists’, and optometrists’ offices, and other medically oriented settings. LTC institutions, however, over the years have made an effort to limit the use of vocabulary prevalent in the medical model of health care delivery. The emphasis has shifted to a home/residential model of care delivery. No longer are the elderly referred to as “older folks.” Even the term “elders” has been suggested to replace the term “elderly.” In general use, “seniors” or “senior citizens” is also common. The patients residing in LTC institutions are referred to as “residents.” This change marked a distinction between emerging nursing homes and earlier poorhouses and mental asylums in which people were commonly referred to as “inmates,” a term that was viewed as dehumanizing.

Improvements in vocabulary are being introduced with the intent of changing both administrative and caregiver mindsets that would be reflected in treating people receiving care in LTC institutions with compassion, respect, and dignity. The change in vocabulary is also viewed as a component of a broad movement called “culture change,” which emphasizes living and thriving in an environment in which each person is made to feel as a useful human being, who may still, in many cases, be able to make meaningful contributions to help others. [Person-centered care](#) delivery emphasizes the centrality of the recipient of care, whereas previously, economic efficiencies of the organization were given a higher priority. Delivery of health care services work around a person’s values and preferences. “Person-centered” appropriately applies to all venues of LTC care delivery; in institutional settings, use of the term “resident-centered” is also in use. Although the terms “institution” and “facility” are difficult to avoid in broad discussions, philosophically, the institution must be viewed as a person’s home. Hence, efforts are made to create a home-like, as opposed to the sterile, institutional environment of yesteryears. The leaders and managers in LTC have a responsibility to ensure that these guiding principles permeate the entire living and caregiving environment.

Regardless of the setting, whether it is institutional or community-based, use of the term “senile” is anathema; such individuals are referred to as “people with dementia.” [Dementia](#) is a general term for progressive and irreversible decline in cognition, thinking, and memory emanating from brain cells that have become damaged or destroyed. Also, the term “mental retardation” has been replaced with “intellectual disability” (ID).

Why the Need for Long-Term Care

Broadly speaking, LTC services are needed under three main circumstances:

- 1. Need for assistance in doing tasks of daily living.** Functional limitations arise because of physical and/or mental disability or severe illness. Both physical disability and cognitive impairment can trigger the need for LTC. **Cognitive impairment** is a mental disorder that is indicated by a person having difficulty remembering, learning new things, concentrating, or making decisions that affect the individual's everyday life. Even mild cognitive impairment is associated with greater physical decline compared to older people considered cognitively normal (Taylor et al., 2019). The severity of a person's dependency—ranging from partial to total—created by functional limitations determines whether low-level informal care or community-based services can meet the person's needs or whether high-level institutional services are necessary. Two standard measures are available to assess a person's level of dependency. The first, the **activities of daily living (ADL)** scale, is used to determine whether an individual needs assistance in performing six basic activities: eating, bathing, dressing, using the toilet, maintaining continence, and transferring into or out of a bed or chair. Grooming and walking a distance of eight feet are sometimes added to evaluate self-care and mobility. Limitations in lower level ADLs, such as bathing, dressing, grooming, and walking without assistance generally do not require a person to be in an institution. Limitations in higher level ADLs, such as eating, toileting, maintaining continence, and transferring, generally indicate the need for assistance in an LTC facility. Limitations in ADLs are about the same among users of home health services and nursing homes, except that nursing home residents have a greater need for assistance with toileting (Harris-Kojetin et al., 2019).
The second commonly used measure is called **instrumental activities of daily living (IADL)**. This measure focuses on activities that support everyday functioning within the home and community and are necessary for independent living. These activities generally entail more complex interactions than those used in ADLs (American Occupational Therapy Association, 2017). Examples of IADLs include doing housework, cooking, doing laundry, grocery shopping, taking medication, using the telephone, and managing money (Gontijo et al., 2020). Deficits in IADLs can generally enable a person to live independently with some support and assistance. The IADL measure is also helpful when a nursing home resident is being discharged for community-based LTC or independent living. It helps in assessing how well the individual is likely to adapt to living independently and what type of support services may be most appropriate to ensure that the person can live independently.
- 2. Need for continuity of care after hospitalization.** As an example, people recovering from accidents or orthopedic surgery, such as hip and knee replacements, require postacute rehabilitation. Other individuals, who are still subject to complications while in recovery, may require what is called **subacute care**, which also includes clinically complex care, such as wound care, tube feedings, or intravenous therapy.
- 3. Need for care in specialized environments.** People with severe dementia need a supportive environment that is designed to reduce stress and provide a moderate amount of stimulation to the senses. Many children and adolescents need care in specialized pediatric environments because of physical and/or mental disabilities. Many children suffer from birth-related disorders that include cerebral palsy, severe autism, spina bifida, and epilepsy. The term **developmental disability** describes the general physical incapacity such children may face at a very early age. Those who acquire such dysfunctions are referred to as developmentally disabled, or DD. **Intellectual disability (ID)**, refers to below-average intellectual functioning, which also leads to DD in most cases. Down syndrome is the most common cause of ID in America. The close association between DD and ID is reflected in the term intellectually/developmentally disabled (IDD). Those with severe ID and/or DD are also likely to have disturbing behavioral issues and usually require institutional care in specialized facilities that provide special programming and services for children. For example, these facilities may have services and

training for children to help them cope with musculoskeletal deformities by using customized braces, splints, and wheelchairs.

Dimensions and Principles of Long-Term Care

No simple definition fully captures the nature of LTC. This is because a broad range of clients and services are involved. Yet, certain dimensions form a common core of what LTC is. Besides furnishing a definition, the explanations covered in this section provide fundamental principles that must undergird the delivery of LTC.

Long-term care can be defined as a variety of individualized and well-coordinated total care services that promote the maximum possible independence for people with functional limitations and that are provided over an extended period of time, using appropriate current technology and available evidence-based protocols, in accordance with a holistic approach while maximizing both the quality of clinical care and the individual's quality of life. This comprehensive definition emphasizes 10 essential dimensions that should govern an ideal LTC system.

Variety of Services

LTC encompasses a variety of services for three main reasons: (1) to fit the needs of different individuals, (2) to address changing needs over time, and (3) to suit people's personal preferences. Needs vary greatly from one individual to another. Even the elders, who are the predominant users of LTC services, are not a homogeneous group. For example, some people just require supportive housing, whereas others require intensive treatments. The type of services an individual requires is determined by the nature and degree of his or her functional disability and the presence of any other medical conditions and emotional needs that the individual may have.

Even for the same individual, the need for the various types of services can change over time. The change is not necessarily progressive, from lighter to more intensive levels of care. An individual may shift back and forth among the various levels and types of LTC services. For example, after hip surgery, a person may require extensive rehabilitation therapy in a nursing facility for 2 or 3 weeks before returning home, where he or she receives continuing care from a home health care agency. After that, the individual may continue to live independently but require a daily meal from Meals on Wheels, a home-delivered meals service. Later, this same person may suffer a stroke and, after hospitalization, may have to stay indefinitely in a LTC facility. Hospice care may become necessary at the end of a person's life.

LTC services are an amalgam of five distinct types of services that are integrated into one total package of care:

- Medical care, nursing, and rehabilitation
- Mental health services and dementia care
- Social support
- Supportive housing
- Hospice services

Medical Care, Nursing, and Rehabilitation

These services focus on three main areas:

1. Continuity of care after hospitalization. Postacute LTC often consists of skilled nursing care, which is physician-directed care provided by licensed nurses and therapists.
2. Clinical management of chronic conditions and comorbidity. Chronic conditions—such as heart disease, cancer, chronic lower respiratory diseases, stroke, and diabetes—persist over time and are generally irreversible but must be kept under control to prevent health complications. Comorbidity, that is, coexisting multiple health problems, often becomes the leading cause of an individual's disability and erode that person's ability to live without assistance. Without LTC intervention in this situation, the risk of further morbidity and mortality greatly increases. Preventing complications from chronic conditions—tertiary prevention—is an important aspect of LTC.
3. Restoration or maintenance of physical function. Rehabilitation involves short-term therapy treatments to help a person regain or improve physical function. Examples of cases requiring rehabilitation include orthopedic surgery, stroke, limb amputation, and prolonged illness.

Mental Health Services and Dementia Care

Mental illnesses are conditions that affect a person's thinking, feeling, mood, or behavior, such as depression, anxiety, bipolar disorder, or schizophrenia. Such conditions may be occasional or long lasting (chronic). Depressive symptoms, comorbidity, and cognitive impairment often coexist and affect functional status

(Marengoni et al., 2004). Mental health services are generally delivered by specialized providers in both outpatient and inpatient facilities. LTC staff, however, must be trained to recognize the need for mental health care among the residents.

In the United States, among those age 65 years and over, an estimated 5 million adults had dementia in 2014, and the number is projected to be nearly 14 million by 2060 (Centers for Disease Control and Prevention, 2019). With the growing prevalence of dementia in the United States and around the world, care for persons with dementia has become a major focus in LTC. Almost all people with dementia will develop at least one behavioral or psychological symptom over a 5-year period, which includes agitation, aggression, depression, etc. These symptoms generally predict the need for nursing home placement (Wang et al., 2020). Consequently, among the various LTC services providers, dementias are most prevalent among nursing home residents (48% in 2016) (Harris-Kojetin et al., 2019).

The most common form of dementia is [Alzheimer's disease](#)—a progressive degenerative disease of the brain, producing memory loss, confusion, irritability, and severe functional decline. Alzheimer's disease is also the sixth leading cause of death in the United States, often matching and surpassing many forms of cancers (Alzheimer's Association, 2019).

Social Support

[Social support](#) refers to a variety of assistive and counseling services to help people cope with situations that may cause stress, conflict, grief, or other emotional imbalances. The goal is to help people make adjustments to changing life events.

Various stressors commonly accompany the aging process itself and create such adverse effects as frailty, pain, increased medical needs, and the inability to do common things for oneself, such as obtaining needed information or running errands. Other stressors are event driven. Events that force an unexpected change in a person's lifestyle or emotional balance—such as moving to an institution or loss of a loved one—require coping with stress or grief. Even the thought of change brings on anxiety. Many people go through a period of "grieving" when coming to terms with change. Grieving may manifest in reactions such as anger, denial, confusion, fear, despondency, and depression. Social support is needed to help buffer these undesirable emotions that may trigger latent mental illness or become manifested in aggressive behavior.

Social support is also needed when problems and issues arise in the interactions among people within social systems. For example, conflicts may arise between what a person wants for himself or herself and what the family may think is best. Conflicts can also arise between residents and caregivers or between two residents.

The level of social support depends on the severity of adverse events a person may go through (Fernandez-Alcantara et al., 2016). Social support includes both concrete and emotional assistance provided by families, friends, neighbors, volunteers, staff members within an institution, organizations such as religious establishments, and professional agencies. For people residing in LTC facilities, remaining connected with the community and the outside world is also an important aspect of social support.

Supportive Housing

[Supportive housing](#) is a key component of LTC because certain functional and safety features must be incorporated to compensate for people's disabilities in order to promote independence. Some simple examples include access ramps that enable people to go outdoors, wide doorways and corridors that allow adequate room to navigate wheelchairs, railings in hallways to promote independent mobility, extra-large bathrooms that facilitate wheelchair negotiation, grab bars in bathrooms to prevent falls and promote unassisted toileting, raised toilets to make it easier to sit down and get up, and pull-cords in the living quarters to summon help in case of an emergency.

Congregate housing—multiunit housing with support services—is an option for seniors and disabled adults. [Support services](#) are basic assistive services, which may include meals, transportation, housekeeping, building security, social activities, and outings. However, not all housing arrangements provide all of these services.

Hospice Services

Hospice services, also called [end-of-life care](#), are regarded as a component of LTC. [Hospice](#) incorporates a cluster of special services for terminally ill persons with a life expectancy of 6 months or less. It blends medical, spiritual, legal, financial, and family counseling services. However, the emphasis is on comfort, palliative care, and social support over medical treatment. [Palliation](#) refers to medical care that is focused on relieving unpleasant symptoms such as pain, discomfort, and nausea.

The hospice philosophy also includes the family as part of the unit of care with the resident. The option to use hospice means that temporary measures to prolong life will be suspended. The emphasis is on maintaining the quality of life and letting the person die with dignity. Psychological services focus on relieving mental anguish. Social and legal services help with arranging final affairs. Counseling and spiritual support are provided to help the individual deal with his or her death. After the individual's death, bereavement counseling is offered to the family or surrogates.

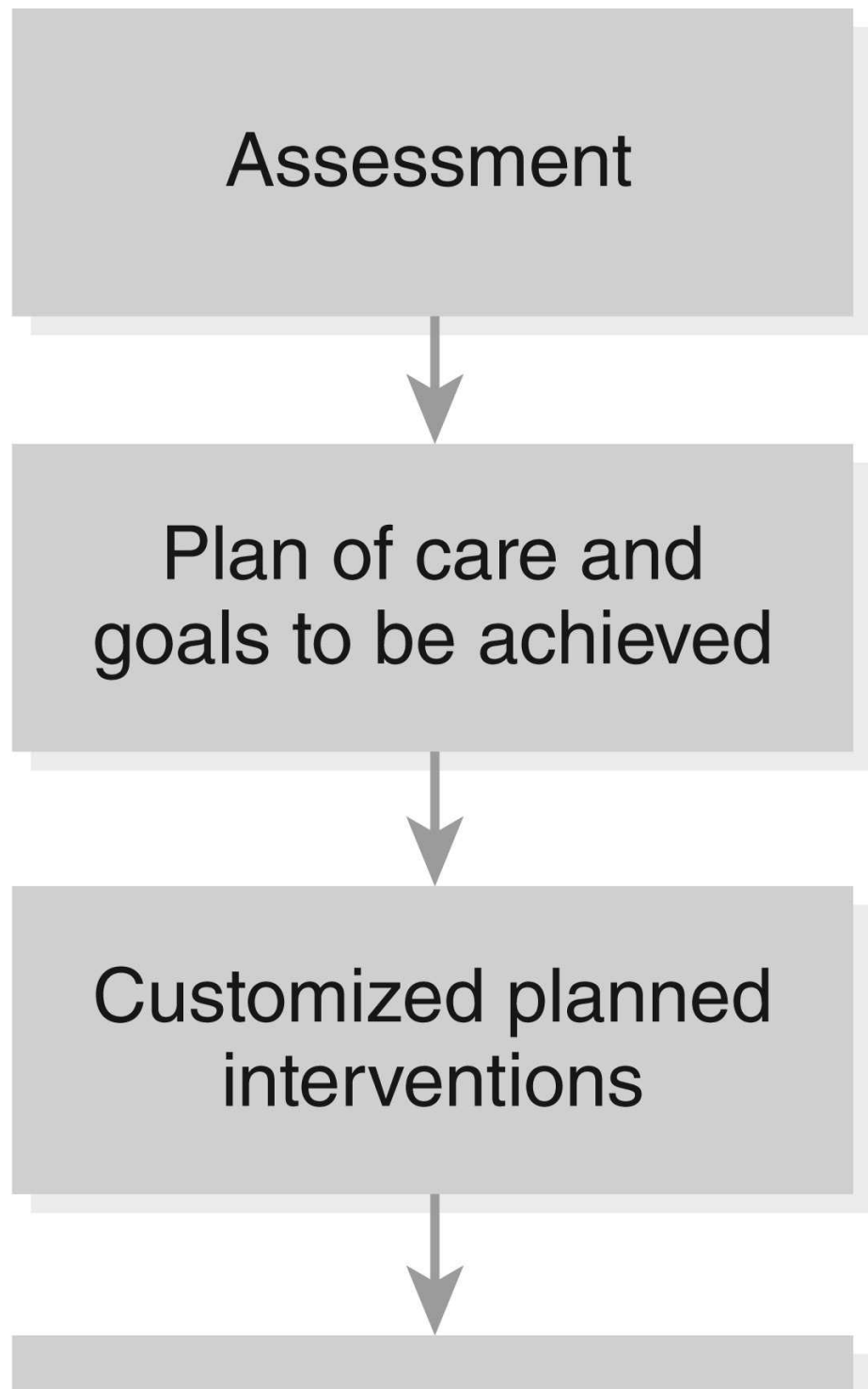
Hospice services are generally brought to the individual, although the option of residing in a freestanding hospice center may also be available. Hospice care can be directed from a hospital, home health agency, nursing home, or freestanding hospice.

Individualized Services

LTC services are tailored to the needs of the individual. Those needs are determined by an assessment of the individual's current physical, mental, and emotional condition.

The philosophy of [resident-centered care](#) (or person-centered care) is founded on the principles of inclusivity, empowerment, and respect for each individual and his or her right to self-determination (Matthews et al., [2018](#)). The resident's choices and preferences are incorporated into care decisions (Janowski, [2019](#)). An individualized plan of care (or care plan, for short) is then developed to include customized interventions to address the resident's needs in a comprehensive manner.

Past history of the individual's medical and psychosocial conditions; a social history of family relationships, former occupation, community involvement, and leisure activities; and cultural factors such as racial or ethnic background, language, and religion can all be incorporated to individualize the plan of care. The flow of individualization and delivery of care is illustrated in [Figure 1-1](#).



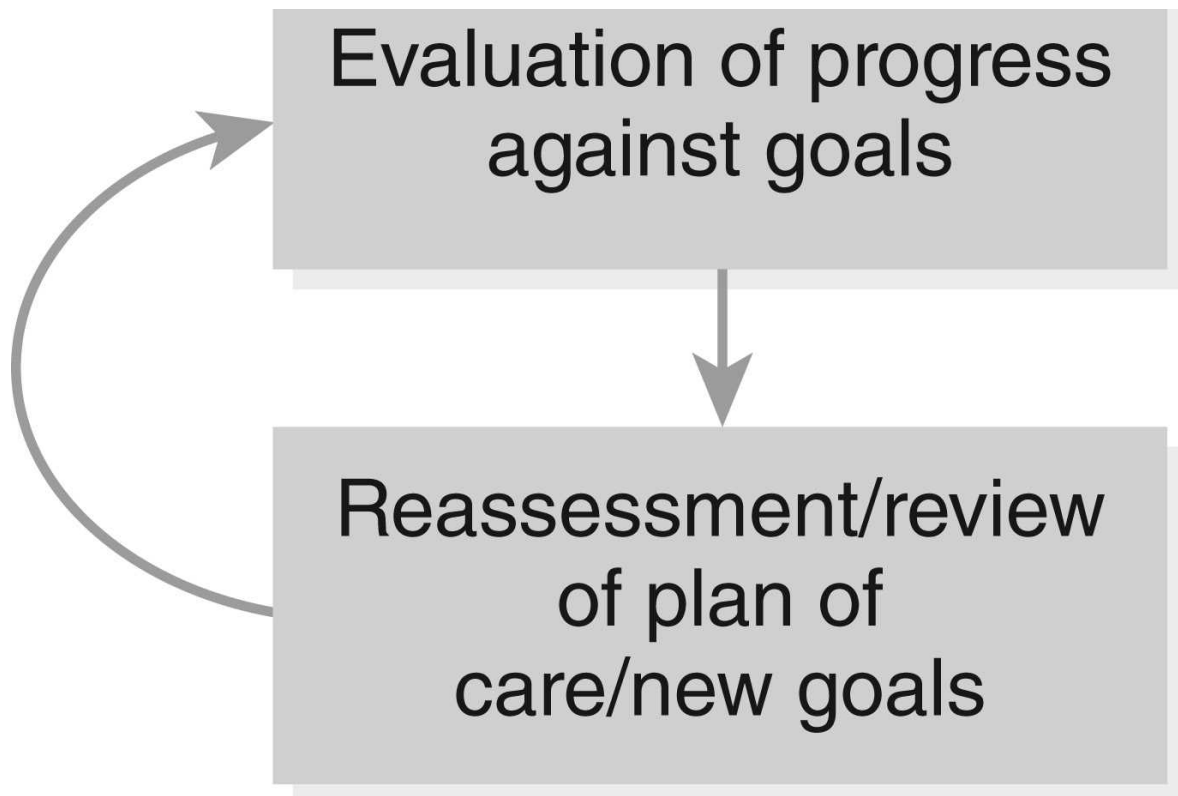


Figure 1-1 Individualization and delivery of care.

Well-Coordinated Total Care

LTC providers are responsible for managing the total health care needs of each resident. **Total care** means that any health care need is recognized, evaluated, and addressed by appropriate clinical professionals. Coordination of care with various medical providers such as the attending physicians, dentists, optometrists, podiatrists, dermatologists, or audiologists is often necessary for prevention as well as the onset of health issues. Hence, LTC must interface with non-LTC services to address a person's total care needs.

Promotion of Functional Independence

The goal of LTC is to enable the individual to maintain functional independence to the maximum level practicable. Restoration of function may be possible to some extent through appropriate rehabilitation therapy, but in most cases, a full restoration of normal function is an unrealistic expectation. The individual may have to be taught to use adaptive equipment, such as wheelchairs, walkers, special eating utensils, or portable oxygen devices. Ongoing maintenance therapy—such as assisted walking, range of motion exercises, bowel and bladder training, and cognitive reality orientation—is necessary to prevent progressive decline, although, over time, some loss of function is to be expected. Caregivers must motivate the person to do as much as possible for him- or herself to prevent further decline. Caregivers then “fill in” for all functions that can no longer be carried out independently. A comatose person who is totally confined to bed, for instance, presents an extreme case in which full assistance from caregivers becomes necessary.

Extended Period of Care

Compared to acute care services that generally last only for a few days, the delivery of LTC extends over a relatively long period. Certain types of LTC services—such as rehabilitation therapies, postacute convalescence, or stabilization—may be needed for a relatively short duration, generally less than 90 days. In other instances, because of severe health and disablement issues, LTC may be needed for years, perhaps indefinitely. It is estimated that 69% of LTC users will use some type of LTC for a period of 3 years (Arias, 2019). Examples include people with severe dementia, incontinence of bowel and bladder, severe psychiatric or behavioral issues, unstable postacute conditions, or those in a comatose/vegetative state. In nursing homes, in 2016, 43% of the residents were short stay, and 57% were long stay (Harris-Kojetin et al., 2019). People receiving community-based LTC services generally need them for a long duration to prevent institutionalization.

Use of Current Technology

LTC providers must keep pace with and adopt new technology when it would facilitate care delivery, improve safety and quality, and promote operational efficiencies. Technologies that promote self-care and independence can enable people to stay in the community.

Use of Evidence-Based Protocols

Evidence-based care relies on the use of best practices that have been established through clinical research. Clinical processes that have been proven to deliver improved therapies have been standardized into clinical practice guidelines. These guidelines become evidence-based protocols that are indicated for the treatment of specific health conditions or clinical circumstances. Numerous guidelines have been developed for use in nursing homes, which may also be adapted for use in other LTC settings such as home health and assisted living.

Holistic Approach

The holistic approach to health care delivery focuses on every aspect of what makes a person whole and complete. In this approach, a person's physical, mental, social, and spiritual needs and preferences are incorporated into medical care delivery and all aspects of daily living.

By its very nature, effective LTC is holistic. The following are brief descriptions of the four main aspects of holistic caregiving:

1. *Physical.* This refers to the technical aspects of care, such as medical examinations, nursing care, medications, diet, rehabilitation treatments, etc. It also includes comfort factors such as appropriate temperature, cozy furnishings, cleanliness, and safety in both home and institutional environments.
2. *Mental.* The emphasis is on the total mental and emotional well-being of an individual. Environmental and social support that reduce stress and anxiety can be instrumental in promoting mental and emotional well-being.
3. *Social.* Almost everyone enjoys warm friendships and social relationships. Visits from family, friends, or volunteers provide numerous opportunities for socializing. The social aspects of health care include companionship, information, counseling, and recreation.
4. *Spiritual.* The spiritual dimension includes personal beliefs, values, and commitments in a religious and faith context. Spirituality and spiritual pursuits are very personal matters, but for most people, they also require continuing interaction with other members of the faith community.

Maximizing Quality of Care

Because of the multifaceted nature of LTC, quality of care can be achieved only with a multidisciplinary approach to caregiving. Quality of care is maximized when desirable clinical- and person-related outcomes have been achieved. Maximization of quality is an ongoing pursuit. Even though it is never fully achieved, the goal is to instill a culture of continuous improvement by focusing on the other nine dimensions of LTC discussed in this section. To improve quality, regulatory standards as well as evidence-based protocols must be implemented. Quality must be evaluated or measured to discover areas needing improvement, and processes should be changed as necessary. This becomes an ongoing effort.

Maximizing Quality of Life

Quality of life refers to the total living experience, which results in overall satisfaction with one's life. Quality of life is related to cognitive functioning (Zimmermann et al., 2015); it also affects the behavioral and psychological symptoms associated with dementia among elderly individuals in LTC facilities (Suzuki et al., 2017). Quality of life is a multifaceted concept that recognizes at least five factors: lifestyle pursuits, living environment, clinical palliation, human factors, and personal choices. Hence, quality of life is enhanced by integrating these five factors into the delivery of care.

1. Lifestyle factors are associated with personal enrichment and making one's life meaningful through activities one enjoys. For example, many residents in institutional settings may still enjoy pursuing their former leisure activities, such as woodworking, crocheting, knitting, gardening, etc. Many residents would like to engage in spiritual pursuits or spend some time alone. Even those whose functioning has

decreased to a vegetative or comatose state can be creatively engaged in something that promotes sensory awakening through visual, auditory, and tactile stimulation.

2. The living environment should be one in which the person feels the most at home.
3. Palliation should be available for relief from unpleasant symptoms such as pain or nausea.
4. Human factors refer to caregiver attitudes and practices that emphasize caring, compassion, respect, and human dignity in the delivery of care. Residents in institutions generally find it disconcerting to have lost their autonomy and independence. Quality of life is enhanced when residents can govern their own lives and are given appropriate privacy.
5. LTC institutions should make every effort to accommodate the residents' personal choices. For example, food is often the primary area of discontentment, which can be addressed by offering a selective menu. Many elders resent being awakened early in the morning when nursing home staff begin their responsibilities to care for residents' hygiene, bathing, and grooming. Flexible schedules should be implemented to accommodate personal preferences.

Seniors and Long-Term Care

Many older adults are in relatively good health. Nevertheless, as a person ages, chronic ailments, comorbidity or multimorbidity, disability, and dependency tend to follow each other. This progression is associated with increased probability that a person would need LTC (**Figure 1-2**).

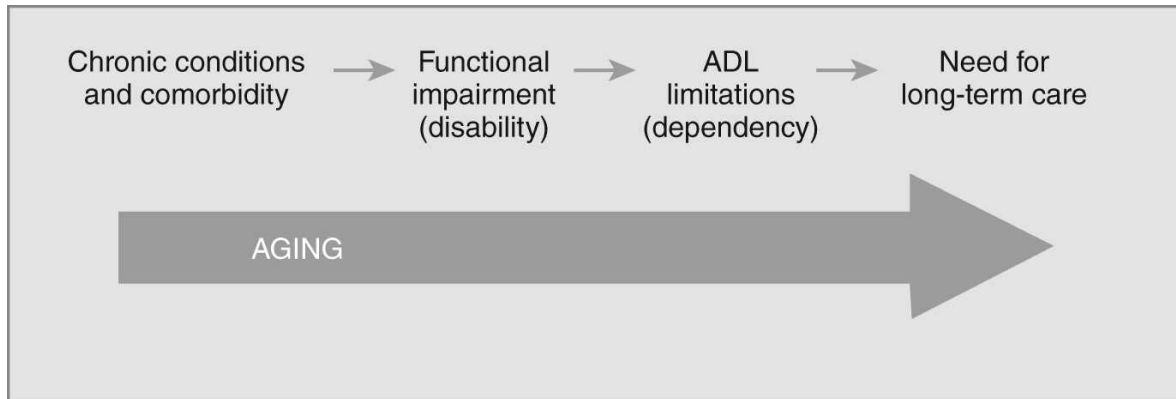


Figure 1-2 Progressive steps toward the need for long-term care among seniors.

The number of functional limitations in ADLs and IADLs rises with both age and multimorbidity (two or more health problems), as illustrated in **Table 1-1** and **Figure 1-3**. Secondly, given the number of chronic conditions, ADL/IADL limitations increase faster among women than among men. Hence, the users of LTC services are overwhelmingly women (Harris-Kojetin et al., [2019](#)).

TABLE 1-1 Association Between Age, Gender, Multimorbidity, and ADL/IADL Limitations

No. of Chronic Conditions	Mean Number of ADL and IADL Limitations			
	Age 65–74		Age ≥75	
	Men	Women	Men	Women
0	0.3	0.3	0.5	0.5
1	0.4	0.4	0.7	0.7
2	0.6	0.7	0.9	1.0
3	0.9	1.1	1.2	1.5
4	1.2	1.6	1.6	2.2
5	1.7	2.5	2.2	3.1
6	2.4	3.8	2.9	4.6
7	3.5	7.5	4.2	6.8
8	4.2	8.8	8.1	10.1

Note: ADL/IADL figures have been rounded.

Data from Jindai, K., Nielson, C. M., Vorderstrasse, B. A., & Quiñones, A. R. (2016). *Multimorbidity and functional limitations among adults 65 or older, NHANES 2005–2012*. Atlanta, GA: Centers for Medicare and Medicaid Services. Retrieved from https://www.cdc.gov/pcd/issues/2016/16_0174.htm#:~:text=Disease%2C%20functional%20limitation%2C%20and%20disability%20should%20not%20be,develop%20interventions%20for%20high-risk%20adults%2065%20or%20older.

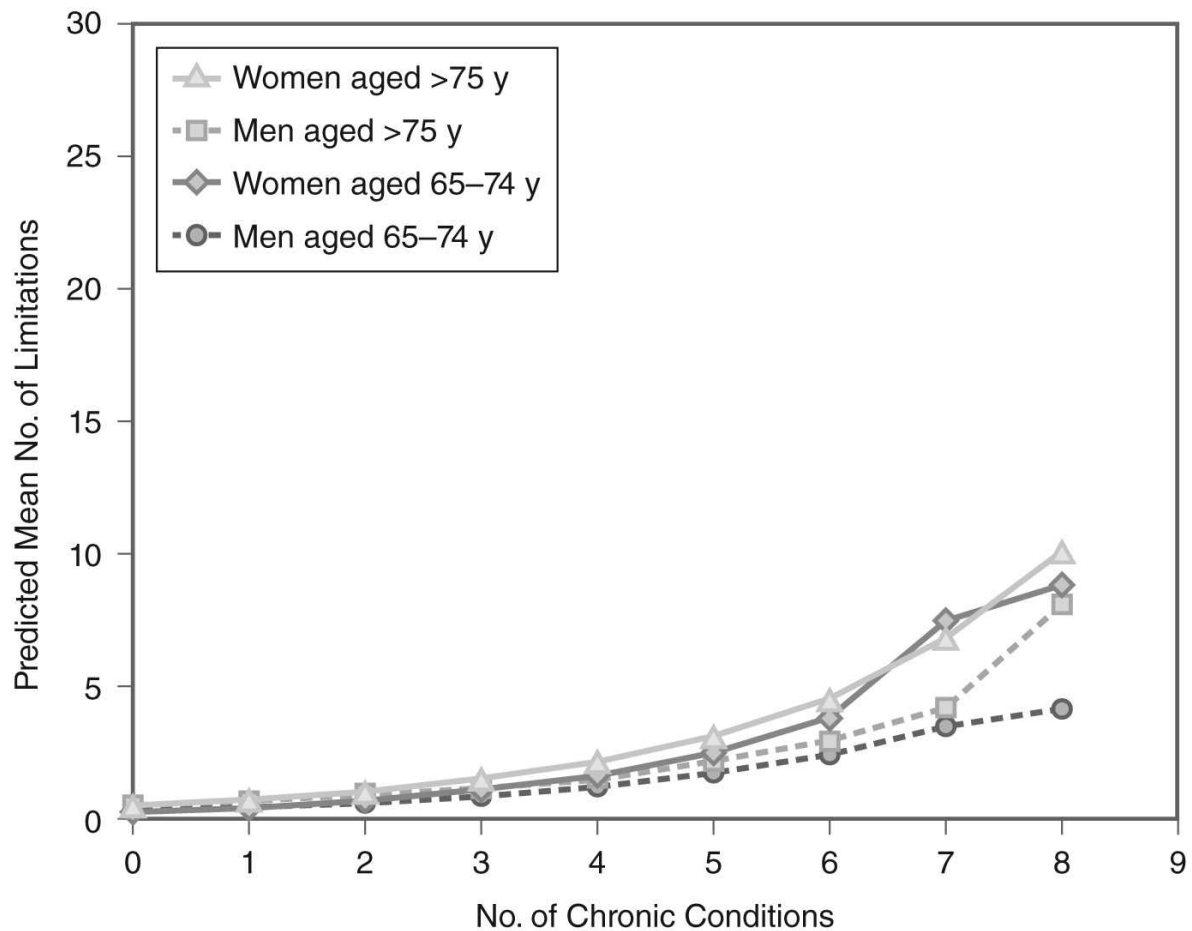


Figure 1-3 Predicted mean number of ADL/IADL limitations by the number of chronic conditions, stratified by gender and age group. Data from Jindai, K., Nielson, C. M., Vorderstrasse, B. A., & Quiñones, A. R. (2016). *Multimorbidity and functional limitations among adults 65 or older, NHANES 2005–2012*. Atlanta, GA: Centers for Medicare and Medicaid Services. Retrieved from https://www.cdc.gov/pcd/issues/2016/16_0174.htm#:~:text=Disease%2C%20functional%20limitation%2C%20and%20disability%20should%20not%20be,develop%20interventions%20for%20high-risk%20adults%2065%20or%20older.

Aging in place is an old concept that refers to an individual's preference and ability to live in one's own home or familiar surroundings where the person's changing needs over time are accommodated. Hence, home- and community-based services (HCBS) are preferred by most seniors, and these services have grown more rapidly than LTC institutions. Severe declines in health, however, necessitate institutional services, particularly for people who need care and monitoring around the clock. Also, short-term institutional services are needed for convalescence and rehabilitation.

The Continuum of Long-Term Care

Continuum of long-term care refers to the full range of LTC services that increase in the level of acuity and complexity from one end to the other—from informal and community-based services at one end of the continuum to the institutional system at the other end. Hence, the LTC continuum has three major segments: informal care, HCBS, and the institutional system.

Although institutional management is the focus of this text, the other two segments, informal care and HCBS, also have important implications for administrators who manage LTC institutions. From an institutional perspective, the other two segments are viewed as competition.

The three subsystems that form the LTC continuum are illustrated in **Figure 1-4**. Different levels of institutional settings also form their own institutional continuum. Apart from personal needs, client preferences, availability of community-based care, and ability to pay for services all play a role in determining which services are used.

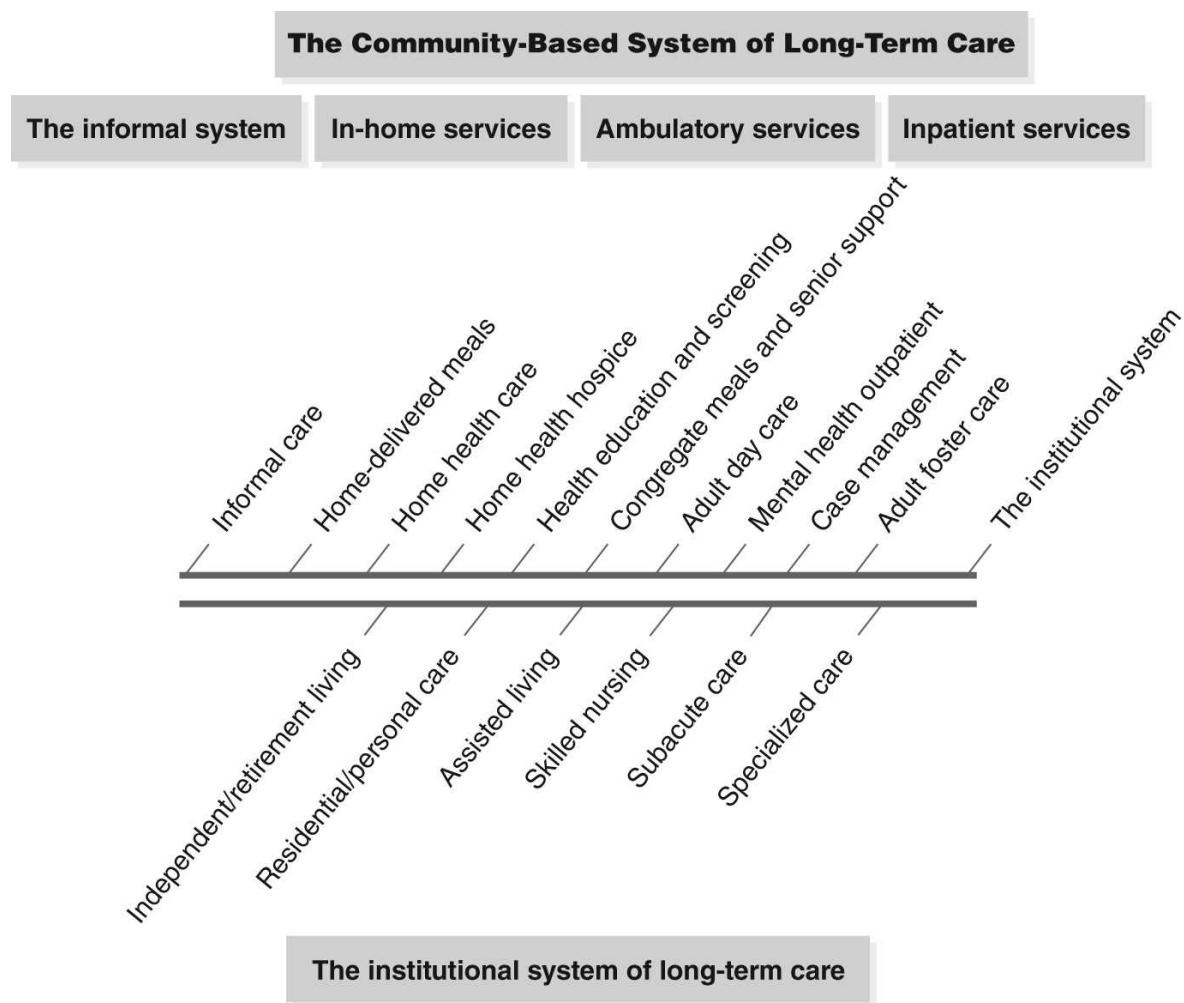


Figure 1-4 The continuum of long-term care.

Informal Care

Most LTC services in the United States are provided informally, without formal payment, by family, friends, and surrogates, such as neighbors and members from church or other community organizations. Informal care is also the predominant form of LTC in other industrialized countries (Kolodziej et al., 2018). For the most part, services rendered are of a basic nature, such as general supervision and monitoring, running errands, helping with medications, cooking meals, and, to a lesser extent, assistance with bathing, eating, grooming, and dressing. However, in some cases, informal caregivers must perform complex tasks for which they receive little preparation, hands-on training, or meaningful support (Reinhard et al., 2019).

It is estimated that 41 million family caregivers in the United States provided an estimated 34 billion hours of care to adults with limitations in daily activities. The estimated economic value of their unpaid contributions

was approximately \$470 billion in 2017 (Reinhard et al., 2019), which exceeds the \$409 billion spent in 2018 from all formal paid sources combined (Colello, [2020](#)).

The extent of informal care that an individual receives depends highly on the extent of the support network the individual has. People who can depend on a network of family and others can often continue to live independently much longer than those who have little or no social support.

The caregiving burden can vary. For some people, caregiving can instill confidence, provide meaning and purpose, enhance skills, and bring the caregiver closer to the older adult. For others, caregiving takes a significant toll in terms of emotional distress, depression, anxiety, or social isolation. Some caregivers also report being in poor physical health themselves (National Academies of Sciences, Engineering, and Medicine, [2016](#)).

The pool of informal caregivers, in relation to the growing senior population needing LTC, is expected to shrink rather dramatically in the future. Various reports suggest that the number of seniors who are divorced, unmarried, or without children has been on the rise. This trend portends that formal services will have to pick up the slack, but at a significant cost to society.

The Home- and Community-Based System

Community-based LTC services can be categorized as intramural and extramural, and they have a fourfold objective:

1. To deliver LTC in the most economical and least restrictive setting whenever appropriate for the person's health care needs.
2. To supplement informal caregiving when more advanced skills are needed than what family members or surrogates can provide.
3. To provide temporary respite to family members from caregiving stress.
4. To delay or prevent institutionalization.

Intramural Services

[Intramural services](#) are taken to people who live in their own homes, either alone or with family. The most common intramural services include home health care and Meals on Wheels. Limited support programs that provide services such as homemaker, chores and errands, and handyman assistance also exist, but the funding to pay for such services is not well established and varies from community to community. [Home health care](#) brings services such as nursing care and rehabilitation therapies to home-based residents who do not need to be in an institution and yet are unable to leave their homes safely to get the care they need.

Extramural Services

[Extramural services](#) are community-based services that are delivered outside a person's own home. These services are available at a community-based location. Examples include services such as adult day care, mental health outpatient clinics, and congregate meals provided at senior centers.

[Adult day care](#) enables a person to live with family but receive professional services in a daytime program in which nursing care, rehabilitation therapies, supervision, and social activities are available. [Senior centers](#) are local community centers where seniors can congregate and socialize. Many centers offer a daily meal. Others sponsor wellness programs, health education, counseling services, information and referral, and some limited health care services. [Respite care](#) can include any formal LTC service (adult day care, home health, or temporary institutionalization) when it allows family caregivers to take time off while the individual's care is taken over by the respite care provider. It allows family members to get away for a vacation or deal with other personal situations.

The Institutional System

Institutional LTC is more appropriate for people whose needs cannot be adequately met in a community-based setting. Facilities within the institutional continuum range from independent living facilities or retirement centers at one end to subacute care and specialized care facilities at the other end (see the lower section of [Figure 1–4](#)). On the basis of the level of services they provide, institutional LTC facilities may be classified under six distinct categories (facilities in the first two categories may be referred to as quasi institutions): Independent or retirement housing, residential or personal care, assisted living, skilled nursing, subacute care, and specialized care.

For most people, the array of facilities, which often go by different names, can be remarkably confusing. This is particularly true as distinctions between some of them can be blurry because the services these facilities provide may overlap. For example, what is defined as board-and-care (i.e., residential and personal care) in one state may be called assisted living in another.

Independent or Retirement Housing

Independent housing units and retirement living centers are not LTC institutions in the true sense because they are meant for people who can manage their own care. These residences do not deliver clinical care but emphasize privacy, security, and independence. Their special features and amenities are designed to create a physically supportive environment, as described previously.

Residential or Personal Care Homes

In addition to providing a physically supportive environment, these facilities generally provide light assistive care, such as medication use management and assistance with bathing and grooming. Other basic services such as meals, housekeeping, laundry, and social and recreational activities are also generally included.

Assisted Living Facilities

An assisted living facility provides personal care, 24-hour supervision, social services, recreational activities, and some nursing and rehabilitation services. These facilities are appropriate for people who cannot function independently but do not require skilled nursing care. To emphasize a residential environment, assisted living facilities generally have private accommodations, rather than semi-private rooms that are common in skilled nursing facilities.

Skilled Nursing Facilities

These are the typical nursing homes at the higher end of the institutional continuum. Compared with the types of residences discussed earlier, the environment in skilled nursing facilities is more institutionalized and clinical. Yet, many facilities have implemented creative ideas in layout and design to make their living environments as pleasant and homelike as practicable.

The facility must be adequately equipped to care for residents who require a high level of nursing services and medical oversight. Yet, the high level of clinical care must be balanced with adequate quality of life in a resident-centered environment.

Subacute Care Facilities

Subacute care, defined earlier, has become a substitute for services that were previously provided in acute care hospitals. It has grown because it is a cheaper alternative to a hospital stay. Medical technology has played a critical role in the development of subacute care outside of hospitals.

Specialized Care Facilities

Some nursing homes have opened specialized care units for residents requiring ventilator care, Alzheimer's and dementia care, intensive rehabilitation, or closed head trauma care. Other specialized facilities include intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). The key distinguishing feature of the latter institutions is specialized programming and care modules for residents suffering from intellectual disabilities and associated comorbidities.

Long-Term Care and Complementary Services

Services within the broader health care delivery system are also needed by LTC recipients. Hence, care coordination between the two systems—LTC and non-LTC—is necessary to meet a person's total care needs. As an example, a person living at home may undergo partial mastectomy for breast cancer, return home under the care of a home health agency, require hip surgery after a fall in the home, and subsequently be admitted to a skilled nursing facility for rehabilitation. This individual will need recuperation, physical therapy, chemotherapy, and follow-up visits to the oncologist. Once she is able to walk with assistance and her overall condition is stabilized, she may wish to be moved to an assisted living facility.

Following are the main non-LTC services that are complementary to LTC:

- **Primary care**, which is defined as medical care that is basic, routine, coordinated, and continuous over time. It is delivered mainly by community-based physicians. It can also be rendered by midlevel providers such as physician's assistants or nurse practitioners. Primary care is also brought to nursing home residents, whereas those residing in less institutionalized settings, such as retirement living communities or personal care homes, commonly visit the primary care physician's office.
- Mental health care is delivered by community-based mental-health outpatient clinics and psychiatric inpatient hospitals.
- Specialty care is delivered by community-based physicians in specialty medical practices, such as cardiology, ophthalmology, dermatology, or oncology. Certain services are also delivered by freestanding chemotherapy, radiation, and dialysis centers. Other services are provided by dentists, optometrists, opticians, podiatrists, chiropractors, and audiologists in community-based clinics or mobile units that can be brought to a LTC facility.
- Acute care is delivered by hospitals and outpatient surgery centers. Acute episodes in an LTC setting require transfer of the individual to a hospital by ambulance.
- Diagnostic and health screening services are offered by hospitals, community-based clinics, or mobile medical services. Some common types of services brought to LTC facilities include preventive dentistry, x-ray, and optometric care.

Terminology for Review

activities of daily living
adult day care
aging in place
Alzheimer's disease
assisted living facility
chronic condition
clinical practice guideline
cognitive impairment
comorbidity
continuum of long-term care
dementia
developmental disability
end-of-life care
evidence-based care
extramural services
holistic approach
home health care
hospice
instrumental activities of daily living
intellectual disability
intramural services
long-term care
palliation
person-centered care
primary care
quality of care
quality of life
resident-centered care
respite care
senior center
skilled nursing care
social support
subacute care
support services
supportive housing
tertiary prevention
total care

For Further Thought

1. How does long-term care differ from other types of medical services?
2. For nursing home residents, dignity and privacy issues are often more important than clinical quality. Identify some staff practices that will promote an individual's privacy and dignity. (Think about how you would like to be treated by caregivers.)

CASE

Can Mrs. Klausman Stay in Assisted Living?

Contributed by Katie Ehlman, PhD, CHES, HFA; Elizabeth Ramos, MS, RD, CD; Julie McCullough, PhD, RD; and Mary Kay Arvin, OTD, OTR, CHT, College of Nursing and Health Professions, University of Southern Indiana.

Mrs. Klausman is a 92-year-old resident in an assisted living facility. She has mild cognitive impairment and needs help with bathing and medication administration. Because of progressive arthritis, she is having difficulty eating. The silverware slips out of her hands and falls to the floor so that staff members must keep replacing it. Mrs. Klausman becomes visibly frustrated and embarrassed. The food service manager and the administrator decide to meet with Mrs. Klausman's daughter and recommend that the family should hire a home care provider to assist Mrs. Klausman at mealtimes. The facility does not have staff resources to feed residents. The resident's daughter is thinking whether a skilled nursing facility would be more appropriate for her mother.

Questions

1. Identify and evaluate Mrs. Klausman's deficit in self-feeding from different perspectives on what long-term care consists of.
2. Should Mrs. Klausman be transferred to a skilled nursing facility? Explain.
3. Is hiring a home care provider appropriate? Why or why not? What do you suggest?

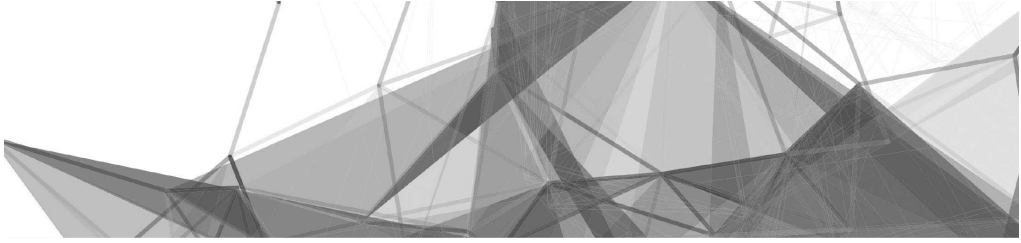
For Further Learning

Administration for Community Living. A federal agency established to promote the well-being of older individuals by providing services and programs designed to help them live independently in their homes and communities. <https://acl.gov>

National Council on Aging: A private, nonprofit organization providing information, training, technical assistance, advocacy, and leadership in all aspects of care for the elderly. <http://www.ncoa.org>

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CHAPTER 2

Long-Term Care Policy: Past, Present, and Future

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WHAT YOU WILL LEARN

- Decisions made by the government in the form of policy can affect numerous groups and classes of individuals. Strategic decisions made in private organizations may also hinge on public policy.
- Health policy can take many different forms and can come from all three branches of government.
- Historically, long-term care policy in the United States has been closely intertwined with general welfare policies.
- The Nursing Home Reform Act of 1987 was instrumental in laying the foundation for current nursing home regulations.
- Cost concerns as well as people's preferences have led to the policy of moving people out of institutions into the community.
- The complex interaction of financing, access, utilization, and quality is critical to current and future long-term care policy.
- The demographic imperative poses several challenges for the future that policy must address.

Introduction

Long-term care (LTC) policy is a subset of broader health policies that fall within the domain of public policy. **Public policy** refers to decisions made and actions taken by the government that are believed to be in the public's best interest. Public policy that is directed at issues pertaining to health care is referred to as **health policy**. Health policies affect groups or classes of individuals, such as physicians, the poor, seniors, and children. They can also affect various types of organizations, such as medical schools, managed care organizations, hospitals, nursing homes, and manufacturers of medical technology. The Affordable Care Act of 2010 (ACA),¹ also known as Obamacare, is a prime example of a major health policy that has affected many aspects of health care delivery, such as health insurance, regulatory mandates, and payments to providers.

LTC policy is specifically crafted to address issues pertaining to access, financing, delivery, quality, and efficiency of LTC services. These policies have been aimed at helping people to receive better services.

Policy may be made at the national, state, or local level of government. For example, national building and fire safety codes govern the construction, design, and safety features for LTC facilities. State policies govern licensure of facilities and health care professionals and sale of insurance products. Local governments establish zoning laws specifying where LTC facilities may be built.

Public policy is often an important consideration when private organizations make strategic decisions. For example, a strategic decision by a skilled nursing facility to convert some of its beds to deliver subacute care may be driven by a public policy to increase reimbursement for subacute care. Hence, in addition to market demand factors, policy considerations can play a critical role in managerial decisions.

¹ Affordable Care Act is the shortened name commonly used for the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010.

Types of Policy

Commonly, policy takes the form of laws passed by legislative bodies such as the U.S. Congress or state legislatures. Administrative bodies, such as the Centers for Medicare and Medicaid Services (CMS) or state health boards, interpret the legislation and formulate rules and regulations to implement the laws. For example, the massive set of regulations crafted by the CMS (contained in the *State Operations Manual: Guidance to Surveyors for Long-Term Care Facilities*) are designed to carry out the mandates of the Nursing Home Reform Act (1987). Thus, administrative bodies also end up creating policy. The term [policy makers](#) is generally applied to legislators and decision makers in regulatory agencies. The two sources of policy making just mentioned are the most common. Less frequently, certain decisions rendered by the courts, and executive orders issued by the president of the United States or state governors, also become policy. Hence, all three branches of government—legislative, judicial, and executive—can make policy. The executive and legislative branches can establish health policies; the judicial branch can uphold, strike down, or modify existing laws affecting health care. Examples in all three areas follow.

Medicare's current methodology for paying skilled nursing facilities goes back to the Balanced Budget Act of 1997 which required Medicare to develop a prospective payment system (PPS). The Protecting Access to Medicare Act of 2014 required the CMS to implement value-based purchasing program that takes into account rehospitalization rates (American Health Care Association, [2020](#)). In 2019, a new patient-driven payment model went into effect. It forced nursing homes across the nation, once again, to readjust their operational strategy. A landmark 1999 decision by the U.S. Supreme Court in *Olmstead v. L.C.* directed states to provide community-based services for persons with disabilities—including people with developmental disabilities, physical disabilities, or mental illness—when such services were deemed more appropriate than nursing facilities. In 2012, the U.S. Supreme Court upheld part of the ACA to be constitutional, but also ruled that the federal government could not coerce the states into expanding their existing Medicaid programs as required by the Act.

The 2004 Executive Order 13335 provided incentives for the use of health information technology (HIT). One of the main objectives of this executive order was to develop a nationwide HIT infrastructure that would allow a patient's electronic health records to be portable and available to different health care providers (i.e., make electronic health records [interoperable](#)).

Policies carry the force of law. Violations can result in penalties that can include monetary fines, withholding of payments by the government, and prison terms for criminal offences.

Long-Term Care Policy: Historical Perspectives

Health care policy making in the United States has followed an ad hoc approach to incrementally address issues as they have cropped up. LTC policies had three major effects:

1. The government became the largest payer for services provided by nursing homes. This promoted the growth of a private nursing home industry.
2. The government implemented policies to regulate nursing homes and hold them accountable for complying with the regulatory standards.
3. For several decades, LTC policy promoted institutionalization. Rising costs put strains on federal and state budgets, but it was not until the 1980s that policies promoting home- and community-based services were crafted.

Welfare Policies and Long-Term Care

The history of LTC policy in the United States goes back to the building of poorhouses in the late seventeenth century. A [poorhouse](#) (or almshouse) was a government-operated institution during colonial and postcolonial times where the destitute of society, including the elderly, the homeless, the orphan, the ill, and the disabled, were given food and shelter, and conditions were often squalid. The first poorhouse in the United States is recorded to have opened in 1660 in Boston (Wagner, [2005](#), p. 10). The poorhouse program was adopted from the Elizabethan system of public charity based on English Poor Laws. In the United States, cities, counties, and states operated these facilities, which were often located on farms and, hence, also referred to as poor farms. The poorhouses were part of a very limited public relief system that was financed mainly by local governments. In response to the growing concerns about abuse and squalid living conditions, some states created state-run Boards of Charities in the mid-1800s to oversee and report on the local poorhouse operations.

Tireless efforts of Dorothea Lynde Dix (1802–1887), a social reformer, were particularly instrumental in convincing Massachusetts' legislature to pass laws that would put the mentally ill in separate facilities. Between 1894 and World War I, the State Care Acts were passed. Each state built its own mental asylum and took financial responsibility for the care of mentally ill patients. These reform efforts even spread abroad to Canada and Europe.

Passage of the Social Security Act in 1935 was a landmark piece of legislation. Senior citizens were particularly hard hit during the Great Depression as many of them saw their lifetime savings disappear. Hence, the federal government specifically addressed the needs of America's seniors. An Old Age Assistance (OAA) program was included in the Social Security Act. The OAA program made federal money available to the states to provide financial assistance to needy seniors (Fetter & Lockwood, [2017](#)). The new law purposely prohibited payments to anyone living in a public institution (i.e., a poorhouse) and was instrumental in putting an end to the poorhouse system (Wagner, [2005](#), pp. 132–133). An unintended side effect of this policy, however, was that it started a private for-profit nursing home industry in the United States because many seniors now were able to pay for services in privately run homes for the aged and boarding homes (Henry J. Kaiser Family Foundation [Kaiser], [2015](#)).

Detachment from Social Welfare

A 1950 Social Security Amendment required payments for medical care to be made directly to nursing homes rather than to the recipients of care (Kaiser, 2015). Thus, health policy led to the recognition of nursing homes as institutions of medical care rather than social welfare. The Amendment also required states to license nursing homes as a qualification to participate in OAA payments. Nursing homes could now contract directly with the state governments and get reimbursed for services delivered to seniors. Not surprisingly, funding for the care of the aged led to a nursing home boom in the United States. It is estimated that by 1960, the United States had 10,000 nursing homes with 400,000 beds (Vladeck, [1980](#)). Direct payments to nursing homes, and later, for community-based LTC, however, had become entrenched in social welfare. Subsequently, Medicaid became the largest payer for LTC.

The Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act, provided federal funds to states for the construction of new nonprofit hospitals. An unplanned result of the Hill-Burton legislation was that many of the old hospitals that were being replaced were converted to nursing homes. In 1954, the Hill-Burton Act was amended to provide funds to nonprofit organizations for the construction of skilled nursing facilities that met certain definitions and hospital-like building standards (Institute of Medicine, [1986](#)). By this time, however, the nursing home industry was already dominated by the for-profit sector. Thus, a somewhat unusual private-public relationship has continued even to this day—most nursing homes are private for-profit entities that are largely financed through Medicaid which is the largest public welfare program in the United

States. In contrast, assisted living facilities rely on private payments because they are not funded by the government.

Financing and Growth of Nursing Homes

The creation of Medicare and Medicaid in 1965 as Title 18 and Title 19 amendments, respectively, to the Social Security Act brought about the most transforming changes in the American health care landscape. Medicare and Medicaid are two major public health insurance programs. [Medicare](#) covers health care services for seniors, certain disabled people, and those who have end-stage renal disease (kidney failure). [Medicaid](#) covers health care services for the poor.

With the creation of Medicare and Medicaid, LTC became more fully integrated into the U.S. health care delivery system. Also, the federal and state governments became the largest payers for LTC services, and the politics of long-term nursing home care took root. Medicare and Medicaid policies favored payments to nursing homes that lawmakers could regulate rather than payments for community-based services that would be difficult to regulate. These policies led to the institutionalization of a large number of people, many of whom did not need to be in nursing homes. It is often referred to as “institutional bias” in LTC.

The massive infusion of dollars into the nursing home industry, which had already acquired a tarnished image, prompted regulations to hold individual nursing homes accountable for meeting minimum standards of care. The Moss Amendments (named after Senator Frank Moss) were passed in 1968, and regulations for skilled nursing facilities were finalized in 1974. Later, these regulations were widely criticized because they concentrated on a facility’s capacity to give care, not on the quality of services actually delivered.

Licensing of Nursing Home Administrators

Licensing of nursing home administrators (NHAs) also came about in response to public outcry over lapses in care. One key characteristic of licensure is that it is a responsibility of each state, not the federal government. State licensure regulations, however, vary considerably regarding educational and training requirements for NHAs. Evidence suggests that higher educational standards and training requirements are associated with better quality outcomes in skilled nursing facilities (Castle et al., [2015](#)). Hence, licensing alone has not provided the answer to quality improvement in nursing homes.

Policies Favoring Community-Based Services

Social Security amendments in 1974 authorized federal grants to states for various types of social services, such as homemaker services, transportation, adult day care, nutrition assistance, and health support (Kaiser, 2015). The Social Security Amendment of 1975 created Title 20, which consolidated the federal assistance to states for social services into a single grant. One of the goals of Title 20 was to prevent or reduce inappropriate institutional care by providing for home- and community-based services. In 1981, Title 20 was amended to create Social Services Block Grants. The single block grants actually reduced federal funding to the states for social services. Also, Title 20 covered services for all ages, not just seniors. Consequently, block grants have provided relatively little money for LTC services.

Also in 1981, the Home- and Community-Based Services (HCBS) waiver program was enacted under Section 1915(c) of the Social Security Act. The 1915(c) waivers, as they are commonly called, allow states to offer LTC services that are not otherwise available through the Medicaid program, which had authorized payments for institutional care only. The waivers have been largely successful, and states have increasingly used them to expand community-based LTC services, thus saving money on institutional care provided in both skilled nursing facilities and the specialized facilities known as intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). The year 1981 is when the policy, in earnest, shifted against the institutional bias in the delivery of LTC services.

A 1988 court ruling on a class-action lawsuit, *Duggan v. Bowen*, opened up broad access to Medicare-covered home health services, and for some time, home health care became the fastest growing service in the United States. To slow down the growth of Medicare spending, Congress enacted the Balanced Budget Act of 1997, which mandated the replacement of Medicare’s cost-based retrospective reimbursement for home health agencies by a PPS, just as skilled nursing facilities had been brought under prospective reimbursement since 1998. The home health PPS reimbursement was implemented in October 2000.

In 2001, President George W. Bush announced the New Freedom Initiative and signed Executive Order 13217 to expedite the implementation of the Supreme Court’s ruling in *Olmstead v. L.C.* (referred to previously) that required individuals with disabilities to have community living options.

The Deficit Reduction Act of 2005 authorized the **Money Follows the Person (MFP) program**. This program accelerated the transfer of individuals from nursing homes to home- and community-based settings. When a person transfers from a nursing home to the community, funds that had previously paid for nursing home care are transferred to community-based services for that person. From the program’s inception in 2008 to the end of 2019, more than 101,000 people had transitioned from institutions back into the community (Liao & Peebles, [2019](#)).

Legislation to Address Quality Issues

Because scandals about substandard quality of care in nursing homes had persisted, Congress commissioned the Institute of Medicine (IOM) to study the issue. The IOM's 1986 study culminated in a scathing report on the state of nursing homes in the United States. The study found that residents of nursing homes were being abused, neglected, and given inadequate care. Sweeping regulatory reforms were proposed. The IOM's prestige lent credibility to its recommendations, and the report triggered the most comprehensive revision of the federal standards, inspection process, and enforcement mechanism for nursing homes since the creation of Medicare and Medicaid in 1965.

In 1987, President Reagan signed into law the Omnibus Budget Reconciliation Act of 1987 (OBRA-87), which contained the Nursing Home Reform Act. The most important provisions of the law are summarized as follows (Castle, 2001; Turnham, 2001):

- Emphasis on residents' quality of life as well as quality of care
- New expectations that each resident's ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons
- A resident assessment process leading to development of an individualized care plan
- 75 hours of training and testing for nursing assistants
- Right to remain in the nursing home absent nonpayment, dangerous resident behaviors, or significant changes in a resident's medical condition
- Procurement of services both inside and outside a nursing home to address the needs of residents with mental retardation (intellectual disability) or mental illnesses
- Right to safely maintain or bank personal funds with the nursing home
- Right to return to the nursing home after a hospital stay or an overnight visit with family and friends
- Right to choose a personal physician and to access one's own medical records
- Right to organize and participate in a resident or family council
- Access to an ombudsman to resolve disputes and grievances
- Right to be free of unnecessary and inappropriate physical and chemical restraints
- New remedies to be applied to certified nursing homes that fail to meet minimum federal standards

Although the regulations have been updated a few times, OBRA-87 still forms the basis for the standards that nursing homes receiving Medicare and Medicaid funding must adhere to. Regular inspections are carried out to enforce compliance.

Regulation of Assisted Living Facilities

States establish and enforce licensing and certification requirements for assisted living facilities (ALFs), as well as requirements for assisted living administrators or executive directors. Although some federal regulations may apply to ALFs, these facilities are largely governed by state regulations. Care in ALFs is predominantly paid through private resources, hence, policy makers have shown little interest in regulating these facilities.

Current State of Long-Term Care Policy

Health policy in LTC has evolved in three main directions: financing, utilization, and quality, although a coordinated approach to policy is often missing. **Utilization** is the actual use of health care that occurs when people needing services have access to them. **Access** is the ability of a person needing services to obtain those services. Two main factors drive access: financing and availability of services. If financing is adequate but availability is limited, the services get rationed, and access is restricted. On the other hand, if services are available but financing is not, access becomes restricted for those who cannot afford to pay for the services. Also, increased utilization affects financing negatively as total expenditures rise. Reduced levels of financing, however, may affect quality negatively if cutting corners becomes the response to reductions in reimbursement.

Financing

Financing enables patients to pay for the services they receive. Care in a skilled nursing facility can be financed through Medicaid, Medicare, private insurance, Veterans Health Administration, or one's own personal funds. Hence, LTC financing is quite fragmented because no single source can be tapped to pay for services. Consequently, access and utilization become uneven. For example, middle-income people who require nursing home care for a long period of time can face a financing nightmare. Medicare pays only for postacute, short-term stays, and Medicaid requires people to exhaust their financial resources to become eligible. Many elders who do not qualify for either program have to pay on a private basis either through private LTC insurance or out of personal savings.

Financing for Home- and Community-Based Care

As a result of 1915(c) waivers and the MFP program, financing of LTC services for seniors and people with physical and mental disabilities has increasingly shifted from institutions to community-based care. By 2013, Medicaid expenditures for HCBS exceeded those for institutional services. In the early 1980s, HCBS represented less than 10% of Medicaid expenditures for LTC; by the late 1990s, HCBS exceeded 25% of Medicaid expenditures. By 2014, 53% of the \$152 billion spent nationally on Medicaid LTC services was for HCBS (Wenzlow et al., 2016). Indeed, the 1915(c) HCBS waiver program has become the largest single payer of LTC services in the United States (Murray et al., 2021). Thus, health policy has had a tremendous effect on the way LTC services are financed and delivered under Medicaid.

The ACA also created a new program, Community First Choice. Under this program, states have the option to provide attendant services and supports. The program has remained small; it accounted for only 3% of Medicaid expenditures for LTC, and most of the expenditures simply replaced the spending for personal care (Wenzlow et al., 2016).

As can be expected, financing alone cannot ensure that services would meet equitable delivery of quality care. Research shows that HCBS do not reduce hospitalizations compared to nursing facility users. Also, racial/ethnic disparities seem to persist (Gorges et al., 2019).

Reimbursement to Providers

It has been widely reported in research studies that reimbursement from government sources of payment—especially Medicaid—is often inadequate to cover the costs of operation, which is a pet peeve of nursing home executives. Research shows that reimbursement levels have ramifications for nursing home quality—increased Medicaid payments result in improvements in clinical quality (Xu & Intrator, 2020). For example, levels of Medicaid reimbursement drive staffing levels (Hackmann, 2019). To cover the shortfall from Medicaid, nursing homes have to balance the resident-mix that includes adequate number of clients with private sources of payment. Shortfalls in government financing have to be made up by charging higher rates to private payers—a practice known as **cost shifting**. Without the ability to shift costs many nursing homes may have to cease operations.

Incentives for Private Insurance

Private LTC insurance is particularly expensive if a plan is purchased in the later years of a person's life. People in younger age groups, for whom the cost of LTC insurance would be more affordable, face other financial priorities, such as saving for retirement, children's college education, life insurance, and buying a home. The need for LTC in the distant future is considered a much lower priority. In recent years, insurers had to significantly increase premiums because both the actual experience with LTC usage and future projections have been worse than had been originally anticipated. Hence, the number of people who have purchased LTC insurance remains small. Indeed sales have been consistently dropping (Schmitz & Giese, 2019). The senior population most likely to benefit from private LTC coverage also has a lower average income than the general population. Hence, LTC insurance has faced a dilemma: How to keep premiums high enough to cover costs, but low enough to attract clients.

In the 1990s, both state and federal governments created tax incentives for the purchase of private LTC insurance. Public policy also created state-based government-private partnership programs (Long-Term Care

Partnership Programs) to encourage the purchase of LTC insurance. So far these policies have had little success, even though 43 states had adopted the Partnership Program in 2016 (Cornell & Grabowski, 2018). The program essentially provides asset protection to qualify for Medicaid in the future if the individual had purchased private LTC insurance. Otherwise, under Medicaid policy, people first have to use up their income and assets before they can qualify for benefits.

Utilization

As pointed out previously, LTC policy has been critical in driving utilization away from nursing homes to community-based care. Consequently, the number of nursing homes, beds, and occupancy rates have declined over time (Table 2-1). There are two additional reasons for this shift: (1) Private paying clients find independent lifestyles in residential/assisted living facilities to be more appealing than in skilled nursing facilities. (2) The number of short-stay residents, who are admitted for convalescence and rehabilitation, has increased over time. Hence, nursing home administrators must grapple with high vacancy rates and lower profits (Grabowski et al., 2012).

TABLE 2-1 Nursing Home Utilization (Selected Years)

	1995	2000	2005	2010	2016
Number of nursing homes	16,389	16,886	15,995	15,690	15,647
Number of beds	1,751,302	1,795,388	1,724,582	1,703,398	1,690,304
Occupancy rates ^a	84.5%	82.4%	83.3%	82.0%	79.7%

^aPercentage of beds occupied (number of residents per 100 available beds).

Data from Health, United States, 2007, pp. 370–371; Health, United States, 2012, pp. 317–318; Health, United States, 2017, Tables 92–93. National Center for Health Statistics, Hyattsville, MD.

Quality

Since the passage of the Nursing Home Reform Act of 1987, several policy initiatives have been undertaken to address quality issues in nursing homes as well as in HCBS. Over the years, regulations governing nursing homes that participate in Medicare and Medicaid have been updated. Similarly, nursing home inspections have become increasingly resident focused and quality focused. Progressive enforcement is undertaken through fines, payment withholdings, and eventual termination from the Medicare and Medicaid programs if the facility is not brought into compliance with the standards (CMS, 2020a).

In 2002, the CMS began a national Nursing Home Quality Initiative (NHQI). Quality measures and performance of individual nursing homes are posted on the Nursing Home Compare website (<https://www.medicare.gov/nursinghomecompare/search.html>), which allows consumers, providers, policy makers, and researchers to compare information on nursing homes.

As mandated by the ACA, the CMS developed and implemented a **Quality Assurance Performance Improvement (QAPI)** program in certified nursing facilities. QAPI is a comprehensive, data-driven approach to maintaining and improving safety and quality. QAPI requires facilities to develop processes throughout the organization for ensuring that care is maintained at acceptable levels in relation to those standards.

Skilled nursing facilities can obtain consultation from a Quality Improvement Organization (QIO) for quality-related questions and issues. QIOs are private, nonprofit organizations staffed by physicians and other health care professionals. They work under contract with the CMS. Their mission is to improve the effectiveness, efficiency, and quality of services delivered to Medicare beneficiaries. Although QIOs were created under the Social Security Act, their scope of work is reviewed every 5 years, and greater emphasis is being placed on quality improvement (CMS, 2020b).

Quality oversight for services being delivered under 1915(c) waivers is states' responsibility, but under federal guidelines. The oversight policy includes quality review process through site visits and steps for continuous quality improvement.

Policies for the Future

Current trends and future projections of aging and disability call for policies to help prepare for an adequate delivery of LTC services in the future. Also, policies for the future must be postulated in a broad framework that includes health and disease, economic growth, quality of immigration, and technology. While much emphasis has been placed on addressing current issues, little to no effort has been evident to tackle issues that would crop up going forward. At least some tentative plans should be formulated as the future unfolds.

The main dilemma for the future is what is referred to as the **demographic imperative**—future growth of the senior population while the working population contracts. It creates an imbalance between those who will need LTC and other health care services and those who will furnish the resources to provide the services, such as direct care, personal funds, and funding of government-paid services through taxation.

Fiscal Challenges

The general pattern of aging-related impairment, functional limitations, and need for care, illustrated in [Figure 1–2](#), holds true in almost all populations. Informal caregiving by members of family decreases the probability of working (Kolodziej et al., [2018](#)), putting further pressures on funding of LTC through personal funds and taxation. Current trends make it evident that the bulk of the financial burden for LTC services delivery cannot be shouldered by the government. Both Medicaid and Medicare are on an unsustainable financial path. Between 2010 and 2018, total U.S. national health care expenditures grew by 41%, but, for the same period, the combined Medicare and Medicaid expenditures grew by 47%. Also, in 2018, at least 45% of the total health care expenditures in the United States were spent on various government-run health programs, up from 44% in 2010. (Note: 1% difference in national health expenditures equaled \$36.5 billion in 2018 [calculations based on data from CMS, [2020c](#)].) These data suggest that cost-containment efforts must take precedence in U.S. health policy.

Innovative Programs

Innovative programs must be tested. For example, Community **Aging in Place**, Advancing Better Living for Elders (CAPABLE) program, designed by Johns Hopkins University—in which services are delivered by an occupational therapist, a nurse, and a handyman over a period of 5 months—has shown to lower inpatient and LTC utilization, thus lowering overall Medicaid spending (Szanton et al., [2018](#)). Such cost-effective programs can help community-living seniors. However, healthy aging campaigns must target younger age groups that would become users of LTC services in the future.

Healthy Lifestyles

Although the ACA took a significant step in requiring all private and public health insurance plans to include preventive care and wellness, doctors alone cannot address individual unhealthy behaviors, such as smoking, poor diet, stress, and lack of exercise. Personal lifestyles have much to do with disease prevention and healthy aging. To promote healthy behaviors, massive public health information and support efforts must become a national priority.

National Wealth

Quality of education for the younger generation, innovations that generate national wealth, and quality of immigration that would promote a strong economy would be necessary to create the resources necessary to help those in need. Socialist policies that have suddenly come into vogue with some politicians and certain sectors of the population, calling for free distribution of goods and services without the means of production, will only produce undesired consequences in meeting the challenges the nation will face. Wealth is created through productive work, not government giveaways that take money from the productive sector only to squander it on programs that do not produce value for society.

Workforce Planning

Experts in LTC rate workforce issues at par with the aging of the population because growth of the workforce is not keeping the same pace. Hence, national policy must focus on the adequacy of a skilled workforce to deliver LTC and other health care services. The Institute of Medicine ([2008](#)) projected that the United States will need an additional 3.5 million LTC workers by 2030 simply to maintain the current ratio of workers per older U.S. resident. Projections by Spetz et al. ([2015](#)) suggest that future need will be greatest for entry-level LTC occupations, such as personal care aides, which necessitates greater attention to supply, training, and retention. Policies in this area will be even more essential if the trend toward greater use of HCBS relative to

institutional services continues. Training deficits in geriatrics among physicians, nurses, therapists, social workers, and pharmacists is another lingering concern.

Nursing Home Administrators

Staffing issues, such as inability to find competent staff, also affects the level of job satisfaction for NHAs and their intention to quit (Nelson et al., 2021). Research over the years has pointed out that well-trained NHAs make a notable difference in the quality of care in nursing homes. As mentioned previously, the education levels and training of NHAs are associated with quality outcomes in care delivery. Over the years, a shortage of qualified NHAs has persisted (Leister, 2009). Moreover, NHAs with better job skills are more prone to leave their positions for other opportunities, generally within the nursing home industry (Nelson et al., 2021), which leaves other facilities to struggle with finding qualified NHAs. A plethora of evidence also shows that NHA job turnover destabilizes a facility's ability to deliver quality care. Such issues will continue to create an industry environment in which quality problems persist unless policy makers and industry leaders join hands to address the underlying problems.

Terminology for Review

access

cost shifting

demographic imperative

financing

health policy

interoperable

Medicaid

Medicare

Money Follows the Person program

policy maker

poorhouse

public policy

Quality Assurance Performance Improvement program

utilization

For Further Thought

1. Why is it important for administrators in the long-term care field to understand policy and policy making?
2. What lessons in U.S. policy making can be learned from the passage of the Nursing Home Reform Act in 1987?

CASE

Long-Term Care for All

The newly elected governor of a small state in which seniors comprise 26% of the total population—twice the national average—is eager to fulfill his campaign promise. He ran for office on the slogan “long-term care for all.” Seniors in the state had overwhelmingly voted for him. Now in office for about 9 months, his advisors tell him that providing LTC services for all citizens in the state will be next to impossible because of high demand for the services. The governor, however, remains undeterred. The cornerstone of his proposed policy includes three things: (1) Develop a state-sponsored LTC insurance plan. The insurance premiums will be income based and will cost at least 15% less than a midlevel private long-term insurance plan being sold in the state. (2) Make it mandatory for all citizens, old and young, to purchase LTC insurance, either from the state or from a private insurance company. (3) Place restrictions on the use of nursing home and assisted living services in favor of home- and community-based services.

Questions

1. Give specific reasons why the governor’s policy may not work, pointing out specific problems that would likely arise.
2. Will the policy work in a large state, everything else being equal? Give reasons.

For Further Learning

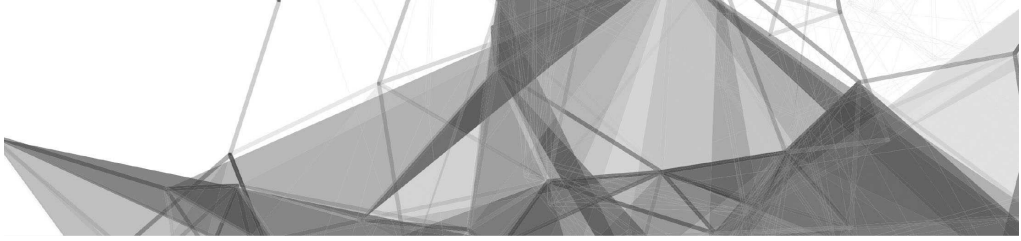
The future of long-term care and the aging network. An article by J. Kwak and L. J. Polivka.

<https://claudepeppercenter.fsu.edu/wp-content/uploads/2015/04/The-Future-of-Long-Term-Care-and-the-Aging-Network.pdf>.

Overview of the Nursing Home Reform Act <https://www.ncmust.com/doclib/OBRA87summary.pdf>.

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CHAPTER 3

The Long-Term Care Profession

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WHAT YOU WILL LEARN

- The long-term care delivery is enabled through various providers, insurers, professionals, and an ancillary sector that interface at many levels.
- The home- and community-based sector includes home care services providers, adult day care centers, and hospice service providers.
- Independent living and retirement centers and personal care providers, such as adult foster care facilities, can be referred to as quasi-institutions.
- Institutional providers range from assisted living facilities to providers that deliver high-level clinical care.
- Continuing care retirement communities integrate and coordinate the independent living and other institution-based components of the long-term care continuum.
- Federal and state governments, commercial insurance companies, and managed care organizations play a critical role in the financing of long-term care services.
- A variety of health care professionals are involved in the delivery of long-term care.
- Case management and ombudsmen are adjunctive to the delivery of long-term care.
- Technology has a number of applications in long-term care.

Introduction

Efficient delivery of long-term care (LTC) services to a nation's population necessitates a coordinated involvement of numerous professional entities, both within and outside institutional facilities. In the private sector, providers constitute mainly organizations that deliver services and can independently bill for those services. Some tax-supported government agencies provide independent housing and deliver social services. Various categories of LTC professionals must meet prescribed levels of qualifications. They can be classified as administrative professionals, clinicians, paraprofessional caregivers, ancillary personnel, and social support professionals. Key partners that play vital supportive roles include the insurance industry, managed care organizations, case management agencies, and LTC pharmacies. Technology has a number of applications in various LTC settings.

The Provider Sector

Technically, the term **provider** refers to an entity that gets reimbursed for services it has delivered. Both LTC institutions and community-based providers are essential to serve a variety of needs. In the United States, the government is the primary source of payment for LTC services on behalf of the service recipients. Certain types of services, however, must be paid privately.

Home- and Community-Based Service Providers

Home- and community-based services include two main types of services: (1) Services that are clinically oriented, such as nursing care and rehabilitation therapies, and (2) personal-care oriented human services, such as assistance with activities of daily living (ADLs). Often, both types of services can be obtained from the same providers, although some may confine their scope of services to personal care. Other community-based services include adult day care and hospice care.

Home Health Care Providers

Home health care is consistent with the philosophy of aging in place and maintaining people in the least restrictive environment. Without the availability of clinical services through home care providers, hospitals and nursing homes will have to deliver the same services at a much higher expense.

The organizational setup commonly requires a community- or hospital-based home health agency that sends licensed professionals and **paraprofessionals**—aides and attendants—to wherever the clients may be residing, such as private homes, retirement centers, or adult foster care homes. When home care involves care delivery by different professionals from multiple organizations, it complicates coherent and integrated care delivery (Patty et al., 2019).

Personal services, such as assistance with ADLs, are generally adjunct to clinical care. Also adjunct to clinical care may be services such as nutritional counseling, pharmaceuticals delivery and consultation, case management, health promotion and prevention services, and hospice care (Centers for Medicare and Medicaid Services [CMS], 2017). Commonly, home health agencies that provide the full scope of clinically oriented services are Medicare-certified because Medicare pays for those services when a beneficiary is home-bound and requires intermittent or part-time skilled nursing care or rehabilitation approved by a physician. Of the 12,200 home health care agencies in 2016, 81% operated on a for-profit basis. Licensed nurses provide the bulk of care to home health clients; 96% of the agencies also provide physical, occupational, and speech therapies (Harris-Kojetin et al., 2019).

Home care providers that focus only on human services address assistive needs with personal care, such as bathing, dressing, eating, and other ADLs. Human services also include light housekeeping, laundry, grocery shopping, meal preparation, assistance with accessing other community services such as senior centers, adult day care, meal delivery, and transportation (CMS, 2017). Human services providers are generally staffed only with paraprofessionals, and such agencies are not certified by Medicare. To varying degrees, states pay for homemaker and personal care for Medicaid beneficiaries, in which case services are coordinated through Area Agencies on Aging.¹ Personal funds are used to pay for these services by those who do not qualify for Medicaid.

Adult Day Care Centers

Adult day care (ADC) is a community-based extramural service. It enables people to live with their families and fulfills family caregivers' need for respite so they can go to work during the day. ADC may be located in senior centers, nursing facilities, churches or synagogues, or hospitals. Many centers also provide transportation from home to the center and back.

Over time, ADC services have become more clinical in nature. Almost 65% of ADC centers provide skilled nursing care, but most are not equipped to deliver care to people with dementia (31% of service users in 2016 had dementia). These centers employ licensed nurses, but the majority of care is delivered by paraprofessionals. In sharp contrast to home health care, the majority (66% in 2016) of service users have Medicaid as the source of funding. In 2016, 4,600 ADC centers provided services to 286,300 clients (Harris-Kojetin et al., 2019).

Hospice Service Providers

Medicare added hospice benefits in 1983, nine years after the first hospice opened in the United States. To qualify for hospice benefits, a physician must certify that the patient is terminally ill and that the patient's life expectancy is 6 months or less (CMS, 2019). Benefit payments by Medicare, however, are not limited to 6 months. The patient must agree to waive the right to medical treatment for the terminal illness, although the person has the right to switch back to medical care at any time. Hospice focuses on comfort and palliative care. Hospice care is a growth area. Between 2006 and 2016, the number of care recipients grew from fewer than 1 million a year to 1.4 million, and Medicare expenditures for hospice care grew from \$9.2 billion to \$16.7 billion. In 2016, 4,374 hospices operated in the United States. Most patients (55%) received care in their own

homes; 25% received care in a nursing facility. Hospices operate predominantly as for-profit organizations (Office of Inspector General, [2018](#)).

Quasi-Institutional Providers

The institutional continuum of LTC includes a range of facilities that often do not have clear-cut distinctions, yet the various facilities can be classified into three broad categories: (1) independent living facilities, which are not truly institutions because they do not generally deliver clinically oriented services; (2) personal and custodial care providers; and (3) assisted living facilities and nursing homes. Here, the first two categories are referred to as quasi-institutions.

Independent Living and Retirement Centers

The three main independent living categories are (1) government-assisted housing, (2) private-pay housing, and (3) cohousing. These dwellings differ from other institutional settings in that staff are generally not present 24 hours a day. A business manager generally maintains office hours 5 days a week and may be available on-call for emergencies.

Government-Assisted Housing

The U.S. Department of Housing and Urban Development (HUD) administers three different housing programs:

1. Under the Public Housing program, HUD administers federal aid to local agencies that manage housing for low-income residents at rents they can afford. Anyone with low income, including seniors and disabled persons, can apply for the program.
2. The Section 8 program offers vouchers or certificates that allow people to choose any housing in the private market that meets certain requirements and apply the voucher or certificate toward rent. Section 8 programs are also managed by local public housing agencies.
3. The Section 202 Supportive Housing for the Elderly program is specifically meant for low-income people who are at least 62 years old at the time of initial occupancy. Supportive housing provides support activities such as cleaning, cooking, transportation, etc.

HUD provides interest-free capital advances to private, nonprofit sponsors to finance the development of supportive housing. HUD also provides rent subsidies for the projects to help make them affordable. A similar program is Section 811 Supportive Housing for Persons with Disabilities.

Private-Pay Housing

Many upscale retirement centers abound, in which one can expect to pay a fairly substantial entrance fee plus a monthly rental or maintenance fee. The fees often include the evening meal. Rooms are furnished with kitchenettes. Apart from congregate housing, some housing units offer detached cottages with individual garages that allow residents to come and go as they please. [Hotel services](#) such as meals, housekeeping, and laundry are often available. Many of these facilities organize local outings for shopping and entertainment. Nursing or rehabilitation services, when needed, can be arranged with a local home health agency.

Cohousing

The concept of cohousing originated in Denmark, as *bofællesskaber*, in 1972, and has since expanded into other countries (Cohousing Association of the United States, 2020). [Cohousing](#) is a type of collaborative housing in which residents actively participate in the design and operation of their own neighborhoods. Although this development is relatively new, the United States has more than 165 cohousing communities, and others are in formation (Cohousing Association of the United States, [2020](#)). The main features of a cohousing community include condos clustered around a central courtyard, a common house where residents can socialize and share meals, and an agreement whereby the residents operate and maintain the property themselves.

Personal and Custodial Care Providers

Personal and custodial care homes go by various names: adult foster care homes, board-and-care homes, personal care homes, sheltered care homes, and domiciliary care homes. [Custodial care](#) is nonmedical care provided to support and maintain a resident's current health status. The emphasis is on personal assistance with basic ADLs, which does not include active nursing or rehabilitative treatments. Each state has established its own standards to license these facilities. Funding typically comes from Medicaid, private insurance, and personal sources. Medicare does not pay for custodial care alone but would cover home health services if the resident meets the criteria for coverage.

[Adult foster care \(AFC\) homes](#) (also called adult family homes or adult family care) are family-run homes that provide room, board, supervision, and custodial care. The homes are modified to accommodate people

with disabilities and prevent unsupervised wandering, because many residents have some degree of dementia or psychiatric diagnosis. Typically, the caregiving family resides in part of the home for 24-hour supervision. To maintain the family environment, most states license fewer than 10 beds per family unit. A skeleton staff is sometimes employed to provide assistance with ADLs, to clean, and to cook meals. State regulations generally require these homes to meet structural and safety standards, and background checks on the owners (Pfeifer, [2018](#)). Medicaid is the main payer for this type of housing under Section 1915(c) waivers.

Institutional Providers

Institutional providers are the most visible sector of the LTC industry. Institutional care generally connotes some degree of confinement to an institution because of a relatively high level of dependency. Such institutions include assisted living facilities, nursing homes, and continuing care retirement communities.

Assisted Living Facilities

Assisted living has been one of the fastest growing segments of the LTC industry, and the aging-in-place philosophy has raised the level of clinical acuity of residents in these facilities. However, assisted living facilities (ALFs) provide an intermediate level of care, somewhere between skilled nursing and custodial care.

In 2015, there were 15,800 ALFs nationwide. Compared to nursing homes, most residents are older than 85 years, and fewer residents are younger than 65 years (Statista, [2016](#)). Eventually, 59% of the residents must move to a nursing home (Anderson, [2019](#)). In 2019, the national median monthly cost was \$4,051, compared to \$7,513 for a semi-private accommodation in a nursing home (ACACIA Insurance Services, Inc., [2020](#)).

ALFs generally have a skeleton staff of licensed nurses who perform admission assessments and deliver basic nursing care. Advanced nursing care and rehabilitation therapies can be arranged through a home health agency. A growing number of ALFs are providing specialized care for elders who have dementia and Alzheimer's disease. All states regulate ALFs by requiring them to be licensed. In the absence of federal standards, regulatory standards vary from state to state.

Nursing Homes

In the minds of many people, LTC is synonymous with nursing homes—a common misconception. The appellation “nursing home,” however, has no specific meaning. In health care literature, the term “nursing home” is generally used for facilities that are licensed as nursing homes by the state and are often certified by the federal government to participate in the Medicare and Medicaid programs.

Skilled Nursing Facilities

A skilled nursing facility (SNF) provides a full range of clinical LTC services, from skilled nursing care to rehabilitation to assistance with all ADLs. Examples of skilled nursing care include monitoring of unstable conditions; clinical assessment of needs; and treatments such as intravenous feeding, wound care, dressing changes, or clearing of air passages. Examples of skilled rehabilitation include postsurgical orthopedic care after knee or hip replacement, cardiopulmonary rehabilitation that is necessary after heart surgery or heart catheterization, and improvement of physical strength and balance. A variety of disabilities—including problems with ambulation, incontinence, and behavior—often coexist among a relatively large number of residents in need of skilled care. Compared with other types of facilities, nursing homes have a significant number of residents who are cognitively impaired because of depression, delirium, or dementia. The social functioning of many of the residents is also severely impaired.

A physician must authorize the need for skilled care. The resident's attending physician must approve the plan of treatment and periodically monitor the resident's medical status. Rehabilitation services are provided by registered therapists—physical therapists, occupational therapists, and speech/language pathologists—who may be employed in-house or contracted from a therapy services provider. The majority of direct care with ADLs is delivered by paraprofessionals but under guidance from licensed nurses and therapists. To capture a larger share of the LTC market, some skilled nursing facilities operate a distinct assisted living unit, specialized unit for Alzheimer's and dementia care, and a separate space for adult day care.

The U.S. nursing home industry is dominated by private, for-profit nursing home chains that operate a group of nursing homes under one corporate ownership. In 2016, there were approximately 15,600 nursing homes in the United States, 69% of which were for profit, and 58% were chain affiliated (Harris-Kojetin et al., 2019). Medicaid is the largest single source of payment for nursing home services.

Subacute Care Facilities

Patients needing subacute care require more nursing intervention than what is typically included in skilled nursing care. They may require technically complex nursing treatments such as wound care, intravenous therapy, blood transfusion, dialysis, ventilator care, or AIDS care.

The three main institutional locations for subacute care—long-term care hospitals (LTCHs), hospital transitional care units (TCUs), or freestanding nursing homes—vary in terms of availability, cost, and quality. Unlike TCUs that are certified as skilled nursing facilities, LTCHs are certified as acute care hospitals. Many LTCH patients with complex medical needs are admitted directly from short-stay acute-care hospital intensive care units. Not surprisingly, LTCHs are the most expensive of the three types of subacute settings. Skilled nursing facilities are often a more cost-effective alternative, but they need to increase the ratio of licensed

nurses to provide adequate care to subacute residents. The number of hospital-based TCUs has steadily declined whereas the number of LTCHs has grown as hospitals have diverted their resources to capture better reimbursement from Medicare.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

Federal regulations provide a separate certification category for LTC facilities classified as ICFs/IID for the intellectually/developmentally disabled (IDD). Most of these residents have additional disabilities. For example, many of them are nonambulatory and may have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of these conditions. The primary purpose of ICFs/IID is to furnish nursing and rehabilitative services that involve “active treatment.” Active treatment entails aggressive and consistent specialized programs that include skill training to help the residents function as independently as possible. Over the years, utilization of ICF/IID facilities has continued to decline, mainly because of deinstitutionalization policies. In 2017, the majority of people with IID lived in the home of a family member or in a small group home. The vast majority of these individuals are supported through Medicaid funding under Section 1915(c) waivers (Larson et al., [2020](#)).

Continuing Care Retirement Communities

Full-service continuing care retirement communities (CCRCs)—also called life-care communities integrate and coordinate the independent living and other institution-based components of the LTC continuum. Different levels of services—independent living, assisted living, skilled nursing care, and dementia/Alzheimer's care—may be housed in separate buildings, but all are located on one campus. A range of services is offered to accommodate the changing needs of seniors while living in familiar surroundings. In keeping with the trend of using euphemisms in the United States, the industry is gradually adopting the term “life plan community.” It is believed that changing the moniker will attract younger seniors who may not immediately need clinical care (CBRE, Inc., [2018](#)).

CCRCs, for the most part, require private financing, with the exception of services delivered in a Medicare-certified SNF. Three types of CCRC contracts are common in the industry: (1) a life care or extended contract incorporates a complete package of services that includes a commitment to provide unlimited future LTC services without an increase in the monthly fee; (2) a modified contract provides for support services in independent living and includes a limited number of days of care in ALF and SNF without an increase in the monthly fee; and (3) a fee-for-service contract that includes only support services in independent living; higher level of services must be paid for out of pocket at the prevailing rates. The life care contract is the most common financial arrangement, which can be regarded as a kind of insurance. There is a wide variation in entrance and monthly fees based on amenities and the type of contract. In 2018, the average entrance fee was \$335,000 and the average monthly fee was \$3,250 (CBRE, Inc., 2018).

In 2018, the United States had an estimated 14,900 CCRCs. Almost 75% of the communities are operated on a nonprofit basis by churches and other charitable organizations (CBRE, Inc., 2018).

¹ More than 600 Area Agencies on Aging (AAA) operate in all states under the auspices of the Administration on Aging, a unit of the Administration for Community Living (under the U.S. Department of Health and Human Services). The main objective of the AAAs is to promote community-based LTC services for the most needy through education, case management, and financing of services. Federal grants to states can cover some financial assistance to those most at risk of nursing home placement. The program is funded through the Older Americans Act of 1965

The Insurance Sector

The insurance sector includes numerous commercial insurance companies that sell individual and group LTC insurance. Group insurance is purchased through employers, unions, professional organizations, or consumer organizations such as the AARP and the Association of Mature American Citizens. Employees of the federal government can purchase LTC insurance at group rates through the Federal Long-Term Care Insurance Program. Generally, group premiums are lower than those for individually purchased insurance because a large number of people band together to purchase insurance through a group sponsor.

Commercial Insurance

Commercial insurance companies are risk underwriters. They determine the level of premiums necessary to cover potential claims in the future. They do not, however, select the providers of services. That choice is left up to the beneficiaries.

LTC insurance typically covers home health care, assisted living, and nursing home care. Besides a person's age, the cost of premiums varies according to critical options selected such as (1) the benefit period over which LTC expenses will be covered (a 3-year plan is considered adequate for most people); (2) inflation protection to keep up with the growing cost of LTC; (3) and the elimination period, or the time that has to pass before insurance will begin paying benefits.

Most people have not been able to afford the cost of LTC insurance. Hence, growth has been slow, and many insurers have stopped selling LTC policies.

Managed Care

Managed care is an approach to delivering a comprehensive array of health care services to a defined group of enrolled members through efficient management of service utilization and payment to providers. The most common managed care organizations that are active in delivering LTC services are health maintenance organizations (HMOs).

HMOs are also insurance entities that underwrite risk. In contrast with commercial insurance companies, however, HMOs select the providers of services. The selected providers are those with whom the HMO has payment contracts.

Both Medicaid and Medicare have managed care options. For Medicaid, the state may enroll the beneficiaries in HMOs. Medicare gives the beneficiary a choice to either remain in the traditional Medicare program or enroll in Medicare Advantage, in which services are provided through various managed care organizations.

Long-Term Care Professionals

A variety of health care professionals are involved in the delivery of LTC. They can be classified as (1) administrative professionals, (2) clinicians, (3) paraprofessional caregivers, (4) ancillary personnel, and (5) social support professionals. The types of personnel involved vary according to the level of LTC services delivered in a given setting. For example, independent living and retirement centers may employ one or two administrative professionals and a small staff of ancillary personnel for hotel services. A nursing home has all five categories of LTC professionals. Certain clinicians may be found only in specialized and subacute care facilities. Growth of the LTC industry will continue to create jobs in all areas, many of which already have critical shortages.

Administrative Professionals

Every agency or organization requires at least one administrative professional to manage the organization. The number and types of administrative professionals increase with the organization's size and complexity.

Administrators

Administrators manage LTC organization's and also oversee compliance with federal and state regulations. They ensure that services are delivered in accordance with the organization's policies and established standards. Administrators must have a good understanding of financing and reimbursement systems. They must be knowledgeable about legal issues and ethical behavior. Administrators must also be skilled in managing human resources, marketing the facility, and overseeing the facility's quality improvement program. Leadership, communication, financial management, and problem-solving skills are also essential for effective management of LTC organizations.

The title for the administrator's position may vary, such as administrator, executive director, director, manager, or general manager. Federal regulations also require each home health agency and nursing home to have a governing body who must assume full legal authority and responsibility for overall management and operations. This section mainly focuses on administrators of home health agencies, ALFs, and nursing homes.

Home Health Agency Administrators

Federal regulations require the governing body of a home health agency to appoint an administrator who is responsible for all day-to-day operations of the agency. One or more qualified individuals—such as a physician or registered nurse—must provide oversight of all patient care services and personnel (CMS, State Operations Manual Appendix B - Guidance to Surveyors: Home Health Agencies, [Rev. 200, 02-21-20]—see Interpretive Guidelines §484.105 [a][b][c]).

Assisted Living Facility Administrators

A number of states require administrators of ALFs to be licensed to ensure that they meet minimum requirements of education and experience. The National Association of Long-Term Care Administrator Boards (NAB) has established requirements for licensure as a residential care/assisted living (RC/AL) administrator. Trends indicate that states will require all candidates for licensure to have passed the RC/AL examination.

Nursing Home Administrators

A nursing home administrator (NHA) must be licensed by the state. Most states require a college degree; some states also require completion of a short course in LTC. A common requirement by all states is passing the national examination administered by the NAB, and a shorter examination on state nursing home regulations. States also require continuing education for license renewal.

In addition to the qualifications just mentioned, some states require an internship of up to one year with a state-certified preceptor who is also a practicing NHA. A [preceptor](#) must meet prescribed qualifications and be certified to mentor interns in an administrator-in-training (AIT) program. An administrator licensed in one state may be able to obtain a license in another state if the two states have a reciprocity agreement. Generally, licensed NHAs are deemed qualified to manage ALFs without any further training.

The NHA position is, in many respects, similar to that of a general manager in a complex human services delivery organization. The NHA must have a 24/7 commitment to an organization that must meet the residents' clinical needs, support their social and emotional well-being, preserve their individual rights, promote human dignity, ensure their safety, and improve their quality of life. The NHA must also have adequate understanding of legal, regulatory, and reimbursement aspects of managing an LTC facility. The nursing home must operate as an efficient business. Hence, the NHA must manage staff relations, budgets and finances, marketing, and quality. The LTC profession has evolved over time, and it will continue to change. Hence, the NHA must adapt to new trends and new demands as they emerge.

Being an NHA is a rewarding career, both financially and professionally. The psychological rewards that can come from delivering high-quality care to residents, helping family members, supporting community initiatives, coaching the staff, and building excellence into the organization often exceed the financial rewards. Despite

high demands placed on them, NHAs generally indicate satisfaction with the work they do (Nelson et al., 2021).

Department Directors

Department directors constitute the middle-management stratum of a nursing home. The organization of nursing homes is well established. The main department directors include the director of nursing, food service director or dietary manager, social worker or director of social services, activity director, business office manager, housekeeping/laundry supervisor, and maintenance supervisor. Sometimes, a director of rehabilitation services may also be employed. The directors report to the administrator and carry out supervisory functions in their respective departments. Their main role is to ensure adequate staffing, availability of supplies and materials, and coordination of service delivery that complies with established standards. Required qualifications are established by state nursing home regulations.

Other Administrative Personnel

Depending on the size and type of organization, administrative personnel may include assistant administrators, bookkeepers, receptionists, and admissions coordinators. Large LTC organizations may also employ human resource or personnel directors and marketing directors. At a minimum, most organizations need (1) a receptionist to greet visitors, provide information, and handle basic office tasks and (2) a bookkeeper whose main responsibility is to handle all billings and collections. Additional help is generally needed for payroll and accounts payable functions.

Clinicians

Various types of clinicians are employed in home health agencies, nursing homes, and some ALFs. They mainly include nurses, rehabilitation professionals, dietitians, and assistants and technicians who work under the direction of these professionals. Rehabilitation professionals may work on a contractual basis. Physicians are generally not employed, but community-based physicians see their patients in nursing homes and ALFs.

Physicians

Most LTC organizations contract with a physician in the capacity of a medical director, which is typically a part-time position. It is not uncommon for the medical director to also provide medical services to many of the residents in the nursing home. The resident, however, has the right to choose his or her attending physician. Admission to a nursing facility or care by a home health agency is also authorized by a physician.

Physicians play a central role in the delivery of medical care. Other clinicians follow physicians' orders for prescribed medical, nursing, rehabilitation, and dietary interventions. Most physicians practicing in the LTC field are generalists or family practitioners because the availability of geriatricians is very limited.

All states require physicians to be licensed in order to practice. The licensure requirements include graduation from an accredited medical school that awards a doctor of medicine (MD) or doctor of osteopathic medicine (DO) degree, successful completion of a licensing examination governed by either the National Board of Medical Examiners or the National Board of Osteopathic Medical Examiners, and completion of a supervised internship/residency program. Both MDs and DOs use traditionally accepted methods of treatment, including drugs and surgery. The two differ mainly in their philosophies and approach to medical treatment. **Osteopathic medicine**, practiced by DOs, emphasizes the musculoskeletal system of the body such as correction of joints or tissues. In their treatment plans, DOs emphasize preventive medicine such as diet and the environment as factors that might influence natural resistance. MDs are trained in **allopathic medicine**, which views medical treatment as active intervention to produce a counteracting reaction in an attempt to neutralize the effects of disease. MDs trained as generalists also use preventive medicine along with allopathic treatments (Shi & Singh, 2019, pp. 140–141).

Nurses

The two main categories of nurses in LTC settings are registered nurses (RNs) and licensed practical (or vocational) nurses (LPNs or LVNs). All nurses must be licensed by the state in which they practice. The two main educational programs today for RNs are associate's degree (ADN) programs offered by community colleges or vocational technical schools and bachelor of science degree (BSN) programs offered by 4-year colleges and universities. Regulations require the delivery of skilled nursing services to be under the supervision of RNs. In LTC settings, RNs compose only a small percentage of the workforce. They mostly hold administrative and supervisory positions such as director of nursing or head nurse. A number of studies have shown that an adequate number of RNs in nursing homes positively affects quality outcomes.

The majority of nurses in LTC settings are LPNs/LVNs who are graduates of 1-year practical nursing programs. LPNs/LVNs render treatments and administer medications. LPNs also function as charge nurses and team leaders and supervise the work of paraprofessional caregivers.

Nonphysician Practitioners

Nonphysician practitioners (NPPs) are clinical professionals who practice in many of the areas in which physicians practice but who do not have an MD or DO degree. The two main types of NPPs who practice in LTC settings are nurse practitioners and physician assistants. Their generalist training and emphasis on

patient relationships make them particularly valuable in LTC caregiving. Some physicians employ NPPs to follow-up on the medical care of their patients residing in ALFs and nursing homes.

Nurse practitioners (NPs) are advanced practice nurses who provide health care services similar to those of primary care physicians. NPs receive advanced graduate-level education and clinical training beyond what is required for RN preparation. Most have master's degrees; some specialize in **geriatrics**—specialization in problems and diseases that accompany aging. The two main types of NP certifications are Adult-Gerontology Primary Care Nurse Practitioner (A-GNP) and Family Nurse Practitioner (FNP; American Academy of Nurse Practitioners National Certification Board, 2019). **Physician assistants (PAs)** are trained mostly at the graduate level in basic medical sciences, behavioral science, and clinical services. The program resembles a condensed version of medical school (Cawley, 2012). Their scope of practice includes performing physical examinations, diagnosing and treating illnesses, ordering and interpreting laboratory tests, and making rounds at LTC facilities.

Rehabilitation Professionals

The most common rehabilitation services are provided by licensed physical therapists, occupational therapists, and speech/language pathologists. Certain treatments can be provided by assistants under the direction and supervision of therapists. Services of a physiatrist are common in facilities that provide intensive rehabilitation.

Physiatrists

A **physiatrist** is a physician who has specialized in physical medicine and rehabilitation. Physiatrists can treat a variety of problems from pain to work- and sports-related injuries. Diagnoses may include severe arthritis, brain injury, spinal cord injury, stroke, multiple sclerosis, amputations, and various conditions requiring postsurgical recovery. Physiatrists may prescribe drugs or assistive devices and direct therapists to carry out various types of treatments to help restore, improve, or maintain function.

Physical Therapists and Assistants

A **physical therapist (PT)** specializes in the treatment of musculoskeletal disorders (loss of function associated with bones, joints, spine, and soft tissue), neuromuscular disorders (loss of function associated with the brain and nervous system, such as stroke), recovery from cardiopulmonary problems, and severe wounds. They specialize in the restoration of various ADL functions.

PTs need a graduate degree from a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education. A Doctor of Physical Therapy (DPT) degree is now common; earlier graduates can still practice with master's degrees. The Federation of State Boards of Physical Therapy develops and administers the national examinations for both PTs and physical therapy assistants (PTAs).

PTAs can provide part of an individual's treatment under the direction and supervision of a PT. Most states require PTAs to complete an associate's degree that includes classroom study and clinical experience.

Occupational Therapists and Assistants

Occupational therapists (OTs) are involved in a broad range of therapies that help patients recover or maintain the daily living and work skills. Their goal is to help patients achieve independence and satisfaction in all facets of their lives. For example, OTs can teach patients how to strengthen their upper limbs or care for their daily needs such as grooming, cooking, and eating. OTs also evaluate and make recommendations for a person's living or work environments to ensure safe independent functioning.

A master's degree in occupational therapy is the minimum requirement for entry into the field; OTs who graduated earlier may have bachelor's degrees. To obtain a license to practice, applicants must graduate from an accredited educational program and pass a national certification examination administered by the National Board for Certification in Occupational Therapy (NBCOT), which confers the designation of Occupational Therapist, Registered (OTR).

Occupational therapy assistants carry out rehabilitative therapies and exercises outlined in a treatment plan developed in collaboration with an OT. An associate's degree is the typical educational requirement, and to be licensed, they must also pass a national certification examination administered by NBCOT, which confers the designation of Certified Occupational Therapy Assistant (COTA).

Speech/Language Pathologists and Audiologists

Speech/language pathologists (SLPs)—informally referred to as speech therapists—assess, diagnose, and treat speech, language, and cognitive disorders. **Dysphagia**, that is, swallowing difficulty, is another common problem that SLPs are called upon to treat in LTC settings.

A master's degree is typically required for licensure in most states; it is mandatory for receiving the Certificate of Clinical Competence from the Council of Clinical Certification of the American Speech-Language-Hearing Association.

An **audiologist** is a professional who specializes in the diagnosis and nonmedical treatment of hearing and balance disorders. They can assess hearing and balance problems and administer treatment. They also dispense and fit hearing aids and cochlear implants. A doctoral degree in audiology is the typical educational requirement.

Clinical Dietitians and Technicians

Clinical [dietitians](#), sometimes referred to as nutritionists, provide nutritional information and diet-related services. They assess individuals' nutritional needs, develop and implement nutrition programs, and evaluate the results. They also confer with physicians and other care professionals to coordinate medical and nutritional needs. Clinical dietitians develop diet plans for people who have renal problems, diabetes, heart disease, and weight loss or weight gain issues.

Minimum qualifications for clinical dietitians include a bachelor's degree in dietetics, foods, and nutrition. To qualify as a registered dietitian (RD) or registered dietitian nutritionist (RDN), the individual must also complete a supervised internship from an accredited program.

Dietetic technicians assist dietitians in the delivery of food service in accordance with nutritional guidelines. Under the supervision of dietitians, they may plan and produce meals based on established guidelines and teach or counsel individuals regarding principles of food and nutrition. Becoming a dietetic technician, registered (DTR) requires at least a 2-year associate's degree, completing a dietetic technician program, and supervised experience.

Paraprofessional Caregivers

LTC services heavily rely on paraprofessional caregivers, who give most of the hands-on personal care and provide assistance with ADL deficits. Paraprofessionals include certified nursing assistants (CNAs), therapy aides, personal care attendants, and home health aides. They constitute the largest group of health care workers in the LTC profession. Paraprofessional positions are at the bottom of the organizational hierarchy. These workers typically carry heavy workloads and are believed to be inadequately paid.

In most LTC organizations, such as nursing homes, ALFs, and home health agencies, paraprofessionals work under the direction of licensed nurses. CNAs are also trained to take vital signs; watch for and report any changes in the residents' condition to nurses; and do simple urine tests for sugar, acetone, and albumin. The 1987 Nursing Home Reform Act mandated that CNAs receive a minimum of 75 hours of training. The training program must include 16 hours of hands-on training in which the trainee demonstrates knowledge while performing tasks for an individual under the direct supervision of a nurse. Some states require training hours beyond the federal minimums. Evidence suggests that the additional training hours and a higher ratio of clinical to didactic hours are related to better quality outcomes (Trinkoff, [2017](#)). CNA students must also pass a state certification exam and skills test and subsequently complete inservice or continuing education each year as required by the state in which the CNA is employed. CNAs can receive further training to become rehabilitation aides who provide basic therapies such as walking and range of motion exercises under the supervision of licensed therapists and nurses. CNAs can also become medication aides after further training to safely give medications to nursing home residents.

Ancillary Personnel

A variety of ancillary personnel provide hotel services such as meals, cleaning, laundry, and maintenance of physical plant and equipment in LTC facilities. Food service personnel such as cooks and cook's helpers prepare meals. Dietary aides wash dishes and cooking utensils. Janitors and housekeepers provide cleaning services. Laundry workers sort and wash linens. Others fold, store, and deliver clean linens to resident care areas in LTC facilities. Maintenance personnel handle basic repairs and groundskeeping.

Social Support Professionals

Social support professionals include social workers and recreational therapists/activity professionals. In LTC settings, social workers engage in diagnostic assessment of residents' cognitive, behavioral, and emotional status; counseling; and conflict resolution. They help people cope with various types of issues in their everyday lives. They also have community resource expertise that is often called upon to obtain professional services available in the community. A bachelor's degree in social work (BSW) is the minimum requirement for social work positions in nursing homes and ALFs. The Council on Social Work Education accredits educational programs in social work. Recreational therapists and activity professionals provide a variety of recreational programs for groups and individuals to improve and maintain the residents' physical, mental, and emotional well-being.

Pharmaceutical Care Management

LTC facility residents are high utilizers of prescription medications. Historically, medication errors, preventable adverse drug events, and delivery of pharmaceutical services have posed some main challenges in LTC facilities. Examples of preventable drug events include therapeutic duplication, drug–disease contraindications, drug interactions, and allergic reactions. Use of mind-altering psychotropic medications and habit-forming opioid pain killers must also be monitored.

Apart from processing and delivering medications, pharmaceutical care in SNFs and ALFs entails medication management, resident safety, and consultation with the facility to comply with regulations, medical records management, narcotics reviews, and medication disposal. Distinct from more commonly known retail

pharmacies, LTC pharmacies are generally not open to the public. LTC pharmacies must coordinate with the facility, physician, and payer to review each prescription, check for drug interactions in medications the resident is on, verify insurance coverage, and meet rigorous packaging and delivery requirements (Avalere Health LLC, 2015).

Adjunct Services

Adjunct services are not directly related to the actual delivery of LTC. Some LTC clients may need their services as circumstances dictate.

Case Management Agencies

Case management is a coordinating function in which a trained professional identifies the special needs of LTC clients and determines which services would be most appropriate within the constraints of available financing to pay for services. Case management agencies do not directly provide LTC services. They assist clients in navigating the system by assessing client needs, identifying sources of payment, identifying appropriate services, making referrals to services, and providing ongoing follow-up and coordination as circumstances change over time.

Case management agencies employ experienced nurses and social workers as case managers. These professionals should have a comprehensive knowledge of both financing and service resources. For the financially needy, the local Area Agencies on Aging have qualified staff to assess care needs and community living options.

Ombudsmen

Amendments to the Older Americans Act in 1978 mandated that each state have an ombudsman program, which is administered by the Agencies on Aging. An ombudsman is a trained professional who works independently with nursing home residents and their families to resolve concerns they may have about their lives in a facility. As an advocate for residents of nursing homes, board-and-care homes, and ALFs, the ombudsman investigates and resolves complaints on behalf of facility residents and informs consumers on how to obtain quality care.

Long-Term Care Technology

Addressing health care needs with technology is a growing trend. Hence, adoption of technology for LTC use will continue to grow in homes, other residential settings, and LTC institutions. Technology can improve nursing home operations and create cost efficiencies so that resources can be directed toward resident-centered care. Even in home settings, various types of [domotics](#) technology, that is, “smart home” technology, can enable a growing number of seniors to live in their own homes. This section presents a classification of technologies although some areas can also overlap.

Enabling Technology

Also referred to as assistive technology, this includes various devices and equipment that enable people to do things independently despite functional impairments. Examples include hearing aids, self-feeding aids such as specially designed eating utensils, dressing and grooming aids, and custom-fitted mobility scooters that improve people’s quality of life regardless of whether they are living independently in their own homes or in LTC institutions.

Other technologies that enable people to live independently include reminder systems that are particularly useful for those with mild cognitive deficits. Automatic enunciators remind people of tasks they must do that day, such as keep a doctor’s appointment and when certain medications must be taken. Monitoring systems that can record blood pressure and certain vital signs are also available with application for Android devices that can connect users with health care professionals, relatives, friends, and other caregivers, creating a social and support network right from a resident’s bedside (Panagopoulos et al., [2019](#)). Various products and devices are available to promote accessibility and safety in the bathroom, bedroom, or kitchen. For example, clapper lighting systems turn on the lights at the sound of clapping.

Facilitating Technology

Certain technologies add to the convenience of doing routine tasks, particularly for nursing home staff that are often overworked. Continuous monitoring technology, used effectively in hospitals, can also be employed in nursing homes to track respiratory rate, heart rate, and movement. This type of monitoring is useful for noticing any signs of resident distress that could result in a fall, for example. Electronic ordering systems are commonly used to order medical supplies and food and to maintain desired inventory levels. Other facilitating technologies include the following:

1. Electronic health records (EHRs) have replaced paper charts, and they may include interoperable capabilities to share records across providers.
2. Intuitive computers have touchscreen and voice recognition technology that facilitate computing tasks.
3. Telehealth and telemedicine technology facilitate consultations with physicians, especially in rural and remote areas, in patients’ own homes, and in nursing facilities.
4. Instead of human monitoring, surveillance technology such as tracking systems and video surveillance can increase the freedom of movement of residents in LTC facilities who have a tendency to wander out unnoticed (Niemeijer et al., [2015](#)). These systems can also track staff in large institutions.
5. Radio frequency identification (RFID) tags to prevent the loss of residents’ property, such as dentures, eye glasses, and hearing aids. RFID systems can also be combined with surveillance technology (Hsiao et al., [2018](#)).
6. Monitoring technologies and smart technologies can be integrated with wireless nurse call systems to replace the traditional call-light alarm systems in nursing homes. These systems can result in shorter response times to residents’ call for assistance that would also enhance resident safety (Dugstad et al., [2020](#)).
7. Digital audio–visual systems facilitate virtual visits between residents and family members or friends. Such systems would have greatly facilitated connection with family members during the COVID-19 lockdowns.

Safety Technology

Fall detection sensors and devices can signal the staff when an at-risk resident attempts to leave a bed, wheelchair, or toilet unattended. Alarming/alerting devices can be a key intervention in the safety of those residents who are prone to falls (Mileski et al., [2019](#)). Residents with cognitive impairments frequently have

limited mobility, but power wheelchairs for such residents present safety concerns. An intelligent power wheelchair system is a potential intervention that could overcome these concerns (Rushton et al., [2017](#)).

Caregiving Technology

Feeding and nutritional therapies—such as enteral and parenteral feeding—have been around for a long time; other technological innovations are more recent. For example, caregivers can use automated medication dispensing systems that improve accuracy and efficiency. Barcode technology has been adopted to verify a resident's identification and dispense medications to the right person. A variety of beds and overlays are available to promote healing of pressure ulcers. Sensor technology can be used to prevent and heal pressure ulcers by detecting moisture levels and length of time spent in one position. Nondrug interventions for managing symptoms and daily routines in dementia can be carried out effectively using advanced technology (Kerssens et al., [2014](#)). Ultrasound bladder scanners are used for the management of urinary incontinence.

Labor-Saving Technology

Labor-saving technology is designed to improve worker efficiency and reduce physical injuries in LTC facilities by decreasing the need for heavy transfers and lifting. Labor-saving technology will also play an important role in overcoming staff shortages. Electrically operated ceiling-suspended dining tables can convert a dining room to a multipurpose room at the flip of a switch. Ceiling-mounted lifting and transfer equipment and labor-saving bathing systems are other examples of labor-saving technology.

Environmental Technology

Products and fibers that have greater fire resistance; improved fabrics for upholstered furniture that resist soil and fluid absorption; new fibers for carpeting that resist soil, stains, and odors; and nonskid floor coverings are some examples that enhance the aesthetics and safety of living environments. Computerized controls for hot water systems are designed to save energy and prevent the supply of overheated water that can cause severe burns. Sensorial signals, such as color and textured materials, are employed to support orientation of cognitively impaired individuals in their own homes and in institutions (Cheek et al., [2005](#)).

Staff Training Technology

Interactive tools, CD-ROMs, and remote video teleconferencing are available to provide training and continuing education on a large variety of topics. Online training and education systems are replacing face-to-face sessions.

Information Technology

Information technology (IT) deals with the transformation of data into useful information. IT is a broad area. In health care organizations, application of IT falls into three main categories:

- **Clinical information systems** are designed to be used by various clinicians to support the delivery of resident care. EHRs are an example of clinical information systems that can also support resident assessment, care planning, and clinical documentation. These systems can be integrated with other applications such as administrative and financial systems, menu planning, and food ordering.
- **Administrative information systems** are designed to assist in carrying out financial and administrative support activities, such as payroll, patient accounting, billing, accounts receivable, materials management, budgeting and cost control, and management of residents' personal funds.
- **Decision support systems** provide information and analytical tools that support effective management. For example, the system can help analyze performance indicators, quality measures, staffing adequacy, staff productivity, rates of infections, and resident incidents such as falls, and staff injuries.

Terminology for Review

administrative information system
adult foster care home
allopathic medicine
audiologist
case management
clinical information system
cohousing
custodial care
decision support system
dietitian
domotics
dysphagia
geriatrics
group insurance
hotel services
managed care
nonphysician practitioner
nurse practitioner
occupational therapist
ombudsman
osteopathic medicine
paraprofessional
physiatrist
physical therapist
physician assistant
preceptor
provider
speech/language pathologist

For Further Thought

Nursing homes delivering skilled nursing care and, in many instances, specialized services are a component of the vast long-term care profession. Why should a nursing home administrator become familiar with the various aspects of the long-term care industry?

CASE

Pathway to Dining

Contributed by Elizabeth A. Berzas, PhD, Our Lady of the Lake College; and Mary Jean Davies, BS, Baton Rouge, LA.

In Slidell, Louisiana, a blind, married couple was living in their own home until the wife's health started to decline and she became wheelchair bound. The couple then moved into an ALF. Both were about 75 years old. Assessment by a health care professional found that both residents could sense some light differentiation. Placement of low-voltage recessed floor lighting down the middle of the main hallway leading to the dining room was recommended, and the administrator followed up on the recommendation. The blind husband could then look up and track the light so that he could orient and guide himself to the dining room while pushing his wife in the wheelchair. Because of this modification, the residents were able to regain at least some independent mobility for accessing the dining room. The staff members were educated to not move or rearrange the residents' living environment because blind people can orient themselves by counting steps and using spatial reference points and tactile cues.

Questions

1. Which health care professional, discussed in this chapter, should take the lead in assessing the need for a lighted pathway and also educating the staff?
2. What quality of life factors exist in this case? How were they addressed by installing floor lighting?
3. The floor lighting can be best classified under which type of technology discussed in this chapter?
4. Should the facility arrange to provide any additional services that would facilitate daily living for this couple? Who should have this responsibility?

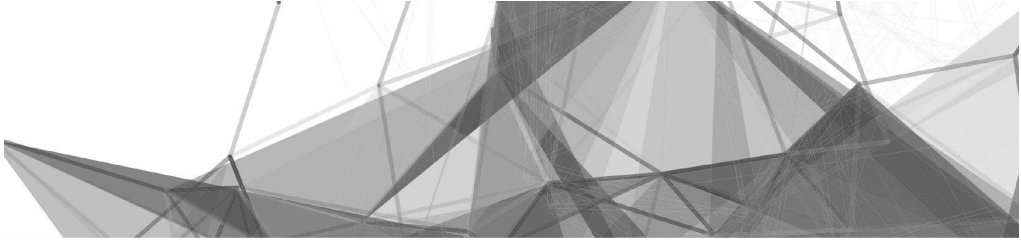
For Further Learning

Administration on Aging: An agency of the U.S. Department of Health and Human Services provides information on various community-based programs. <http://www.aoa.gov>

National Association of Long Term Care Administrator Boards (NAB). This organization administers the national licensure examinations for assisted living and nursing home administrators. It has publications available to prepare for the examination. The website also provides links to the licensing agencies in all states. <http://www.nabweb.org>

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CHAPTER 4

Aging and Long-Term Care

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WHAT YOU WILL LEARN

- Populations in developed nations are rapidly becoming older, with consequences for the delivery of long-term care.
- Racial and ethnic minorities in the United States are in poorer health compared to whites. The implications for future long-term care delivery cannot be overstated.
- Nursing care facility personnel must acquire a basic knowledge of gerontology.
- Four basic theories of aging described in this chapter are simple enough and have useful applications in the context of person-centered care.
- Ageism and infantilization are stereotypes that are detrimental to the overall well-being of seniors.
- Depression, delirium, and dementia may present similar symptoms, but they require different interventions.
- People with HIV/AIDS are growing older. They have higher levels of dependency and multiple comorbidities.
- War veterans placed in nursing facilities present unique physical and psychosocial needs.
- Cultural stereotyping can be just as detrimental as ageism. In the context of person-centered care, cultural competence is necessary to deliver services in accordance with the cultural needs and preferences of the clients.
- Death and prolongation of life have legal and ethical ramifications.

Introduction

In American society, people are generally considered elderly or senior citizens when they are in their mid-60s. At this age, people frequently take formal retirement from work, become eligible for Social Security and Medicare, and start paying more attention to some of the symptoms that naturally accompany advancing age. By 2030, seniors will constitute 20% of the U.S. population, up from 12% in 2000. The number of people older than 85 years will grow the fastest (Institute on Aging, [2018](#)). The U.S. population is also becoming increasingly diverse in race and ethnicity.

Around the world, the proportion of the aging population is also increasing while the fertility rates continue to decrease. Notably, by the end of 2019, the number of older adults worldwide exceeded infants and young children (Guo et al., [2020](#)). The senior population as a proportion of the total population in developed countries, such as Japan, Germany, France, and Great Britain, is already higher than it is in the United States. For example, in 2018, seniors constituted 28% of the population in Japan (Song & Tang, [2019](#)) compared to 16% in the United States. The developed world, in particular, already faces aging-related problems and challenges in providing adequate long-term care (LTC) services.

Caregivers' understanding of aging, their biases, and attitudes can influence how elders in LTC facilities are treated. Recognizing the factors that make each individual different from others is essential for delivering resident-centered care. This chapter furnishes basic knowledge about aging, the biases that must be overcome, differences in physical and psychosocial functioning, and the need for acquiring cultural competence.

Seniors in America

Growth of the senior population will bring a corresponding surge in the number of people with functional and cognitive limitations. Thus, the need for LTC is expected to increase sharply in the coming decades. Although 45% of noninstitutionalized elders in the United States report their health to be excellent or very good (Administration on Aging, 2018), it is reasonable to assume that the segment of the senior population in fair to poor overall health is likely to require LTC at some point. Even for those in good general health, short-term LTC may become necessary after an accident, surgery, or acute illness.

Racial and ethnic minority population in the United States has increased from 19% of the older adults in 2006 to 23% in 2016 and is projected to constitute 28% of older adults in 2030 (Administration on Aging, 2018). Current data indicate that nearly 40% of the total population identifies with a race or ethnic group other than white. Indeed, diversity is occurring at an even faster rate than had been predicted previously (Frey, 2020). Compared to whites, fewer blacks, Hispanics, Asians, and American Indians/Alaska Natives rate their health as excellent or very good (Administration on Aging, 2018). Implications for future LTC delivery cannot be overstated. Social and cultural factors important to each group will present new challenges that LTC providers must become prepared to address. Currently, in nursing homes, approximately 25% of the residents are black or ethnic minority. Adult day care centers are the most racially and ethnically diverse (Harris-Kojetin et al., 2019).

Understanding Aging

Aging is loosely regarded as the culmination of a life cycle that started at birth. Although aging may be the final stage of life, this stage can last a long time, and as further changes occur, substages within this stage can manifest themselves. Caregivers must acquire a basic knowledge of **gerontology**—an area of learning that deals with the understanding of the aging process, the changes accompanying aging, and the special problems associated with aging.

Whereas a person's age provides a chronological context, different people age differently. Aging must be understood in the context of ability (Moreira, [2015](#)), which is commonly a reflection of a person's health status and attitudes. Even though most older adults are in good health, approximately one-third of noninstitutionalized adults age 65 and older have a limitation of activity (Office of Disease Prevention and Health Promotion, [2020](#)). However, activity limitation in itself does not equate with dependency because assistive devices can be used to bridge the gaps in functional deficits.

Attitudes toward one's own aging, and behaviors associated with the issues of aging, differ from person to person. Positive attitudes are reflected in a person feeling younger than his or her chronological age. For example, those who seek out new experiences and are flexible in adapting to change may feel younger than their chronological age. Such people have higher self-esteem, cognitive functioning, well-being, health status, and longevity (Weiss et al., [2019](#)). Indeed, the elderly are a very heterogeneous group. For example, many people choose to continue working into their 70s, and in a few cases, even into their 80s.

Research shows that the vast majority of people want to age in an age-integrated neighborhood, with children and younger people close by (Merrill Lynch, 2016). This has led to the concept of "care communities." In practice, LTC facilities implement programs that invite the community to come into the facility and allow the residents to intermingle with members of the community. For example, a local artist may be invited to an art show to display his or her art in the facility (Calkins, [2018](#)).

Theories of Aging

During the past 50 years or so, numerous theories have been proposed in an effort to understand behaviors associated with aging. Each theory has its limitations, and even together all the theories do not account for every possible situation. Out of the many theories, four are considered simple enough and useful for their application to LTC. These theories can help caregivers to understand residents' attitudes and behaviors and the need for motivating them to engage in pursuits that may lead to more successful aging.

Activity Theory

According to **activity theory**, people in their old age seek to remain active in meaningful ways. This theory counters the "rocking chair" stereotype, according to which elders are often visualized as sitting passively in a rocking chair and dozing off because of inactivity and boredom. Many elders are capable of engaging in activities of interest provided opportunities are created for such engagement.

Engagement in activities, however, varies among elders. For example, many elders consider television viewing to be a far from passive activity. TV viewing is a way of maintaining routines and habits developed over prior years. Each individual determines which activities are meaningful to them, and these activities are continued regardless of age (Topaz et al., [2014](#)).

Disengagement Theory

Disengagement theory postulates that as people grow old, they have less engagement with friends and relatives. Inactivity and loneliness follow (Asiamah & Lee, [2017](#)). This theory can be critiqued for focusing on old age as a time spent preparing for death rather than a life stage with its own growth and development (Topaz et al., 2014). Yet, not everyone wants to remain socially active, and the notion of what constitutes satisfying relationships can differ significantly from one person to another. People also need time for quietude and inner reflection. Yet disengagement, such as retirement from work, is associated with increased cognitive declines. Such declines are moderated when individuals continue to engage in challenging activities and goal pursuits (Hamm et al., [2020](#)).

Continuity Theory

The major assumption of **continuity theory** is that the experiences of one's earlier years prepare an individual to adapt to and cope with the demands of aging. Levels of physical and mental activity from earlier stages of life can promote successful aging (Mañas et al., [2020](#)). This underscores the importance of incorporating a resident's social history in the assessment process. A person's past habits, occupations, preferences, hobbies, and leisure pursuits can guide caregivers in finding roles that elders in LTC settings would find fulfilling. For example, a career postal worker may enjoy distributing mail to other nursing home residents. Many older women still enjoy baking, cooking, knitting, and other activities that should be incorporated into the facility's recreational planning. An understanding of residents' past routines can also help facility personnel to think about ways in which routines can be made more flexible to help the residents better adapt to a new setting.

Labeling Theory

Labeling theory helps one understand how a person's self-concept is molded by the labels others use for that person. It strikes at the negative stereotypes because elders may believe these stereotypes to be true, and they may assimilate those stereotypes into their behaviors. For example, the belief that once people become old, they become dependent may actually promote dependency in elders (Harrigan & Farmer, 1992).

Ageism and Infantilization

Certain myths and distorted views about aging encourage stereotyping, which results in treating elders in ways that are detrimental to their self-esteem, independence, and psychosocial as well as physical health. Prejudicial treatment of elders based on stereotypes is called **ageism**. Ignorance is the main cause of ageism, which creates barriers for adequate delivery of health care and social services to elders. Regular contact with older clients alone might not reduce stereotypes and may in fact reinforce stereotypes if the contact between caregivers and residents underscores the older person's dependency, as the case is in many nursing home settings. However, education about aging is a promising area that can help overcome stereotyping. It is also suggested that giving elderly clients more control over their daily activities and basic care may promote greater cooperation, shared goals, and interdependence between residents and caregivers and may reduce the burden on caregivers who have the most contact with residents (Reyna et al., 2007).

Facility policies can also address certain stereotypes. For example, LTC staff may tend to treat older adults as children, a process called **infantilization**. It is not uncommon for nursing home staff members to address residents by their first names, which may be taken as demeaning, even though the resident is not likely to openly protest about it. Similarly, addressing residents as "cutie," "sweetie," "baby," or "honey" is regarded as condescending. Residents are already dependent upon the caregivers; infantilization further strips away the residents' self-respect and dignity. The respectful approach is to ask older adults how they would like to be addressed rather than making assumptions.

Certain changes—such as sensory decline in vision, hearing, tactile feeling, smelling, and tasting—occur naturally as a person ages. Sleep disorders may also become more common. The need to avoid stereotyping is one reason that assessments, care plans, and interventions are individualized and resident-centered care has become the norm. Hence, a person's background and social history that include his or her upbringing, education, hobbies and interests, marriage, divorce, death of spouse, children, siblings, major illnesses, occupation, economic achievement, dysfunctions, and recent occurrences are important to learn. This information is then used for planning strategies to help the individual cope, adapt to new circumstances, and get the best out of life despite current illness and declining physical functioning.

Old age does not necessarily mean that people lose the desire to remain physically attractive or to provide for their own needs. Economic and physical constraints may interfere with one's ability to maintain proper grooming. In this area too, assistive devices can help promote independence. Examples of these devices include elongated reaching devices to assist with dressing and baskets with grooming items to have them within reach.

It is erroneous to think that the elders like being dependent on others. To the contrary, older adults like to have control over their life decisions, and to the extent they can, they wish to take care of their own needs. Independence fosters self-esteem. Many residents in nursing homes may also be able to make a contribution to the community. A sense of being useful, competent, and needed must be preserved as much as possible. Interdependence often develops mutual bonds with other residents and pets in the nursing home.

Assuming that inactivity results from old age is incorrect. Because of sleep disorders, some elders may compensate for lack of sleep at night by taking naps during the day, or they may fall asleep while sitting because of boredom and inactivity. Presuming that physical exertion is harmful for older people is also inaccurate. Within the parameters of physical limitations, most elders can engage in various types of physical activities under proper medical guidance.

Many elders are interested in, and indeed capable of, learning new things, such as new hobbies, crafts, or using the computer. Older people generally also have their long-term memory quite intact.

Mental and Cognitive Disorders

Mental health disorders are frequently comorbid, that is, they occur along with a number of common chronic illnesses, decline in mobility, chronic pain, and overall frailty. An estimated 20% of elders in the United States suffer from some type of mental health issue, including depression, cognitive disorders, anxiety, and other mood disorders. Almost half of nursing home residents suffer from dementia (Harris-Kojetin et al., 2019).

Depression

Traditional nursing home environments tend to promote dependency and negative affect, which increase the risk of depression (Simning & Simons, 2017). However, biological, psychological, and social factors also contribute to depression. Depression and dementia tend to coexist, and depression is a risk factor for dementia (Peakman et al., 2020). Depression is also associated with higher morbidity, greater mortality, and poor quality of life. Hence, observing the mental, emotional, and behavioral state of residents is critical. Nurses and CNAs may be able to recognize residents with depression and make appropriate referrals for medical evaluation. Common depressive symptoms include loss of interest in things that otherwise bring enjoyment; feelings of worthlessness; diminished ability to make decisions; fatigue; underactivity (psychomotor retardation) or overactivity (psychomotor agitation); loss of appetite; sleeping too much; insomnia; and recurrent thoughts of death or suicide.

Delirium

Delirium is defined as a transient, reversible neuropsychiatric syndrome of acute (abrupt or sudden) onset (León-Salas et al., 2020). It is a state of acute mental confusion that often manifests itself in the form of disorientation, incoherent speech, and physical agitation due to distress. Memory impairment and hallucinations may also be present. The onset of delirium is usually rapid—within a few hours or a few days. Symptoms can fluctuate significantly and frequently throughout the day. Contributing factors include a severe or chronic illness, changes in metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug intoxication or withdrawal (Mayo Clinic, 2020). No therapeutic interventions reverse delirium or reduce its duration once the syndrome has developed (Lee-Steere et al., 2020). Hence, a number of nonpharmaceutical interventions are recommended, which include cognitive stimulation, reorientation, sensory stimulation, family involvement, hydration, promotion of good sleep patterns, nutritional support, and improved mobility (Martinez et al., 2015).

Dementia

The prevalence of dementia is another piece in the demographic puzzle. Alzheimer's disease, the most common form of dementia, becomes progressively worse and eventually results in death. Trends indicate that the risk of dementia may be increasing particularly among the less educated (Hale et al., 2020). Studies also indicate that minority groups with dementia may fare worse in functional improvement compared to nonminority groups (Wang et al., 2020).

Diagnosing dementia is challenging, particularly in its early stage. Depression and delirium must first be ruled out. Dementia can be classified into mild, moderate, severe, and very severe stages (Sloane et al., 2001).

- *Mild dementia.* Unreliable memory for recent events. Difficulty managing various instrumental activities of daily living (IADLs). May need supervision for dressing and bathing. Difficulty in carrying out a conversation.
- *Moderate dementia.* Very poor memory for recent events. Easily confused or upset by changes in routine, new places, or unfamiliar people. Needs 24-hour supervision and assistance with bathing, dressing, and grooming. Displays confusion, repetitive questioning, disorientation, mood swings, delusions, and wandering.
- *Severe dementia.* Poor memory for both recent and past events. Recognizes only persons seen very regularly. Difficulty following daily schedules. May develop gait instability and sustain falls. Resists caregiving, may have delusions, and may display physical abusiveness, such as hitting and biting, and other socially inappropriate behaviors, such as saying inappropriate things and disrobing in public.
- *Very severe dementia.* Little awareness of surroundings. Speaks in a few words or unintelligible sounds. Rarely recognizes individuals, even close family members. Needs almost total assistance with activities of

daily living (ADLs). May be able to shuffle short distances with assistance or is nonambulatory.
Incontinence of bowel and bladder. Resists caregiving and has screaming episodes.

Unlike depression and delirium, dementia is irreversible. Because of the issues just mentioned, caregiving becomes challenging, and the burden of caregiving increases as the disease progresses. Patients with Alzheimer's disease may live for 8 to 10 years after the disease is first diagnosed. During this time, the disease often progresses to the very severe stage.

In LTC settings, however, it is necessary to go beyond the biomedical understanding of dementia. Individuals with dementia should be viewed as people who can still experience meaningful interactions and relationships despite their losses (Hughes, 2014).

Emotional behaviors of caregivers can be sensed by even residents suffering from severe dementia. For example, negative behaviors by CNAs may contribute to increased behavioral problems and agitation in dementia residents. Research shows that when caregivers wear street clothes instead of uniforms, improved relationships and communication occur between caregivers and residents who have dementia (Bailly et al., 2020). Person-centered communication strategies (e.g., validating the individual's feelings, and providing support by helping to fill in the gaps in what the person may be trying to communicate) are recommended to understand and respond to the individual's needs.

Aging and HIV/AIDS

Treatment with highly effective drugs has successfully transformed AIDS (acquired immune deficiency syndrome) from a terminal illness to a chronic condition. With reduced mortality, the prevalence of HIV (human immunodeficiency virus) infection in the population has actually increased, including among seniors. In the United States, in 2016, more than 22% of the population living with HIV and almost 28% of those living with AIDS were aged 60 and older. This population is also disproportionately male and black (Data from Centers for Disease Control and Prevention, [2018](#)).

Studies suggest that the proportion of people with HIV who are admitted to and experience extended nursing home stays is growing (Justice & Akgün, [2019](#)). Compared to the general nursing home population, residents with HIV are younger (mean age of 60), predominantly male (60%), and black (40%) (Miller et al., [2019](#)). Also, residents with HIV tend to be admitted to nursing homes with higher concentrations of HIV and lower quality than nursing homes in which residents are without HIV (Meyers et al., [2019](#)). People with HIV who also have dementia are more physically dependent and vulnerable to deterioration of physical functioning (Cai et al., [2019](#)).

People with HIV/AIDS are more susceptible to liver and kidney disease and many common forms of cancer. At least some of them in nursing homes will need treatments such as dialysis, surgery, chemotherapy, radiation, and palliation. Hence, multiple comorbidities have also increased. Long-term placement for these levels of care may be particularly challenging, requiring frequent coordination with other providers of medical care. Spiritual and psychological support and end-of-life planning are also frequently necessary (Justice & Akgün, 2019).

Aging Among the Veterans

Veterans represent service men and women from World War II, Korean War, Vietnam War, and other recent wars. An estimated 40% of the veteran population is over age 65 compared to only 13% of the general population, and the number of veterans age 65 and older is projected to increase from 600,000 in 2016 to more than 1 million by 2025 (Levy et al., 2019). Hence, there is high demand for LTC services among veterans. Because of capacity limitations within the Veteran's Administration (VA) system, many veterans are placed in community nursing homes. Diverse types of combat exposures put veterans at high risk of post-traumatic stress disorder (PTSD), psychiatric distress, and depression, which affect their psychosocial functioning (Kelber et al., 2019). Many also suffer from traumatic brain injury (TBI). Hence, delivering clinical services to veterans has unique challenges. However, it also requires sensitivity to the unique behaviors, values, and beliefs that veterans have acquired by working in the military, which involves highly organized and regimented routines. Often, the military culture affects not only the service members but also their families (Westphal & Convoy, 2015).

Homelessness among veterans is also a grave issue. Homeless veterans not only experience accelerated aging, but they also commonly have tri-morbidity characterized by substance abuse, mental illness (that may include dementia), and physical illness. At some point, these veterans do require postacute services in a nursing facility, which may become a long-term medical/social environment for many homeless veterans (Jutkowitz et al., 2019).

Diversity and Person-Centered Care

American society is not only racially and ethnically diverse, but within the broad racial/ethnic groups various subgroups also exist. Hence, numerous cultural variations make the delivery of LTC services a growing challenge. The much lower utilization of nursing homes by minority elders (mainly blacks and Hispanics) compared with white elders is no longer true; minority populations now utilize nursing homes at about the same rate (Sakauye, [2015](#)). Nevertheless, there is some evidence of racial segregation in U.S. nursing homes, and racial segregation has a negative impact on racial minorities and facility-level quality outcomes (Mack et al., [2020](#)). Studies have reported that compared to whites, racial/ethnic minorities tend to be cared for in facilities with limited clinical and financial resources, low nurse staffing levels, and a relatively high number of care deficiency citations from regulators, although improvement has been noticed (Li et al., [2015](#)).

Although immigrants from other countries and cultures may go through a process of acculturation in the United States, this process is far from uniform. Many people remain at the traditional level where they retain beliefs and behaviors of their culture of origin. Religion, for example, is one area that is generally not amenable to acculturation. Beliefs, attitudes, rituals, routines, language differences, dietary norms, and other sociocultural elements define people's preferences and taboos. These differences call for cultural accommodation within the broader context of person-centered care.

Cultural competence is the term used for an organization's ability to deliver health care services in accordance with the cultural needs and preferences of the clients. The idea of cultural competence evolved from research that has consistently demonstrated racial and ethnic disparities in health care delivery. Cultural competence initiatives later evolved into eliminating cultural and linguistic barriers that can interfere with the effective delivery of health care. However, cultural competence in LTC settings must go beyond eliminating linguistic barriers.

Cultural competence begins with respect for the individual. It requires an inquiry-centered approach by carefully questioning the client in an effort to understand the person's beliefs and values and how those differences can be accommodated. Assumptions should not be made based on a person's name or country of origin, for example. It also requires that caregivers honestly assess their personal biases and try to understand cultural differences with a nonjudgmental attitude.

Cultural stereotyping can be just as detrimental as ageism. Another type of bias is **ethnocentrism**—a belief that one's way of life and view of the world are inherently superior to those of others and that those views are desirable for others to acquire. It involves judging another's culture as inferior to one's own (Ribeiro et al., [2017](#)).

Cultural Accommodation

Certain types of accommodations are relatively simple to make. These include choice of apparel, preference for either male or female attendants, dietary restrictions from a cultural standpoint, and ability to follow certain religious practices. Other restrictions, particularly those that may have implications for a person's health and well-being or that may be disruptive to other residents, require a more careful approach. In some situations, it would be wise to obtain legal counsel because they may have implications for a person's civil rights.

Soliciting information from someone of a different ethnic origin requires tact. For instance, an outright inquiry about a person's religion is generally not appropriate. It may also be inappropriate to ask someone, "Do you understand English?" Many immigrants from other countries speak and understand English quite well and may perceive such a question as an insult. Instead, it would be appropriate to pose exploratory questions, such as, "Do you have any particular needs that we should be aware of? We want you to feel very comfortable in our facility."

Learning about some common beliefs and customs is helpful for understanding other cultures. But caution must be exercised in how such learning is applied: many subcultures often differentiate among people from the same general background. For example, not everyone from Vietnam is a Buddhist, not everyone from the Middle East is a Muslim or a Jew, and not everyone from India is a Hindu. Hence, broad assumptions should not be made. Also, people from the same ethnic or religious background often have individual differences; some are orthodox, others are liberal, and most are likely to be somewhere in between. Many westernized Hindus eat beef, many unorthodox Muslims use alcohol, and many nonobservant Jews consume pork products. Hence, it is critical to ascertain individual needs and preferences.

It is almost impossible to furnish accurate details on all different cultures and subcultures found in the United States today. However, some main cultural differences in the areas of religious observances, dietary restrictions, and health care preferences are summarized here:

- **Observances.** Catholics and most Christian denominations observe Sunday as a day of religious observance. Orthodox Jews and Seventh-day Adventists (members of a Christian denomination) observe Saturday as a holy day. More specifically, they observe the Sabbath from sundown on Friday evening to sundown on Saturday evening. Muslims observe Friday as a day for prayers. Christmas, on December 25, is the most widely celebrated Christian holiday; however, some Christians regard the holiday as anti-

Christian and pagan. On the other hand, social celebrations associated with Christmas are not offensive to most people. Hanukkah is the most widely celebrated Jewish holiday, which falls in November or December, according to the Hebrew calendar. Other major Jewish observances are the Passover, which occurs in the spring, and Yom Kippur (Day of Atonement), considered the holiest of all Jewish observances, comes in the fall. Most observant Jews fast during Yom Kippur. Ramadan, the month of fasting, is observed by devout Muslims during the daylight hours. Catholics and some other Christians observe the season of Lent, which begins with Ash Wednesday and culminates with Easter Sunday. Catholics particularly refrain from eating meat (a practice called “abstinence”) on Fridays during Lent. Other devout Catholics observe abstinence on all Fridays of the year. For many Christians, Good Friday and Easter are considered more important than Christmas in remembrance of the death and resurrection of Jesus Christ. Many Christians, such as the Amish and the Mennonites, observe Thanksgiving and New Year’s Day as religious holidays. Many Christians say a short prayer before a meal; many Jews pray both before and after a meal.

- *Dietary restrictions.* Most Christians do not have any faith-based dietary restrictions, but many do. Among Seventh-day Adventists, for example, about half are strict vegetarians. Those who consume meat, poultry, and fish confine themselves to foods considered biblically clean, which are listed in [Chapter 11](#) of Leviticus in the Bible. Some of the unclean meats include pork, rabbit, frog, squid, shellfish, and fish that do not have scales. Most Seventh-day Adventists do not drink caffeinated beverages. They also shun tobacco in all its forms and the use of any kind of alcohol and consider such practices to be offensive. The Mormon Church also prohibits use of tobacco, alcohol, and caffeinated beverages. For Jehovah’s Witnesses, tobacco and alcohol are forbidden. They also do not eat certain meats such as sausages because they may contain blood. Jewish dietary practices are also based on Leviticus, except that meat and milk may not be served together. To be considered kosher, animals and poultry must be slaughtered in accordance with Jewish rituals. A similar practice of ritual killing is followed by Muslims for meat or poultry to be considered *halal*. Muslims also do not eat pork. Many Buddhists and Hindus are vegetarians. Those who eat meat generally prefer chicken or fish over beef, or they may shun beef and veal altogether.
- *Health care preferences.* Nontraditional or alternative medical treatments, such as use of herbs, acupuncture, and rites and rituals are historically embedded in many cultures. People from these cultures accept Western medicine but may also insist on using alternative remedies. For example, some ethnic groups believe in the theory of *yin* and *yang*, based on which many elders refuse cold liquids, because they believe that old age is associated with an excess of cold (*yin*) elements. Facility hydration programs need to address these beliefs with warm liquids that residents may more readily accept (Nichols, [2016](#)). Residents have the legal right to follow or not follow treatments prescribed by a physician. For example, Jehovah’s Witnesses refuse blood transfusion on religious grounds. In other cultures, immunization, such as flu shots, is refused. Treatment such as artificial prolongation of life may be refused by some. Religion may also govern certain ritualistic practices that can vary considerably among cultures. For example, various forms of prayers, singing of hymns, sacraments for the sick, anointing with oil, and so forth, may be practiced according to different belief systems.

Making cultural accommodations do not require a faith-based organization to compromise its religious philosophies and values. Many nursing homes in the United States are operated by various Christian denominations and Jewish congregations. They accept residents regardless of their religious affiliations but do not compromise their own principles. A nursing home run by the Catholic Church, for example, will hold regular Mass services, but attendance would be optional. A Jewish nursing home will serve only kosher meals. A Seventh-day Adventist nursing facility will not serve pork or other meats considered biblically unclean but may allow family members to bring in such products for individual consumption.

End-of-Life Issues

Approximately 20% of all deaths in the United States occur in LTC settings (Statista, [2020](#)). Although death is a natural occurrence, a stage marked by the end of life, what constitutes death has been a controversial subject in developed nations. The United States adopted the concept of brain death in the Uniform Determination of Death Act, 1981. It defines brain death as the “irreversible cessation of all functions of the entire brain.” Yet, in some isolated cases, prolonged biological survival has occurred even after brain death (Truog et al., [2020](#)). Hence, the criterion of brain death has been challenged. The law also states that the determination of death must be made in accordance with accepted medical standards, but it does not specify what those standards are. Hence, this function varies from state to state. For example, depending on the state, the declaration of death can be certified by a physician, a registered nurse, or some other clinical professional. “Only after the death certificate is filed, and the potential need for involvement by the medical examiner or coroner determined, can burial proceed” (American Medical Directors Association, [2003](#)).

Continuity of life-sustaining measures—mechanical breathing, tube feeding, etc.—for the terminally ill also raises legal and ethical issues. In the United States, an estimated 60%–70% of the residents in nursing facilities have written [advance directives](#) (Hold et al., [2019](#)), which are intended to ensure that the resident's end-of-life wishes are carried out. Because a significant number of residents are admitted without advance directives, the facility should try to obtain written resident preferences for life-sustaining treatment. Such a document would define resident and family choices for resuscitation and implementation of fluids, nutrition, medications, and antibiotics (Hold et al., [2019](#)). The facility can formulate a standard form that complies with state and federal regulations.

Terminology for Review

activity theory

advance directive

ageism

continuity theory

cultural competence

delirium

disengagement theory

ethnocentrism

gerontology

infantilization

labeling theory

For Further Thought

1. How does an understanding of aging promote person-centered care?
2. Two of the four theories of aging discussed in this chapter may have contradictory overtones. How can the two theories still be applied in LTC settings?

CASE

Why Too Few Minorities?

A 30-year-old young woman, Cindy Banks, has been appointed the administrator of a 120-bed skilled nursing facility located in a small town of 35,000. Most of the working people in this town are employed by various small manufacturing plants located within 15 to 20 miles of the town's main street. Some of the residents also take seasonal jobs to work in some of the fruit farms surrounding the main town. Almost half the town's population consists of people who immigrated from Mexico, Central America, or parts of the African continent. The parents of many of these immigrants came under the family reunification program of the U.S. Citizenship and Immigration Service; and they have been receiving Medicare and Medicaid benefits for health care. Within her first week on the job, Ms. Banks learned that the facility was operating at 78% occupancy, averaging approximately 94 residents per day. She asked the social worker to give her a breakdown of the various ethnic groups represented among the facility's residents and was given the following information: 74 whites, 12 blacks, and 8 Hispanics. The social worker also informed Ms. Banks that the previous administrator had the opinion that people from other cultures did not place their elders in nursing facilities. Ms. Banks did not believe this to be true. She arranged a meeting with the president of the small corporation that owned the facility. After some discussion, she was able to convince the president that an advertising budget of \$7,000 should be approved to attract more minority residents to the facility. If the occupancy could be increased to just 85%, the advertising would pay for itself. The request was approved.

1. What may be the possible reasons that the facility's resident mix does not reflect the surrounding population?
2. Which advertising medium(s) should Ms. Banks focus on? Why?
3. What should be the content of the advertisement? What message(s) should be conveyed?
4. Apart from advertising, what else should Ms. Banks do to improve the occupancy?

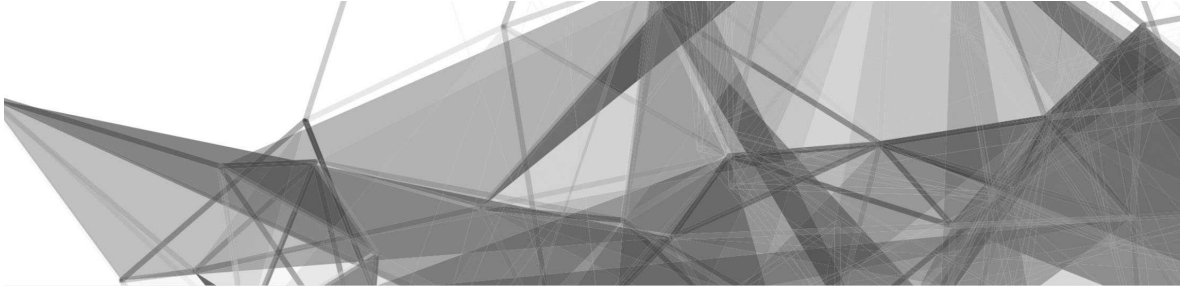
For Further Learning

Alzheimer's Association, Person Centered Care in Nursing Homes and Assisted Living,
https://www.alz.org/media/greatermissouri/Person_Centered_Care.pdf

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PART II

Laws, Regulations, and Financing

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Chapter 5 Legal Environment

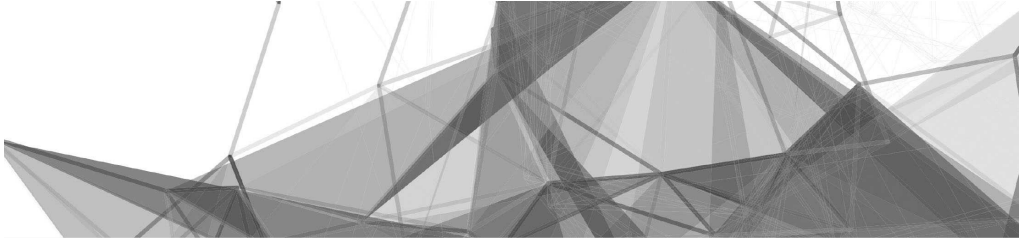
Chapter 6 Regulation and Enforcement

Chapter 7 Financing and Reimbursement

The long-term care environment continues to become increasingly more challenging because of growing legal threats, a more stringent enforcement of rules and regulations, and new mandates under the Affordable Care Act to incorporate quality outcomes into the Medicare reimbursement system. Hence, an understanding of laws, regulations, and financing, as they apply to long-term care, has become indispensable in nursing home administration. The three chapters in this section furnish the much-needed core of knowledge in these areas.

- Chapter 5 centers on the legal environment and how different classes of laws apply to nursing home administration. The chapter also discusses the concepts of negligence and medical malpractice, circumstances when criminal law may apply, situations in which administrators may be personally liable and when corporations may be liable. Administrators frequently have to deal with contracts and agreements. It is also critical for them to understand licensure and certification of facilities, resident rights, privacy of medical information, anti-discrimination laws, and elder abuse.
- Chapter 6 details regulations and their enforcement. It covers the Requirements for Participation in the Medicare and Medicaid programs, the survey process, types of deficiencies, the *Life Safety Code*[®], accessibility requirements under the Americans with Disabilities Act, and safety standards and recordkeeping required by the Occupational Safety and Health Act.
- Chapter 7 focuses on financing and reimbursement for nursing homes. It covers private out-of-pocket and insurance financing, the four parts of Medicare, the prospective payment system (including the new Patient Driven Payment Model), Medicaid, the Program of All-Inclusive Care for the Elderly (PACE), managed care, and opportunities for partnerships with other organizations. The chapter also covers the federal fraud and abuse law and False Claims Act as they apply to financing and reimbursement.

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CHAPTER 5

Legal Environment

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WHAT YOU WILL LEARN

- Litigation is a means for seeking redress for wrongs. It is not a means to improve quality.
- There are different ways of classifying laws. Nursing homes must comply with all applicable federal, state, and local laws and regulations.
- Civil law encompasses tort law and contract law. Certain conditions must be met for a contract to be legally enforceable.
- Tort law differentiates between negligence and medical malpractice.
- Nursing home administrators and other professionals can be held personally liable when they knowingly do something wrong.
- Corporations can be held liable for the tortious conduct of their employees under the doctrine of *respondeat superior*. An agent is not held liable when acting within the scope of his or her authority.
- Three main types of ownership can be formed under corporate law. Type of ownership has tax and other implications.
- All nursing facilities must be licensed to legally conduct business. Certification and accreditation are voluntary, but most nursing homes are certified to admit patients covered under Medicare and Medicaid.
- Numerous resident rights have been identified in the federal regulations that govern nursing homes. Federal regulations also govern abuse, neglect, and exploitation of residents.
- Various laws govern privacy of medical information and discrimination.

Introduction

The legal environment is vast and complex. The purpose of this chapter is to furnish basic legal understanding, and associated terminology, necessary for day-to-day management of assisted living, nursing care facilities, and other long-term care (LTC) services. A basic understanding of the law to prevent potential legal actions and seeking legal counsel before minor issues turn into major problems are vital elements of effective management.

Nursing Home Litigation

Litigation refers to legal action brought before a court of law, and it involves two main parties. A **plaintiff** is one who brings legal action by filing a complaint with a court to seek damages or other legal remedies. The other party is called a **defendant**, against whom a lawsuit is brought.

By seeking legal redress against a nursing home, the plaintiff wishes to obtain compensation for pain and suffering or wrongful death. Legal action may also get the public's attention through media reports. The main drawback of litigation as a method of nursing home oversight is that it provides remedies for harm that has already occurred. It is also questionable whether litigation changes management's behavior in preventing harm to others. Research shows that litigation does not improve the quality performance in nursing homes; it may actually decrease it (Stevenson et al., 2013). It may be because litigation increases health care costs and diverts funds that could be used for improving quality. On the other hand, even the best-performing nursing homes are not immune from being sued. The difference in the odds of being sued is only marginally less compared to worst-performing nursing homes (Studdert et al., 2011). This suggests that harm resulting from human error may be a contributing factor that may eventually lead to litigation.

The nursing home sector has been subject to substantial litigation activity. Hoey (2018) has suggested that corporatization of the nursing home industry—a move away from earlier mom-and-pop operations—in which big players may be focused on reducing costs and delivering profits to shareholders may have resulted in a decline in care provided to the residents.

Classifications of Laws

Laws can be classified in several different ways. **Figure 5-1** provides a simple classification arrangement.

By the level of government (level of government at which a law is formulated)	Federal, state, and local laws
By the source of law (source from where the law is derived)	Constitutional law Statutory law Administrative law Common law
By the law's application (to whom it applies)	Public law Private law
By the nature of litigants (private parties or a private party v. the public)	Civil law Criminal law
By the type of wrong committed (a civil wrong or a breach of contract)	Tort law Contract law

FIGURE 5-1 Classifications of laws

Federal, State, and Local Laws

Laws are formulated at the federal, state, and local levels of government. Generally, federal laws supersede state and local laws. This is called **federal preemption**. Accordingly, states and local jurisdictions can enact and enforce only those laws that do not conflict with federal law (Pozgar, 2019, p. 25). On the other hand, the United States is governed under the principle of **federalism**, which gives the states considerable power in matters of governance. Certain matters have been specifically delegated to the states. For example, states have the authority to regulate LTC insurance, establish Medicaid reimbursement for nursing homes, and license health care facilities and personnel. In other areas, both federal and state laws may apply. For example, federal law specifies the hourly minimum wage to be paid to workers. A state may establish its own minimum wage, but it cannot be lower than the federal minimum wage. Laws passed by the local governments (counties, cities, and municipalities) are generally referred to as **ordinances**. For example, local zoning ordinances prescribe land use for commercial or residential purposes.

Constitutional, Statutory, Administrative, and Common Law

The U.S. judicial system relies on four main sources of law. **Constitutional law** is based on the Constitution of the United States, which is the supreme law of the nation. The U.S. Constitution defines the structure and powers of government and the rights of individuals. The U.S. Supreme Court is the final arbiter in constitutional matters. For example, in June 2012, the Supreme Court ruled that the mandate under the Affordable Care Act to require all citizens to have health insurance was constitutional, but it could not mandate the states to expand their existing Medicaid programs. **Statutory law** comprises statutes passed by legislative bodies, such as the U.S. Congress, state legislatures, or legislative bodies of local governments. **Administrative law** is formulated by the departments or agencies of the executive branch of government. It consists of rules and regulations, which are used to implement statutory laws crafted by the legislative branch. For example, to this date, the U.S. Department of Health and Human Services (DHHS) has been continually updating rules and regulations to improve nursing home quality as mandated by the Nursing Home Reform Act of 1987. **Common law** (also referred to as case law) is the body of legal principles and precedents that have been handed down in the form of court decisions. In rendering a decision on a case before it, a court must apply settled principles of law from previous cases embracing similar facts and involving similar principles. Common law is the only source available when statutory and administrative law are silent about a matter before a court.

Public and Private Laws

Public laws affect society as a whole. For example, criminal law deals with wrongs committed against society. **Private laws** affect an individual, family, or small group. For example, a contract between two parties falls in the category of private law because the contract affects only the parties who entered into the contract. Harm caused to an individual or damage to someone's property by another also fall under private law. Thus, private law deals with civil matters.

Civil and Criminal Law

Civil law is the body of laws governing private legal affairs, such as private rights and duties, contracts, and commercial relations. In civil law, a private party (individual or corporation) files the lawsuit and becomes the plaintiff. Civil penalties in the form of monetary damages—as opposed to jail terms—ensue from a breach of what the law prescribes.

Criminal law defines crimes and provides punishments for them. A **crime** is an offense committed against the general public, regardless of the number of individuals wronged. Jail terms, fines, or both may be imposed for criminal offenses. Examples of crime include theft, murder, disorderly conduct, and sexual abuse. Other types of actions specific to health care may also constitute crimes. Billing the Medicare program for services that are not medically necessary, billing for services that were not performed, or gross violation of commonly recognized standards of care may constitute Medicare fraud, which is a criminal offense. A reckless disregard for the safety and well-being of residents may constitute criminal negligence. Crimes are ranked as felonies and misdemeanors. A crime classified as a **felony** is of a serious nature and is subject to a jail term of more than 1 year. A **misdemeanor** is a less serious crime that may be punishable by a jail term of less than 1 year.

The wrongdoer who commits a crime is subject to prosecution by the state. A public prosecutor, not a private party, brings the case before a court. Prosecution of an action that has been deemed a crime may still allow the wronged party to pursue civil action when the same conduct violates both criminal and civil laws.

Tort and Contract Law

Civil law distinguishes between tort and breach of contract. Generally, injury must be sustained to claim damages. **Injury** can be in the form of physical, financial, or emotional harm.

Tort Law

A **tort** is defined as a civil wrong—other than a breach of contract—committed against a person or a corporation. In broad terms, a tort almost always constitutes the violation of some duty. It can be in the form of wrongdoing—that is, something was done incorrectly or something that should have been done was omitted (Miller & Hutton, 2000, p. 361). On admitting a resident, the facility becomes duty bound to meet the resident's total care needs. If the facility is not equipped to meet all of the resident's needs because of staff shortages, lack of expertise, or any other reason, the resident should not be admitted. If a resident's condition deteriorates so that a higher level of care would be more appropriate, the facility must make the needed transfer arrangements, including safe transportation to another facility or a hospital.

In tort law, **compensatory damages** are generally awarded to "make the person whole again." However, the court may also award punitive damages in excess of the actual losses suffered. **Punitive damages**, also called *exemplary damages*, are generally awarded when the defendant's conduct is determined to be egregious or blatant. The intent is to make a public example to deter future wrongful conduct by others. Punitive damages are generally not paid by the defendant's insurer (Thornton, 2006).

Egregious conduct generally falls into four categories:

1. *Malicious intent*. Also called **malice**, it involves knowingly doing something with the desire to cause harm. The plaintiff is required to demonstrate that the defendant carried some ill will toward the plaintiff and that the defendant acted on that ill will to cause serious injury (Thornton, 2006).
2. *Gross negligence*. This is more than ordinary negligence (discussed later). In **gross negligence**, the defendant would have acted with conscious indifference to the rights, safety, or welfare of another and should have known of the potential harm he or she might cause.
3. *Blatant disregard for the rights of others*. Punitive damages are particularly relevant in torts involving harm to the plaintiff's dignity (e.g., invasion of privacy) or other breaches of civil rights, for example, when there is intentional discrimination.
4. *Fraud*. This is a knowing disregard of the truth that results in harm. It involves deception and an intent to defraud someone.

Fuqua v. Horizon/CMS Health Care Corporation. This landmark 2001 verdict from Texas illustrates the kind of circumstance in which punitive damages may be warranted. In one of the largest-ever jury verdicts at the time in a nursing home malpractice lawsuit, brought by Cecil Fuqua on behalf of the estate of his mother, Wyvonne Fuqua, the plaintiff was awarded \$2.7 million in compensatory damages and an additional \$310

million in punitive damages. The suit was filed after the death of 76-year-old Wyvonne Fuqua in 1997. Fuqua had been admitted to a nursing home in Fort Worth, Texas, in 1994, following a stroke. In late 1996, Fuqua began developing severe pressure ulcers. As her condition deteriorated, the nursing home staff allegedly did not apprise the family of Fuqua's condition and did not discharge her to a facility that could adequately treat her pressure ulcers. In April 1997, Fuqua's adult children moved her to a local hospital. She arrived in a state of malnutrition, with 16 pressure ulcers, of which 9 were Stage III and 5 were Stage IV (the most severe type in which bone or muscle may be exposed). Fuqua died 2 months after she left the nursing home (Schabes, 2002).

Contract Law

A civil wrong involving the violation of a specific agreement between two parties constitutes a **breach of contract**, not a tort. In a civil case, the remedy is often in the form of recovery of damages. However, the injured party has the duty to mitigate (i.e., reduce) potential damages. For example, an employee who is separated from an organization in breach of a contract that existed between the employee and the organization has the duty to try to find other employment. Punitive damages are not available in breach of contract cases.

A **contract** is a legally binding agreement between two or more parties to carry out a legal purpose. For instance, two parties cannot enter into a contract to commit fraud. Although most contracts are executed in writing, certain verbal agreements can also be legally viewed as contracts. A contract essentially represents a mutual assent or "meeting of the minds."

Contracts are commonly encountered in health facility administration. Contracts may concern residents or parties responsible for them, certain employees, independent providers of services to the facility's residents, construction contracts, lease contracts, loan agreements, purchasing contracts, etc.

For most contracts to be legally enforceable, two main conditions must be met:

1. Making of an offer and its acceptance should have occurred, indicating that an agreement has actually been reached. All parties to a contract should sign a written document to affirm the agreement.
2. Promise of a price or benefit—called consideration—should be stated. A **consideration** is something of value promised to another in exchange for something else of value. The party that is being required to perform under the contract will receive the consideration upon performance. For example, a roofing contractor will receive the agreed-upon payment only when the job is done in accordance with the specifications of a contract between the facility and the roofing contractor.

Only contracts executed between competent parties are legal. To be considered **competent**, the parties must be of sound mind and of legal age. Thus, agreements with minors or those who do not have the mental capacity to enter into a contract because of mental illness, intellectual disability, dementia, or substance abuse are not enforceable. In most cases, competence can be determined by a physician. In more difficult situations, the matter is referred to a court. Agreements reached under duress may also be unenforceable. Unless a court determines a contract to be invalid, and therefore unenforceable, the parties must perform according to the terms of the agreement. Otherwise, the aggrieved party can bring a complaint before a court for breach of contract and recover damages.

When admitting a resident, a nursing home enters into a contract with the resident or someone acting on his or her behalf, such as a family member. The **admission agreement** is a contract that spells out the services the nursing home will provide and the cost of those services. The nursing home can be sued for breach of contract if a resident is harmed and if the harm is determined to have resulted because services promised in the contract were not delivered. On the other hand, the resident or a responsible party who signed the admission agreement may be sued for nonpayment.

Ordinary Negligence, Malpractice, and Intentional Torts

Ordinary Negligence

Ordinary negligence is more common than the egregious conduct described as gross negligence (discussed previously). Ordinary negligence is the failure to exercise the degree of care that a reasonable person would have exercised in similar circumstances. It is commonly associated with carelessness. A nursing facility has a duty to exercise due care. For instance, it must have adequate equipment and staff to provide services as required by the needs of its residents. However, to be legally actionable, negligence must result in injury. For example, a facility that fails to install an alarm system to monitor residents who may wander out of the facility is not liable unless a resident has actually wandered away and sustained injury.

For a plaintiff to establish injury from negligence, four conditions must be present:

1. A duty must be owed. For instance, nursing facilities have the duty to maintain a safe environment and provide services that meet acceptable standards. They have a duty to monitor the quality of care and make improvements when services do not meet acceptable standards.
2. There must be a breach of duty.
3. An injury must be sustained.
4. A direct cause-and-effect relationship must be present between the breach of duty and the injury sustained.

The duty that is breached can be in the form of an act of commission, such as a nurse giving the wrong medication. Conversely, it can be an act of omission, such as a nurse failing to give the prescribed medication. In either case, if no injury is sustained, no legal action can be taken.

Difference Between Negligence and Malpractice

Tort law differentiates between negligence and malpractice. Malpractice, or medical malpractice, is defined as failure to provide services according to accepted standards of care so that harm is caused to the recipient of care. Whereas negligence would fall within the common knowledge and experience of a jury, malpractice falls in the domain of professional judgment used by caregivers. The main difference between the two is in the context of what a reasonable person should have done (negligence) versus violation of clinical standards of care (medical malpractice). During a court trial, expert testimony is needed to establish malpractice; it is not needed to establish negligence. Hence, the threshold to prove malpractice is much higher than it is for ordinary negligence.

The numerous regulations governing the quality of care and quality of life in nursing homes have been broken down into specific federal standards (identified by F-Tags¹) and are widely regarded as minimum standards of care. Nursing facilities, especially those participating in the Medicare and Medicaid programs, are required by law to comply with the regulatory standards. Deficiencies cited by state inspectors when the standards are not met, and the facility's own quality assurance programs that may demonstrate lapses in corrective actions when improvements are called for, are often used to establish malpractice in lawsuits. The facility must also have its own policies and procedures, for example, about how to operate resident-care equipment safely, following the manufacturer's instructions. In addition, expert professional opinion may be used to establish whether or not care delivered to a resident was in accordance with both professional and regulatory standards.

Intentional Torts

An intentional tort is a willful act that violates the rights or interests of others. *Willful* means that a person knows and desires the consequences of his or her acts. Actions commonly regarded as intentional torts are assault, battery, false imprisonment, invasion of privacy, defamation of character, fraud, and intentional infliction of mental distress.

- An assault creates a threatening environment in which a person fears being touched in an offensive, insulting, provoking, or potentially injurious manner. No physical contact has to occur, but the assaulted individual must reasonably believe that the aggressor has the ability to carry it out presently. If the aggressor actually touches the other individual without consent, that action results in battery. In this context, restraining a resident without a physician's order or the resident's consent may amount to battery.

- **False imprisonment** is the unlawful restriction of freedom. Unlawful use of restraints may constitute false imprisonment in addition to battery. Also, generally accepted clinical procedures and regulatory guidelines must be followed when isolating residents who have a contagious disease.
- Invasion of privacy concerns both privacy and confidentiality. A resident's name, pictures, or private affairs should not be made public without proper authorization. Unreasonable search or intrusion, such as opening personal mail without consent, is a violation of a resident's privacy rights. Residents' medical records belong to the LTC facility, but these records are confidential. Release of information to persons not involved in resident care requires the resident's authorization, or its release may be governed by law (see the section on Privacy of Medical Information).
- Defamation of character involves making false reports that result in damage to someone's reputation. The false reports may be in written form (constituting a **libel**), or they may be spoken (constituting a **slander**).
- **Fraud** occurs when harm or loss is incurred because of a knowing disregard of the truth. Fraud is almost always an egregious act and a crime.
- Intentional infliction of mental distress is considered intentional tort when some outrageous conduct results in mental or emotional trauma. Residents and their families must be treated in a civil manner. Health care professionals can be held liable when outbursts of anger, abusive language, or other irrational behavior results in mental distress.

¹ Federal regulations for nursing homes are identified by F-Tags. See Exhibit 5-2.

Personal and Corporate Liability

Liability refers to the potential damages ensuing from legal action. Liability may be ascribed to an individual or a corporation.

Personal Liability

As a general rule, both tort law and criminal law ascribe personal liability to the individual who commits wrongful acts. For example, falsification of medical records may be grounds for criminal prosecution of the individual committing those acts. The administrator would be held personally responsible only when he or she has acted on his or her own behalf, has engaged in a tortious act (i.e., behavior that constitutes a tort), or has remained passive about something that results in a tort when he or she knew or should have known but failed to take action. It is advisable for health care facility administrators to carry professional liability insurance for situations in which the organization's insurance may not cover certain acts of the administrator. Administrators are not medical caregivers, but rather they deal with administrative concerns and regulatory compliance, so they cannot be held liable for medical malpractice.

Estate of Hazelton ex rel. Hester v. Cain. Maggie Hazelton, who was 83 years old, was admitted to Driftwood Nursing Center on April 9, 1999, and was discharged on May 30. She was readmitted in June of the same year and then discharged to a hospital in August. Two days later Maggie died in the hospital. Darlene Hester, administratrix of the decedent's estate, filed suit against the nursing home and its administrator, Richard Smith. The lawsuit alleged personal injuries and wrongful death. Hester alleged that the resident was a victim of neglect and, as a result, had suffered pneumonia, falls, unexplained injuries, urinary and kidney infections, weight loss, and ultimately death. Hester asserted that the nursing home's negligent conduct caused the resident to lose her dignity and caused her death to be preceded by extreme and unnecessary pain, degradation, anguish, unnecessary hospitalization, and emotional trauma. In his defense, Smith filed a motion for **summary judgment**, that is, a prompt disposition of the case without a trial. The trial court granted the motion for summary judgment and entered final judgment of dismissal in favor of Smith. In essence, the court held that Smith could not be held personally liable for any alleged negligence on the part of any of the employees of the nursing home. Later, the Court of Appeals of Mississippi affirmed the summary judgment in favor of Smith (Leagle, [2019](#)).

Corporate Liability

The ultimate legal responsibility for the facility's operations and for its outcomes is vested in the governing body or board. Responsibility for daily management is delegated to the administrator. Generally speaking, individual members of the governing body are not held personally liable for negligence amounting to errors of judgment. They may, however, be held liable for gross or willful negligence. Hence, board members acting in good faith can have wide latitude in fulfilling their roles and responsibilities. Acting in **good faith** (Latin: *bona fide*) generally means how a reasonable person would have acted under similar circumstances. On the other hand, board members may be held criminally liable in cases involving fraud or engaging in activities for personal gain.

The corporation is often held responsible for systemic failures in a nursing home's operation, care, or management, for example, when injuries are attributed to lapses in care emanating from chronic staff shortages. In the past two decades, however, nursing home corporations have created complex structures to implement layers of protection against liability claims that arise from a lack of care their nursing homes provide (Hoey, [2018](#)).

Respondeat Superior

All people are responsible for their own tortious conduct. At times, however, the law will hold liable for a tort not only the tortfeasor (i.e., person who commits the tort) but also the organization that hired the tortfeasor. In most instances, the nursing facility is held liable for the wrongful acts of its employees when such acts are committed during the course of their employment. It does not matter if the organization takes all reasonable steps in selecting, training, and supervising its employees. The fact that the facility may have disciplined or discharged an employee for wrongdoing is often not an adequate defense (Hoey, [2018](#)).

A corporation's liability for the acts of its officers or employees is known as **vicarious liability**, which is founded on the legal doctrine of **respondeat superior** (let the master respond). A supervisor is not regarded as an employer and is not held liable except for his or her own personal acts, as described in the previous section. Also, *respondeat superior* does not absolve the employee of personal liability (discussed previously), nor does it obligate the employer to provide liability protection to its employees.

The doctrine of *respondeat superior* does not apply to the wrongful acts of an independent contractor, who is responsible for his own acts. Hence, it is important to differentiate between an employee and a contractor, but this distinction is not always clear in law. For instance, it is a common practice in LTC facilities to contract rehabilitation services. Generally, a facility would not be liable for the wrongful acts of contracted therapists treating residents in the facility. However, if the facility exercises some measure of control over the therapists

(such as resident scheduling, billing, and compliance with the facility's policies) and if the therapists are represented to clients as employees of the facility, they may not qualify as independent contractors under law. On the other hand, a facility is not liable for the actions of a nonemployed attending physician who generally is not under the control of the facility's staff.

Facility administrators can minimize legal exposure by adhering to the following practices pertaining to independent contractors:

- Review and document the qualifications and credentials of clinical professionals who may be rendering services to the facility's residents as independent contractors.
- Verify and document that all personnel providing services to residents are duly licensed if they are required to be licensed under state laws. Maintain documentation on current licenses.
- Ensure that licensed professionals do not provide services outside their scope of practice.
- Investigate, document, and report any professional misconduct to the appropriate licensing authority.

Agency

An **agent** is someone who is authorized to act on behalf of another, called a *principal*. For example, the facility administrator is, in many instances, an agent of the corporation that employs him or her. The corporation (i.e., the principal) would generally be liable for the acts of commission or omission of its agent when the latter acts within its authority. For example, when the administrator enters into a contract with a third party within the scope of his or her authority, any liability ensuing from a breach of contract will fall on the corporation; the administrator will not have personal liability. On the other hand, if the third party has been led to believe that the agent is a principal, the agent would be liable if a breach of contract occurs.

Corporate Law

Statutes concerning the rights and responsibilities of private corporations may be loosely referred to as [corporate law](#). An organization's ownership structure defines, in a broad sense, its rights and responsibilities. There are three main classes of corporate ownership:

- Public
- Private nonprofit
- Private for-profit (proprietary)

Public Facilities

A [public facility](#) is owned by the government. It may be operated under a specific statute enacted by a city or county. That statute would include the specific duties and limitations for the organization.

Private Nonprofit Facilities

A privately owned facility incorporated as a [nonprofit](#) (also called not-for-profit) entity is prohibited from distributing its profits to individuals. A nonprofit nursing facility is not prohibited from earning a profit, but the facility must serve a charitable purpose. Nonprofit corporations are exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code. These organizations are also exempt from state income and sales taxes and may be exempt from local taxes, such as property taxes. Tax law also enables nonprofit entities to obtain private donations, for which the donors can claim a charitable deduction on their income tax returns.

The owners and administrators of nonprofit facilities must be particularly careful that the privileges afforded under the law are not abused. "Charity" does not mean that the facility is required to provide free care to anyone. It does mean that the facility must make its services available at the lowest feasible price and that it should not force anyone who cannot pay for services to move out. To provide care to residents who are unable to pay, the facility may participate in government funding programs such as Medicaid, obtain private donations, or cover such costs out of its own profits.

Private For-Profit Facilities

A [for-profit facility](#) (or proprietary facility) is operated to generate a profit that can be distributed to its owners or shareholders. Proprietary enterprises are also required to pay all federal, state, and local taxes. There are three types of proprietorships:

- Corporations
- Partnerships
- Sole proprietorships

A [corporation](#) is formed as a legal entity that is entirely separate from its owners. For-profit corporations may be owned by a group of private investors or by a parent corporation—such as a nursing home chain or a proprietary hospital—or by shareholders who have invested in the company's stock through the stock market.

A [partnership](#) is an association of two or more individuals or organizations for the purpose of conducting business for profit, and for sharing profits among the partners. They also share the expenses and liabilities of the partnership. In a [general partnership](#), the potential liability of the partners is unlimited. A [limited partnership](#), however, can be established to limit the individual liability of partners. Limited partners are liable only to the extent of their investment, as long as they do not participate in the management and control of the operations (Miller & Hutton, 2000, p. 25). Thus, limited partners can be viewed as mere investors in a business enterprise.

A [sole proprietorship](#) consists of a single owner who has not incorporated the business. All income of the business is taxed as personal income of the owner, and the owner's potential liability is unlimited. Because of the many complex tax and legal issues they entail, nursing facilities are rarely operated as sole proprietorships.

Licensure, Certification, and Accreditation

Licensure, certification, and accreditation carry different meanings, but all three serve at least one main purpose—to establish minimum standards of quality and to enforce compliance with those standards. **Exhibit 5–1** provides a summary of the main distinctions between licensure and certification.

Exhibit 5–1 Differences Between Nursing Home Licensure and Certification

Licensure

- State function
- Mandatory
- Basic requirement for operating a nursing home
- Does not make a facility eligible for public funds
- There is one licensing category for nursing care facilities
- With the exception of the *Life Safety Code*®, licensing standards differ between states

Certification

- Federal function
- Optional
- A facility must first be licensed before it can apply for certification
- Necessary for receiving public funds
- Uniform federal standards for all states
- Three categories, depending mainly on the source of government funding and types of residents served:
 1. Skilled Nursing Facility (SNF)—Medicare, postacute, short stay
 2. Nursing Facility (NF)—Medicaid, long stay (if the resident qualifies)
 3. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)—Medicaid, long stay, intellectual disability/developmental disability residents only

Licensure

A license is a legal requirement without which it will be unlawful to operate a nursing facility. License to operate a nursing facility is issued by the state in which the facility is located.

The licensure process starts at the planning stage, before a new facility can even be built. If an existing facility is acquired, it must be relicensed. The license must be maintained, generally through an annual renewal process. Many states have **certificate of need (CON)** laws that require a state planning agency to approve building a new facility or expansion of an existing one. In some states, transfer of ownership must also go through the CON approval process.

Certification

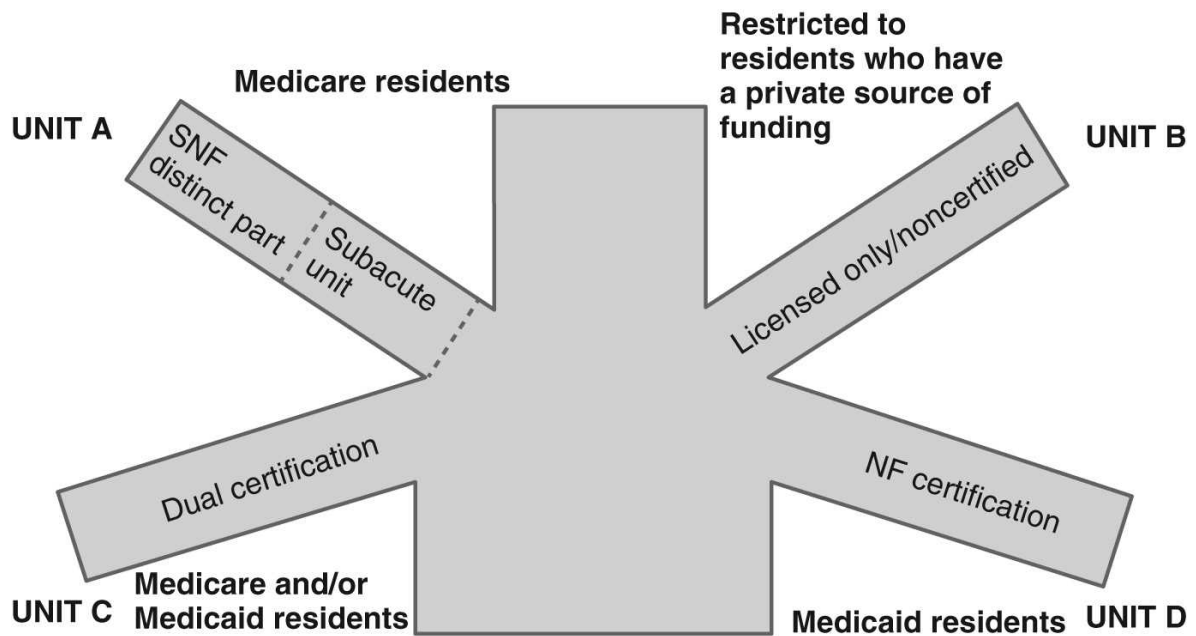
All facilities must be licensed, but **certification** is not mandatory. Certification is required for admitting residents enrolled in the Medicaid or Medicare programs. In contrast to licensure, which is a state function, certification is a federal function. The Centers for Medicare and Medicaid Services (CMS), a federal agency under the DHHS, has established requirements of participation with which nursing facilities must comply to retain their certification status.

The Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) created two categories of nursing homes for certification purposes. A nursing home certified as an **skilled nursing facility (SNF)** can admit residents covered under Medicare. Such a facility can be freestanding or a **distinct part**—that is, a section of a nursing home that is certified apart from the rest of the facility. When SNF certification applies to a distinct part, Medicare residents can be admitted only to that particular section of the facility.

A facility certified as **nursing facility (NF)** can serve residents covered under Medicaid, but not Medicare. SNF and NF are both legal terms associated with certification, not necessarily with the level of services. A facility may be dually certified as both SNF and NF. Facilities that have **dual certification** can admit both Medicare and Medicaid residents. More than 90% of certified nursing homes have dual certification. The federal standards for the delivery of care in SNFs and NFs are the same.

A third certification category is [intermediate care facility for individuals with intellectual disabilities \(ICF/IID\)](#). To qualify for Medicaid reimbursement, ICFs/IID must be licensed by the state and must comply with federal standards that are specific to these facilities.

A few facilities have elected not to participate in the Medicaid and Medicare programs. These noncertified facilities can admit only those residents who have a private source of funding for nursing home care. [Private-pay residents](#) can be admitted to both certified and noncertified facilities. Most nursing homes are certified because they can serve private-pay residents as well as those on public assistance. [Figure 5-2](#) illustrates how a facility can have distinctly certified sections.



The entire facility must be licensed by the state

FIGURE 5-2 Distinctly certified units in a nursing home

Accreditation

In contrast to licensure and certification, which are government functions, [accreditation](#) is a private function. Hence, accreditation is totally voluntary. The Joint Commission (previously Joint Commission for the Accreditation of Healthcare Organizations)—a private nonprofit organization—accredits hospitals, nursing homes, and other types of health care sites and has issued its own standards for the purpose of accreditation. Compared with hospitals, relatively few nursing facilities have opted to seek accreditation because many facilities find that accreditation fees are high in relation to the benefits reaped. However, quality of care based on several quality measures has been found to be better in accredited nursing facilities compared to their nonaccredited counterparts (Williams et al., [2017](#)).

Another independent, nonprofit organization, CARF International, accredits health and human services that include adult day care programs, assisted living facilities, nursing facilities, home and community services, case management, and dementia care programs (CARF International, [2020](#)).

Resident Rights

Resident rights are founded on both legal and ethical principles. The rights of residents living in LTC facilities are spelled out in the federal regulations that apply to all facilities participating in the Medicare and Medicaid programs. It is a good practice to follow the same standards in noncertified facilities. The individual standards, identified by F-Tags 550 to 586 (see **Exhibit 5–2**), pertain to the general resident rights.

Exhibit 5–2 Federal Regulations on Resident Rights (Summarized)

F- Resident Rights and Facility Obligations

Tags

- F550 The resident has the right (i) to be treated with dignity and respect, (ii) to have self-determination, (iii) to have communication with and access to persons and services inside and outside the facility, (iv) to have equal access to quality care, and (v) to be able to exercise the rights as residents of the facility and as citizens or residents of the United States without interference, coercion, discrimination, or reprisal from the facility.
- F551 In accordance with state law, the resident can designate a representative, who may exercise the resident's rights to the extent provided by law or by a court order.
- F552 Right to be informed in advance (i) of the care to be furnished and the type of caregiver that will furnish care, (ii) of the risks and benefits of the proposed care, and (iii) of alternative treatments and options. The resident has the right to choose the alternative or option he or she prefers.
- F553- Right (i) to participate in his or her plan of care, (ii) to self-administer medications if it is deemed appropriate for him or her to do so, and (iii) to choose his or her attending physician.
- F555
- F557 Retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
- F558 Reasonable accommodation of the resident's needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
- F559, Share a room with his or her spouse or with a roommate of choice when practicable. Refuse a room transfer if it is solely for the convenience of staff.
- F560
- F561 Self determination: Choose activities (including social, religious, and community programs) and schedules (including sleeping, dining, and bathing times) consistent with his or her interests.
- F562 The facility must provide immediate access to a resident by a state official, ombudsman, representative of protection and advocacy systems, the resident's physician, and the resident's representative.
- F563, To receive visitors or deny visitations. The facility must inform the residents of visitation policies and procedures and any clinical or safety restrictions.
- F564
- F565 The facility must allow resident and/or family group meetings, provide space, and designate a staff person to assist with such meetings. Staff, visitors, and any guests may attend only when invited.
- F566 The facility must not require a resident to perform services for the facility except when the resident so desires and it is documented in the resident's plan of care.
- F567- To manage his or her own financial affairs. The facility must act as a fiduciary when the resident chooses to deposit his or her personal funds with the facility. The facility must maintain separate accounting and provide quarterly statements to the resident. The facility must notify the resident who receives Medicaid benefits when his or her personal funds reach within \$200 of the SSI limit to prevent the loss of Medicaid eligibility. Upon transfer from the facility or death, funds must be conveyed within 30 days to whoever must receive those funds. The security of funds must be assured with a surety bond. The facility must not charge the resident for services covered by Medicaid or Medicare payments.
- F571
- F572 The facility must inform each resident of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.
- F573 Have access to personal medical records and obtain copies of the same.
- F574, The facility must provide each resident a written description of resident rights. Such a document must include the names, addresses, and telephone numbers of all pertinent state regulatory and informational agencies, resident advocacy groups, ombudsman, and protection and advocacy agencies. This information should also be posted. The facility must not prohibit communication with any such external agencies.
- F575, F586
- F576 Have reasonable access to a telephone, privacy in communication, send and receive mail and packages, and have access to the Internet (at the resident's own expense).
- F577 The facility must post results of the most recent survey (inspection) conducted by the state or federal inspectors. Also post a notice that results of surveys, certifications, and complaint investigations for the preceding 3 years are available for review by anyone.
- F578 The right to accept or refuse medical treatment, to participate or refuse to participate in experimental research, and to formulate advance directives.
- F579 The facility must post written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
- F580 The facility must inform all concerned parties of any accidents/injuries involving the resident; of any deterioration in health, mental, or psychosocial status of the resident; of any significant changes in treatment; and of any decision to transfer or discharge the resident from the facility.
- F582 The facility must notify in writing a Medicaid-eligible resident of items and services that are covered by the Medicaid program, and the charges for any noncovered items and services.
- F583 Right to privacy and confidentiality in accommodations, medical treatment, records, communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
- F584 Right to a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. The facility must exercise reasonable care for the protection of the resident's property from loss or theft.
- F585 Right to voice grievances to the facility or other agencies without fear of discrimination or reprisal.

F556 and F581 are not currently in use.

Excerpted and summarized from State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities (rev. 11/22/17). <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>.

Informed Consent

F-Tag 552 pertains to what is legally referred to as **informed consent**—the right of a patient to make an informed choice about medical care. To make an informed choice, the nursing home resident must be given sufficient information to make a decision. Legal consent, however, requires that the resident has actually understood whatever he or she is consenting to. Hence, if a resident is not legally competent to give consent and has designated a representative (F551) or has a court-appointed guardian, that person would have legal authority to act on the resident's behalf. The resident has the right to refuse treatment (F578), even when the treatment is medically advisable. However, "the resident's refusal does not absolve facility staff from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. For example, facility staff would still be expected to provide appropriate measures for pressure injury prevention, even if a resident has refused food and fluids and is nearing death" (CMS, 2017, p. 48).

Advance Directives

An **advance directive** provides an avenue for the resident to convey his or her wishes about medical treatment in the event of incapacitation. Advance directives must be prepared before a person loses his or her competency for making decisions. Three types of commonly used advance directives include a living will, a do-not-resuscitate order, and a durable power of attorney. A **living will** specifies a person's wishes regarding medical treatment in the event this person becomes incompetent. A **do-not-resuscitate order (DNR)** specifies that the person does not wish to have heartbeat or breathing restored in the event of a cardiac or respiratory arrest. By executing a **durable power of attorney (DPOA)**, a person appoints another individual to make decisions on his or her behalf after the person becomes incompetent.

Privacy of Medical Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 makes it illegal to gain access to personal medical information for reasons other than health care delivery, facility operations, and reimbursement. To the extent it is necessary to promote quality of health care, information can be shared among physicians, nurses, and other professionals. It can also be used for getting reimbursement for services delivered and to facilitate operations such as transfer of a resident from one facility to another.

The Privacy Rule under HIPAA requires appropriate safeguards to protect the privacy of a resident's personal health information (PHI). The law applies to all medical records and other PHI regardless of whether the information is electronic, on paper, or orally transferable. LTC facilities must provide a notice to residents detailing the ways in which the facility will use or disclose a resident's PHI. Releasing the PHI for any purpose other than resident care should be done only with the resident's express written consent. Residents also have the right to examine their medical records, obtain copies, and request corrections (DHHS, [2020b](#)). The Security Rule under HIPAA requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic medical records (DHHS, [2020c](#)).

Anti-discrimination Laws

Title VI of the Civil Rights Act of 1964 applies to facilities and programs receiving federal funds. The law prohibits denial of benefits on the basis of race, color, or national origin. Denial of benefits may be construed to mean discrimination in admission, segregation by race or ethnicity, and unequal treatment in other respects. Section 1557 of the Affordable Care Act of 2010 adds the categories of disability, sex, and age to the antidiscrimination laws (DHHS, [2020a](#)).

Section 504 of the Rehabilitation Act of 1973 prohibits any facility receiving federal funds from discriminating on the basis of physical or mental handicap. Admission to a facility may be denied only if that facility does not provide the level of services that a resident in a protected category requires. Individuals with HIV/AIDS are also protected under the Rehabilitation Act.

The Americans with Disabilities Act (ADA) of 1990 goes beyond the requirements of the Rehabilitation Act. It specifically states that “no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.”

Elder Abuse

Elder abuse is sometimes called elder mistreatment or maltreatment. Five types of elder abuse are commonly recognized: (1) physical abuse, or acts carried out with the intention to cause physical pain or injury, (2) psychological or verbal abuse, or acts carried out with the aim of causing emotional pain or injury, (3) sexual abuse, defined as nonconsensual sexual contact of any kind, (4) financial exploitation, involving the misappropriation of an older person's money or property, and (5) neglect, or the failure of a designated caregiver to meet the needs of a dependent older person (Lachs & Pillemer, 2015).

Abuse is a willful action to inflict injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

The word 'willful' means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. (CMS, 2017, p. 66)

In LTC, studies have uncovered high rates of interpersonal violence and aggression toward older adults; in particular, abuse of older residents by other residents in LTC facilities is more common than physical abuse by staff (Pillemer et al., 2012). Federal regulations address the issue of abuse, neglect, and exploitation in F-Tags 600 to 610 (**Exhibit 5-3**).

Exhibit 5-3 Federal Regulations on Abuse, Neglect, and Exploitation (Summarized)

F- Resident Rights and Facility Obligations

Tags

- F600- The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, or any physical or chemical restraint that is not required to treat the resident's medical symptoms. The resident has the right to be free from misappropriation of property and exploitation (taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion).
- F603
- F604, Restraints must not be used for the convenience of staff. When medically indicated, the least restrictive alternative must be used for the least amount of time with ongoing reevaluation of the need for the restraint.
- F605
- F606 The facility must not employ anyone who has a record of abuse, neglect, exploitation, or mistreatment or misappropriation of property (indicated by court action, state nurse aide registry, or disciplinary action against professional license).
- F607 The facility must have written policies and procedures to prohibit, prevent, and investigate abuse, neglect, and exploitation of residents and misappropriation of resident property. Training must be provided to staff.
- F608, The facility must have policies and procedures for the reporting of any reasonable suspicion of a crime (as defined by law) committed against a resident. Allegations of crimes must be reported within prescribed time frames.
- F609
- F610 All allegations of abuse, neglect, exploitation, or mistreatment must be investigated and reported to appropriate persons and agencies.

F601 is not currently in use.

Excerpted and summarized from State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities (rev. 11/22/17). <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>.

The Elder Justice Act was signed into law in March 2010 and was made part of the Affordable Care Act. The law intends to enhance coordination of elder justice activities; establish forensic centers to develop expertise in elder abuse, neglect, and exploitation; strengthen adult protective services; and require LTC providers to prevent and respond to elder abuse, neglect, and exploitation.

Terminology for Review

abuse
accreditation
administrative law
admission agreement
advance directive
agent
assault
battery
breach of contract
certificate of need
certification
civil law
common law
compensatory damages
competent
consideration
constitutional law
contract
corporate law
corporation
crime
criminal law
defendant
distinct part
do-not-resuscitate order
dual certification
durable power of attorney
egregious conduct
false imprisonment
federal preemption
federalism
felony
for-profit facility
fraud
general partnership
good faith
gross negligence
informed consent
injury
intentional tort
intermediate care facility for individuals with intellectual disabilities
liability
libel
limited partnership
litigation
living will
malice
malpractice
misdemeanor
nonprofit
nursing facility
ordinance
ordinary negligence
partnership
plaintiff
private law
private-pay resident
public facility
public law
punitive damages

respondeat superior
skilled nursing facility
slander
sole proprietorship
statutory law
summary judgment
tort
vicarious liability

For Further Thought

1. Review the case, *Fuqua v. Horizon/CMS Healthcare Corporation*, embedded in this chapter. (a) What main lesson can be learned from this case? (b) What do you think may have been the main reasons for awarding huge punitive damages in this case?
2. Review the *Estate of Hazelton ex rel. Hester v. Cain* case embedded in this chapter. (a) On what basis did both the trial court and the appellate court rule in favor of Richard Smith? (b) Who should be held liable? (c) Discuss the liability issue from the perspective of both personal liability and corporate liability.

CASE

Ordinary Negligence or Medical Malpractice?

Catherine Hemming was a resident at Oak Woods Nursing Center. She suffered from dementia and diabetes, had suffered several strokes, and required 24-hour care that included assistance with grooming, eating, toileting, and bathing. The resident's condition impaired her judgment and reasoning ability and, in turn, caused cerebral atrophy (loss of brain cells). Hemming had no control over her movements in bed, and hence, was prone to sliding about without sensing her position in bed. This lack of control was addressed in the resident's plan of care in which the facility's medical director authorized the use of various physical restraints. These included bed rails to keep the resident from sliding out of the bed and a restraining vest that would keep her from moving her arms, thereby impeding her ability to slide. The physician's orders also included wedges or bumper pads that were placed on the outer edge of the mattress to keep the resident from hurting herself by striking, or by entangling herself in the rails. According to nursing home regulations, the use of restraints of this sort must be authorized by a physician to prevent overuse and excessive resident confinement.

Hemming died of asphyxiation after her neck got caught between the raised bed rails and the mattress. The day before her death, two nursing assistants had found the resident tangled in her restraining vest, gown, and bed sheets. The employees untangled her, repositioned her, and used wedges and pads so that she would not slide into the gap between the mattress and the bed rail. Whether the aides informed their supervisor about the risk remained unclear.

Denise Benton, as personal representative of Hemming's estate, sued Oak Woods. After subsequent amendments to the initial complaint, the case eventually came before the state's Supreme Court. In claiming medical malpractice, Benton's complaint made four specific allegations: (i) Oak Woods failed to ensure that Hemming was provided an accident-free environment; (ii) Oak Woods failed to train its staff to assess the dangers posed by bed rails and the risk of potential asphyxiation; (iii) Oak Woods failed to inspect the beds, bed frames, and mattress to ensure that the risk of positional asphyxia did not exist; and (iv) Oak Woods failed to take adequate corrective measures and protect Hemming after she had been found entangled in her bedding on the day before her death from asphyxiation. The complaint alleged that the facility had notice of the risk of asphyxiation through the nursing assistants, but despite this knowledge of the problem did nothing to rectify it.

Notes: 1. There are different types of bed rails that can be prescribed based on a patient's medical history and behavior. 2. This is a real court case that was initially brought before a county circuit court. All names have been disguised.

Questions

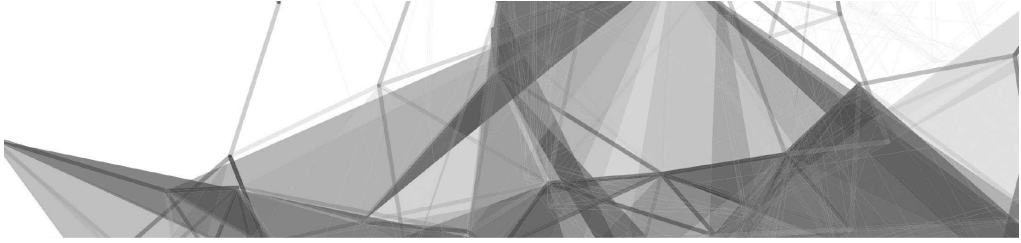
1. The state's Supreme Court did not rule uniformly on the four allegations contained in the lawsuit. One of them did not constitute either malpractice or negligence. Provide explanations and identify which allegation(s) constituted ordinary negligence, which one(s) constituted medical malpractice, and which one was neither.
2. Can any of these be held personally liable? (a) the two nursing assistants, (b) the nurse supervisor, (c) the administrator. Provide explanations.

For Further Learning

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CHAPTER 6

Regulation and Enforcement

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WHAT YOU WILL LEARN

- Long-term care is heavily regulated because the government is a major payer and the recipients of services are among the most vulnerable.
- Certified nursing facilities must demonstrate substantial compliance with the Requirements of Participation.
- The seriousness of each deficiency noted during the survey process is indicated by its severity and scope. Remedies, such as civil monetary penalties, are based on the seriousness of the deficiencies.
- Compliance with the Requirements of Participation incorporates compliance with the *Life Safety Code*®.
- Nursing homes are required to comply with the accessibility standards for the disabled under the Americans with Disabilities Act.
- The Occupational Safety and Health Administration enforces standards and recordkeeping pertaining to workplace safety.

Introduction

The health care sector has been the object of numerous regulations, for two main reasons: (1) As a major payer for health care services under Medicare, Medicaid, and other public programs, the government retains a vested interest in how the tax dollars are spent by health delivery organizations. (2) Health care in general, and long-term care (LTC) in particular, provide services to the frailest and most vulnerable individuals in society. The regulatory system is deemed obligated to ensure that residents in LTC facilities receive needed services for which they are eligible and that the services provided meet at least certain defined minimum standards of quality.

Administrative agencies have the power to enforce the rules and regulations that they formulate. The most important federal agency that regulates nursing facilities is the Centers for Medicare and Medicaid Services (CMS), an administrative agency under the U.S. Department of Health and Human Services (DHHS). The U.S. Department of Justice enforces compliance with the accessibility standards for the disabled. Workplace safety rules are enforced by the Occupational Safety and Health Administration (OSHA), an agency of the U.S. Department of Labor.

Nursing Home Oversight

Regulatory oversight for clinical care delivered in certified nursing homes is authorized under the Nursing Home Reform Act (OBRA-87). States can use their enforcement powers to take action against facilities that do not comply with federal and state standards. Regulatory oversight, however, has its weaknesses. Monitoring for compliance is based on periodic inspections and complaint investigations. Inspections of a nursing home may take place as much as 15 months apart. This sporadic system of monitoring does not ensure that compliance with standards is continuous.

Nursing home oversight begins with the licensing of facilities by each state. Second, regulations, broadly referred to as Requirements of Participation, govern federal certification for Medicare and Medicaid. Although the CMS is responsible for overseeing compliance, the actual task of monitoring for compliance is delegated to each state. The agency responsible in each state (generally the health department or department of human services, under contract from the CMS) to determine compliance with the state licensure standards and the federal Requirements of Participation is referred to as the [State Survey Agency](#). Monitoring is carried out through an annual inspection, called a [survey](#), of the facility. In addition to surveys, ad hoc complaints submitted by residents, their families, ombudsmen, or other third parties are also investigated.

Requirements of Participation

The [Requirements of Participation](#) are broad categories of federal standards. First published in the Federal Register on February 2, 1989 (54 FR 5316), the requirements for participation have been revised to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery, safety, and quality assessment. Pursuant to President Donald Trump's Executive Order 13777, the CMS had proposed rules to remove regulations that were unnecessary, obsolete, or excessively burdensome on LTC facilities (CMS, [2019](#)). It is highly doubtful that the proposed rules will be put into effect under the Biden administration.

Regulatory standards are widely regarded as minimum standards of quality for nursing facilities. Each regulatory standard is identified by a unique [F-Tag](#). A complete list of the requirements is reproduced in [Exhibit 6–1](#).

Exhibit 6–1

Requirements of Participation and F-Tags for Nursing Homes

F540	Definitions	483.12	Freedom from Abuse, Neglect, and Exploitation	483.24	Quality of Life
483.10	Resident Rights	F600	Free from Abuse and Neglect	F675	Quality of Life
F550	Resident Rights/Exercise of Rights	F602	Free from Misappropriation/Exploitation	F676	Activities of Daily Living (ADLs)/ Maintain Abilities
F551	Rights Exercised by Representative	F603	Free from Involuntary Seclusion	F677	ADL Care Provided for Dependent Residents
F552	Right to be Informed/Make Treatment Decisions	F604	Right to be Free from Physical Restraints	F678	Cardio- Pulmonary Resuscitation (CPR)
F553	Right to Participate in Planning Care	F605	Right to be Free from Chemical Restraints	F679	Activities Meet Interest/Needs of Each Resident
F554	Resident Self-Admin Meds-Clinically Appropriate	F606	Not Employ/Engage Staff with Adverse Actions	F680	Qualifications of Activity Professional
F555	Right to Choose/Be Informed of Attending Physician	F607	Develop/Implement Abuse/Neglect, etc. Policies	483.25	Quality of Care
F557	Respect, Dignity/Right to have Personal Property	F608	Reporting of Reasonable Suspicion of a Crime	F684	Quality of Care
F558	Reasonable Accommodations of Needs/Preferences	F609	Reporting of Alleged Violations	F685	Treatment/Devices to Maintain Hearing/Vision
F559	Choose/Be Notified of Room/Roommate Change	F610	Investigate/Prevent/Correct Alleged Violation	F686	Treatment/Svcs to Prevent/Heal Pressure Ulcers
F560	Right to Refuse Certain Transfers	483.15	Admission, Transfer, and Discharge	F687	Foot Care
F561	Self Determination	F620	Admissions Policy	F688	Increase/Prevent Decrease in ROM/Mobility
F562	Immediate Access to Resident	F621	Equal Practices Regardless of Payment Source	F689	Free of Accident Hazards/Supervision/Devices
F563	Right to Receive/Deny Visitors	F622	Transfer and Discharge Requirements	F690	Bowel/Bladder Incontinence, Catheter, UTI
F564	Inform of Visitation Rights/Equal Visitation Privileges	F623	Notice Requirements Before Transfer/Discharge	F691	Colostomy, Urostomy, or Ileostomy Care
F565	Resident/Family Group and Response	F624	Preparation for Safe/Orderly Transfer/Discharge	F692	Nutrition/Hydration Status Maintenance
F566	Right to Perform Facility Services or Refuse	F625	Notice of Bed Hold Policy Before/Upon Transfer	F693	Tube Feeding Management/Restore Eating Skills
F567	Protection/Management of Personal Funds	F626	Permitting Residents to Return to Facility	F694	Parenteral/IV Fluids
F568	Accounting and Records of Personal Funds	483.20	Resident Assessments	F695	Respiratory/Tracheostomy care and Suctioning
F569	Notice and Conveyance of Personal Funds	F635	Admission Physician Orders for Immediate Care	F696	Prostheses
F570	Surety Bond—Security of Personal Funds	F636	Comprehensive Assessments & Timing	F697	Pain Management
F571	Limitations on Charges to Personal Funds	F637	Comprehensive Assmt After Significant Change	F698	Dialysis
F572	Notice of Rights and Rules	F638	Quarterly Assessment At Least Every 3 Months	F699	(PHASE-3) Trauma Informed Care
F573	Right to Access/Purchase Copies of Records	F639	Maintain 15 Months of Resident Assessments	F700	Bedrails
F574	Required Notices and Contact Information	F640	Encoding/Transmitting Resident Assessment	483.30	Physician Services
F575	Required Postings	F641	Accuracy of Assessments	F710	Resident's Care Supervised by a Physician
F576	Right to Forms of Communication with Privacy	F642	Coordination/Certification of Assessment	F711	Physician Visits-Review Care/Notes/Order
F577	Right to Survey Results/Advocate Agency Info	F644	Coordination of PASARR and Assessments	F712	Physician Visits-Frequency/Timeliness/Alternate NPPs
F578	Request/Refuse/Discontinue Treatment; Formulate Adv Di	F645	PASARR Screening for MD & ID	F713	Physician for Emergency Care, Available 24 Hours
F579	Posting/Notice of Medicare/Medicaid on Admission	F646	MD/ID Significant Change Notification	F714	Physician Delegation of Tasks to NPP
F580	Notify of Changes (Injury/Decline/Room, Etc.)	483.21	Comprehensive Resident Centered Care Plan	F715	Physician Delegation to Dietitian/Therapist
F582	Medicaid/Medicare Coverage/Liability Notice	F655	Baseline Care Plan	483.35	Nursing Services
F583	Personal Privacy/Confidentiality of Records	F656	Develop/Implement Comprehensive Care Plan	F725	Sufficient Nursing Staff
F584	Safe/Clean/Comfortable/Homelike Environment	F657	Care Plan Timing and Revision	F726	Competent Nursing Staff
F585	Grievances	F658	Services Provided Meet Professional Standards	F727	RN 8 Hrs/7 days/Wk, Full Time DON
F586	Resident Contact with External Entities	F659	Qualified Persons	F728	Facility Hiring and Use of Nurse
483.40	Behavioral Health	F660	Discharge Planning Process	F729	Nurse Aide Registry Verification, Retraining
F740	Behavioral Health Services	F661	Discharge Summary	F730	Nurse Aide Perform Review—12Hr/Year In-service
F741	Sufficient/Competent Staff-Behav Health Needs	483.45	Specialized Rehabilitative Services	F731	Waiver-Licensed Nurses 24Hr/Day and RN Coverage
F742	Treatment/Svc for Mental/Psychosocial Concerns	F825	Provide/Obtain Specialized Rehab Services	F732	Posted Nurse Staffing Information
F743	No Pattern of Behavioral Difficulties Unless Unavoidable	F826	Rehab Services-Physician Order/Qualified Person		
F744	Treatment/Service for Dementia				
F745	Provision of Medically Related Social Services				
483.45	Pharmacy Services	F812	Food Procurement, Store/Prepare/ Serve-Sanitary	483.85	Compliance and Ethics Program
F755	Pharmacy Svcs/Procedures/Pharmacist/Records	F813	Personal Food Policy	F895	(PHASE-3) Compliance and Ethics Program
F756	Drug Regimen Review, Report Irregular, Act On	F814	Dispose Garbage & Refuse Properly	483.90	Physical Environment
F757	Drug Regimen is Free From Unnecessary Drugs	483.70	Administration	F906	Emergency Electrical Power System
F758	Free from Unnec Psychotropic Meds/PRN Use	F835	Administration	F907	Space and Equipment
F759	Free of Medication Error Rates of 5% or More	F836	License/Comply w/Fed/State/Local Law/Prof Std	F908	Essential Equipment, Safe Operating Condition
F760	Residents Are Free of Significant Med Errors	F837	Governing Body	F909	Resident Bed
F761	Label/Store Drugs & Biologicals	F838	Facility Assessment	F910	Resident Room
483.50	Laboratory, Radiology, and Other Diagnostic Services	F839	Staff Qualifications	F911	Bedroom Number of Residents
F770	Laboratory Services	F840	Use of Outside Resources	F912	Bedrooms Measure at Least 80 Square Ft/Resident
F771	Blood Blank and Transfusion Services	F841	Responsibilities of Medical Director	F913	Bedrooms Have Direct Access to Exit Corridor
F772	Lab Services Not Provided On-Site	F842	Resident Records—Identifiable Information	F914	Bedrooms Assure Full Visual Privacy
F773	Lab Svcs Physician Order/Notify of Results	F843	Transfer Agreement	F915	Resident Room Window
F774	Assist with Transport Arrangements to Lab Svcs	F844	Disclosure of Ownership Requirements	F916	Resident Room Floor Above Grade
F775	Lab Reports in Record-Lab Name/Address	F845	Facility closure-Administrator	F917	Resident Room Bed/Furniture/Closet
F776	Radiology/Other Diagnostic Services	F846	Facility closure	F918	Bedrooms Equipped/Near Lavatory/Toilet
F777	Radiology/Diag. Svcs Ordered/Notify Results	F847	Enter into Binding Arbitration Agreements	F919	Resident Call System
F778	Assist with Transport Arrangements to Radiology	F848	Select Arbitrator/Venue, Retention of Agreements	F920	Requirements for Dining and Activity Rooms
F779	X-Ray/Diagnostic Report in Record-Sign/Dated	F849	Hospice Services	F921	Safe/Functional/Sanitary/ Comfortable Environment
483.55	Dental Services	F850	Qualifications of Social Worker > 120 Beds	F922	Procedures to Ensure Water Availability
F790	Routine/Emergency Dental Services in SNFs	F851	Payroll Based Journal	F923	Ventilation
F791	Routine/Emergency Dental Services in NFs	483.75	Quality Assurance and Performance Improvement	F924	Corridors Have Firmly Secured Handrails
483.60	Food and Nutrition Services	F865	QAPI Program/Plan, Disclosure/Good Faith Attempt	F925	Maintains Effective Pest Control Program
F800	Provided Diet Meets Needs of Each Resident	F866	(PHASE-3) QAPI/QAA Data Collection and Monitoring	F926	Smoking Policies
F801	Qualified Dietary Staff	F867	QAPI/QAA Improvement Activities	483.95	Training Requirements
F802	Sufficient Dietary Support Personnel	F868	QAA Committee	F940	(PHASE-3) Training Requirements—General
F803	Menus Meet Res Needs/Prep in Advance/Followed	483.80	Infection Control	F941	(PHASE-3) Communication Training
F804	Nutritive Value/Appear, Palatable/Prefer Temp	F880	Infection Prevention & Control	F942	(PHASE-3) Resident's Rights Training
F805	Food in Form to Meet Individual Needs	F881	Antibiotic Stewardship Program	F943	Abuse, Neglect, and Exploitation Training
F806	Resident Allergies, Preferences and Substitutes	F882	Infection Preventionist Qualifications/Role	F944	(PHASE-3) QAPI Training
F807	Drinks Avail to Meet Needs/P references/ Hydration	F883	Influenza and Pneumococcal Immunizations	F945	(PHASE-3) Infection Control Training
F808	Therapeutic Diet Prescribed by Physician	F884	Reporting—National Health Safety Network	F946	(PHASE-3) Compliance and Ethics Training
F809	Frequency of Meals/Snacks at Bedtime	F885	Reporting—Residents, Representatives & Families	F947	Required In-Service Training for Nurse Aides
F810	Assistive Devices—Eating Equipment/Utensils	F886	COVID-19 Testing-Residents & Staff	F948	Training for Feeding Assistants
F811	Feeding Asst-Training/Supervision/Resident			F949	(PHASE-3) Behavioral Health Training

Centers for Medicare & Medicaid Services. Retrieved from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf>

Interpretive Guidelines

The CMS has formulated interpretive guidelines to clarify and explain each F-Tag in detail. The interpretive guidelines (detailed in *State Operations Manual: Guidance to Surveyors For Long-Term Care Facilities*—see the section, **For Further Learning**) also spell out the procedures the surveyors would use to verify compliance. The same guidelines are an invaluable resource for nursing home personnel to help them understand what procedures they must implement to comply with each standard. Among other details, the interpretive guidelines contain a description of each requirement, definitions of terms used in the requirements, intent of the regulation, guidance, and procedures that can be implemented by the nursing home to achieve compliance.

Survey and Enforcement

Enforcement of the standards is based on substantial compliance rather than “zero tolerance” because perfect compliance sets expectations that are unrealistic in most instances and could disqualify most nursing facilities from providing services to Medicare and Medicaid residents. The Code of Federal Regulations defines **substantial compliance** as “a level of compliance with requirements of participation such that any identified deficiencies pose no greater risk to patient health and safety than the potential for causing minimal harm.” In simple language, it means that violation of a federal standard should not endanger the health and safety of a resident. The law also emphasizes the need for continued rather than cyclical compliance with the standards. To achieve this, the facility must implement policies and procedures for continuous monitoring of the processes of care and the outcomes achieved.

The Modern Survey

Historically, monitoring the performance of thousands of nursing homes for quality assurance purposes has been difficult to carry out effectively and reliably. The surveys had focused on theoretical facility capability rather than actual performance in the delivery of care because compliance was often determined on the basis of record reviews rather than direct observation. To remedy these drawbacks, the Institute of Medicine (IOM), in a landmark report, recommended that the surveys must be resident-centered and outcome-oriented (IOM, 1986).

Over time, the survey process has continued to evolve, mainly driven by two factors. (1) Based on the recommendations of the IOM report, surveys have become resident-centered in which observations of how staff interact with the residents in the delivery of services, and interviews with residents and their representatives play an important role. In addition to the processes of care delivery, actual outcomes are given adequate weighting. (2) The advancement of computer-based information technology has been incorporated into the survey process.

The Survey Process

The purpose of surveys is to verify substantial compliance with the regulatory requirements. To observe conditions and care practices that are typically present, all surveys are unannounced, and their timing is unpredictable. If the survey team suspects substandard quality of care, the survey may be expanded to ascertain whether or not substandard quality of care exists.

The survey is based on a sample of the residents in the facility. The sample is partially selected before the survey begins, based on electronic data submitted to the State Survey Agency and the facility's history of compliance. Sampling is completed after initial observations in the facility, interviews, and limited review of medical records.

Certified facilities are required to transmit resident-specific data to the state using the Certification and Survey Provider Enhanced Reporting System (CASPER). These data produce reports on facility-level and resident-level quality measures, which can trigger areas of concern in a facility that must be investigated. The facility's Quality Assurance/Performance Improvement (QAPI) program is also reviewed. QAPI is a data-driven program that focuses on outcomes of care and quality of life (Horowitz, 2019).

At the completion of the investigation into all the requirements, the surveyors compile a Quality Assessment and Assurance (QAA) review. Regulations require the facility to have a QAA Committee. The surveyors review their findings against those of the QAA Committee to determine if the QAA Committee has been aware of issues and has made any good faith attempts to correct the issues.

At the conclusion of the survey, the survey team makes compliance decisions and assesses the scope and severity of each violation. Finally, the team conducts an exit conference with the administrator and key staff to relay areas of deficient practice.

Deficiency, Severity, and Scope

A **deficiency** is cited when a standard is not met, along with evidence for the existence of the deficiency. Deficiencies are characterized as resident centered or facility centered. Resident-centered requirements must be met for each resident, and a violation affecting any single resident is cited as a deficiency. Facility-centered violations refer to the operational systems, such as staffing, food preparation, and infection control.

Deficiencies are also evaluated in terms of their severity and scope. **Severity** is determined by the extent of actual or potential harm and negative health outcomes as a result of not meeting a standard. For example, a deficiency may have the potential to cause only minimum harm in terms of physical, mental, and/or psychosocial discomfort to a resident. On the other hand, a deficiency, unless immediately corrected, may cause serious injury, harm, or even death. **Scope** describes the number of residents who are potentially or actually affected as a result of a standard not being met. For example, there may only be an isolated case of a particular deficiency that affects a limited number of residents. On the other hand, a problem may be widespread and pervasive in the facility. As an example, the hot water supplied to all resident rooms may exceed safe temperature and may have the potential to cause serious burns. A deficiency may also represent

systemic failure that may affect a large number of residents. As an example, failure to maintain food at safe temperatures may have the potential to cause food poisoning among the resident population.

Although most nursing homes have some violations of the numerous regulations that they must comply with (the average being 6 or 7 deficiencies per inspection), a minority of nursing homes have more quality-related problems, some of which may cause harm or injury to residents. Such facilities may also demonstrate a pattern of serious problems that persist over time. The CMS has created a Special Focus Facility program to flag and more closely monitor such nursing homes.

Scope and Severity Grid

On the basis of both its severity and scope, each deficiency is assigned to one of 12 categories using a grid (**Figure 6-1**). The categories determine how serious a deficiency is. A *category A* deficiency is the least serious and is isolated in scope, whereas a *category L* deficiency is the most serious and has been evaluated to be a widespread problem that presents immediate jeopardy.

Severity	Immediate jeopardy to resident health or safety	J	K	L
	Actual harm that is not immediate jeopardy	G	H	I
	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
	No actual harm with potential for minimal harm	A	B	C
		Isolated	Pattern	Widespread
		Scope		

	Substandard quality of care
	Substantial compliance

FIGURE 6-1 Scope and severity grid for rating nursing home deficiencies.

Courtesy of Centers for Medicare and Medicaid Services.

Enforcement and Remedies

The remedies imposed by the state and federal authorities take into account the seriousness of deficiencies. The law also provides that sanctions should be imposed in a timely manner so as to minimize the time

between identification of violations and the final imposition of sanctions. For example, in situations that pose immediate jeopardy, the regulations require that either a facility is terminated from the Medicare and Medicaid programs within 23 days, or temporary management is imposed to remove the immediate jeopardy within 23 days. In addition, daily civil monetary penalties may be imposed. When immediate jeopardy does not exist, a determination is made whether the facility will be given an opportunity to correct its deficiencies before remedies are imposed. In this case, the facility must submit an acceptable plan of correction (CMS, 2018). The plan of correction describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected. The nursing home has the right to appeal any enforcement action.

Achieving Continuous Compliance

Nursing home inspections by the state can only be conducted sporadically. The onus falls on the facility to be in compliance at all time and also to demonstrate compliance at the time of the survey. Over the years, the compliance requirements have only grown, and nursing home administrators often complain of being overregulated. Yet, the regulations are not going to go away.

To achieve ongoing compliance, the nursing home must have a quality assurance system in place that includes periodic mock surveys conducted by the facility's staff or on contract by an external organization. Given staff turnover, education and training of staff must be ongoing. The QAPI program's effectiveness must be documented. Also, with the focus shifting to person-centered care, the staff must know their residents and have their care plans completed within 48 hours of admission (McKesson Corporation, 2017).

In short, the facility should be continuously monitoring its performance against the F-Tags and continuously making improvements. That is made possible by the online survey tools that are available today. The administrator has access to the CASPER reports. It is recommended that they should be downloaded and used monthly.

Nursing Home Compare and Five-Star Ratings

Results of certification surveys and other quality measures pertaining to individual facilities are public information. The CMS provides web-accessible information on all Medicare and Medicaid certified facilities in the nation through a program called *Nursing Home Compare*. The information allows consumers to compare different nursing homes when selecting a facility.

The information includes five-star quality ratings that incorporate performance on survey inspections, quality measures, and hours of care provided per resident by nursing staff. Detailed as well as summary information is provided on deficiencies noted during the three most recent inspections and complaint investigations. Quality measures include percentage of residents with pressure ulcers, urinary incontinence, etc. Information is also provided on any penalties against the nursing home. Staffing information includes the number of registered nurses (RNs), licensed practical (or vocational) nurses (LPNs/LVNs), physical therapists, and nursing assistants. Despite its value, the five-star rating system remains controversial. One recent criticism is that the Nursing Home Compare five-star ratings do not reflect quality of life (Kim et al., [2013](#)) and resident safety (Brauner et al., [2018](#)).

Life Safety Code

Modern health care facilities are designed and built to exacting building codes that are primarily concerned with people's life and safety. The CMS has not developed its own fire safety standards. Instead, the standards developed by the National Fire Protection Association (NFPA) are incorporated by reference into the Requirements of Participation.

The NFPA is an international private nonprofit organization and the world's leading advocate of fire prevention and public safety. Among the many codes and standards developed by the NFPA, the ones that apply to nursing facilities are *NFPA 101®: Life Safety Code®* (LSC) and NFPA 99 Health Care Facilities Code. The LSC establishes minimum requirements for new and existing buildings to protect their occupants from fire, smoke, and toxic fumes. It covers construction, protection, and operational features. The LSC is not applicable where CMS finds that a state has in effect a fire and safety code imposed by state law that adequately protects residents in health care facilities.

The LSC is a complex document that also incorporates by reference a number of other NFPA codes. Hence, expert consultation is almost always necessary especially when an organization is planning to undertake new construction, expansion of existing facilities, and major renovations. **Exhibit 6–2** provides an overview of the code. *Life Safety Code®* and *NFPA 101®* are registered trademarks of the National Fire Protection Association, Quincy, MA.

Exhibit 6–2 NFPA 101, Life Safety Code*

Main requirements as found in the 2009 edition of the LSC are summarized here for illustrative purposes following 10 general principles of fire protection. Sections of the LSC, and any other NFPA codes, are given in parentheses.

1. Fire-resistive construction. There are two major groups based on the construction materials: noncombustible construction (Types I and II) and combustible construction (Types III, IV, and V). Type I buildings are noncombustible, made of concrete and steel, and provide the highest degree of fire resistance. Type II buildings are also of noncombustible construction; however, the level of fire resistance is usually less than that required for Type I structures. All new construction is required to be fully sprinklered (18.1.6.1).

Corridor walls are required to be continuous from the floor to the floor or roof deck above. These walls must rise through suspended ceilings and any other types of spaces (19.3.6.2.1) and must have a minimum of ½-hour fire resistance rating (19.3.6.2.2). With the exception of doors protecting vertical openings, exits, or hazardous areas, doors protecting corridor openings must be 1¼ in. thick of solid-bonded core wood construction and must be able to resist the passage of fire for at least 20 minutes (19.3.6.3.1). Clearance between the bottom of the door and floor covering is to be no more than 1 in. (19.3.6.3.4). The doors must be capable of fully closing on their own when a force of 5 lbf (pound-force: a unit of force) is applied at the latch edge of the door (19.3.6.3.5). These requirements do not apply to doors for toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Fireplaces are not permitted in patient rooms. They can be located in areas that are separated from patient sleeping rooms by construction that has at least a 1-hour fire-resistance rating and must have an approved enclosure that can withstand a temperature of 650° F (19.5.2.3).

2. Subdivision of spaces.

Areas of refuge

Large spaces must be compartmentalized to provide fire and *smoke compartments* inside a building. Every story with more than 30 patients must have at least two smoke compartments. In addition, the size of a smoke compartment must not exceed 22,500 sq. ft. and the travel distance to the smoke compartment must not be greater than 200 ft. Required smoke barriers must have a minimum of ½-hour fire-resistance rating (19.3.7). In newer buildings, smoke barriers must have a 1-hour fire-resistance rating. An *area of refuge* is a zone of safety within a building that is protected from the effects of fire and smoke, and provides direct access to an exit. It permits a delay in egress so that people can safely wait in the area of refuge until professional help arrives.

Fire barriers

Fire barriers are used to provide enclosure, subdivision, or protection by using building materials that have fire-resistance ratings. The ratings must be determined by a nationally recognized testing agency in accordance with NFPA standards (8.3.3.2). All fire-rated products, such as doors and windows, must bear an approved label, which must be maintained in a legible condition (8.3.3.2.3). Fire doors are required to be self-closing or automatic-closing.

3. Protection of vertical openings. Vertical openings are open shafts through the floors of a building, such as stairways, elevator shafts, and laundry chutes, or they may be openings through a roof. Doors in stair enclosures must be self-closing and must normally be kept in the closed position (19.3.1.7).

4. Provision of adequate means of egress. Means of egress refers to a continuous and unobstructed way of travel that enables a person to exit a building. At least two separate exits must be accessible from every part of every story of a building (19.2.4.2). As a general rule, door openings in means of egress must be at least 32 in. in clear width (7.2.1.2.3.1). They must be 41½ in. in new construction for means of egress from

patient rooms (18.2.3.6). Dead-end corridors must not exceed 30 ft (18.2.5.2), and common path of travel to a means of egress shall not exceed 100 ft (18.2.5.3) in new construction. If locks are used, they must provide egress without having to use a key, a tool, special knowledge, or effort for opening the door (7.2.1.5.3). For stairs that are a component of the means of egress, the new code requires a width of 36 in., provided the total number of occupants (occupant load) served by the stairs is less than 50. Risers should be between 4 and 7 in. and tread depth should be 11 in. (7.2.2.2.1.2). Dimensions for existing stairs: width 36 in., risers 8 in. or less, tread depth 9 in. or more. Stairs and ramps must have handrails on both sides (7.2.2.4.1.1) and must continue for the full length of each flight of stairs (7.2.2.4.2).

5. Provision of exit marking, exit illumination, and emergency power. Exits must be clearly visible. If not, the route to every exit must be clearly marked. On signs reading EXIT, the letters must be at least 6 in. high and ¾ in. wide. Exits should also be illuminated. In addition, each exit door must have tactile signage that must comply with ICC/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities (7.10.1.3).

Emergency power supply

The facility must either have a Type 60, Class 2, Level 2 emergency power supply system or an approved emergency generator that has a fuel supply to operate for 2 hours. The room where the generator is located must be separated from the rest of the building by fire barriers having a minimum 1-hour fire-resistance rating (7.2.3.12). The equipment must be tested twice a year by approved personnel and a log of the results must be maintained (7.2.3.13). The emergency generator must kick on within 10 seconds of a power failure (7.9.1.3) and it must illuminate all means of egress. Emergency illumination must be provided for a minimum of 1½ hours (7.9.2.1).

6. Limits on the use of interior finish materials. Interior wall and ceiling finishes are classified into three categories according to their capacity to spread fire and produce smoke (10.2.3.4):

Class A: Flame spread index, 0–25; smoke developed index, 0–450

Class B: Flame spread index, 26–75; smoke developed index, 0–450

Class C: Flame spread index, 76–200; smoke developed index, 0–450

Chapter 10 of the *NFPA 101, Life Safety Code®* (2009 edition) provides details on when certain materials such as textile, vinyl, plastic, and paper may or may not be used.

Interior floor finishes are classified into two categories that indicate the flammability of the materials. These materials are classified according to their critical radiant flux rating that is determined by a test called the flooring radiant panel test:

Class I: critical radiant flux rating of at least 0.45 W/cm² (watts per square centimeter).

Class II: critical radiant flux rating of between 0.22 W/cm² and 0.44 W/cm².

Draperies, curtains, and other similar loosely hanging furnishings and decorations must be made of flame-resistant materials and shall have a permanently affixed label bearing the identification of size and material type as required by NFPA 701 (10.3.1). Upholstered furniture and mattresses must be resistant to a cigarette ignition (smoldering). Generally, a Class I rating on the materials, in accordance with NFPA 260, is permitted.

7. Fire alerting facilities. The building must be adequately protected with fire alarms and smoke alarms. Even when a facility has automatic fire detection systems to initiate the fire alarm system, no less than one manual fire alarm box must be provided (9.6.2.6).

8. Control of smoke movement. Dividing a building into compartments helps limit the spread of fire and restrict the movement of smoke. Walls and partitions serve as smoke barriers when all openings between floors and ceilings through which smoke can travel are appropriately sealed with smoke-resistant materials to create smoke compartmentation.

9. Protection of hazardous areas. Some of the main hazardous areas in health care facilities are boiler rooms; fuel-fired heater rooms; central laundries; repair shops; paint shops; soiled linen rooms; trash collection rooms; and laboratories employing flammable, combustible, or hazardous materials (19.3.2.1.5). Hazardous areas must be protected with either an automatic extinguishing system or a fire barrier having a 1-hour fire resistance rating (19.3.2.1). Protection or separation is not required in areas where domestic cooking equipment is used for food warming or limited cooking (19.3.2.5.2). Commercial cooking equipment that produces grease-laden vapors must be protected by fire-extinguishing equipment (10.1.1, NFPA 96). An automatic fire-extinguishing system should be installed as primary protection and portable fire extinguishers should be provided as secondary backup (10.2.1, NFPA 96).

10. Operational features.

Fire safety plan and fire drills

The administration must develop a plan for the protection of all persons in the event of fire. The plan must include evacuation to areas of refuge within the building and evacuation from the building when necessary. Written copies of the plan must be made available to all supervisory personnel. Periodic instruction and review of duties must be provided to all employees. Fire drills must be conducted at least quarterly on all shifts. The drills must include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that coded announcements instead of audible alarms are permissible when drills are conducted between 9:00 p.m. and 6:00 a.m. Employees must also receive instruction in life safety procedures and devices (19.7.1).

Smoking

“No smoking” signs must be posted and smoking prohibited in enclosed spaces where flammable liquids, combustible gases, or oxygen are used or stored. Patients classified as “not responsible” must not be allowed to smoke except when the patient is under direct supervision by a staff member. Noncombustible ashtrays and metal containers with self-closing covers into which ashtrays can be emptied must be available in all areas where smoking is permitted (19.7.4).

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One lingering issue with the enforcement of LSC is waivers granted to older facilities. The law provides for waivers that may be granted to exempt older facilities from having to comply with current LSC standards in areas where full compliance would present unreasonable hardship. However, as a condition of participation in Medicare and Medicaid, all nursing homes have been required to have automatic sprinkler systems as of August 2013. This mandate came after multiple deaths had been related to nursing home fires.

In 2016, the CMS relaxed two main requirements of the LSC. (1) Fireplaces are permitted in smoke compartments without a 1-hour fire wall rating, which makes a facility more home-like for residents. (2) Cooking facilities may have an opening to the hallway corridor. This permits residents to cook food if they so choose and enables facility staff to provide supervision of the residents (CMS, [2016](#)).

The survey and enforcement process described previously includes verification of compliance with the LSC. Qualified fire safety inspectors who have received training from the CMS conduct these surveys. Deficiencies are cited as warranted.

General Accessibility Standards

Accessibility for disabled people is required under the Americans with Disabilities Act (ADA) of 1990. The legislation is a general civil rights law designed to protect the rights of handicapped people in all aspects of their lives, including employment, recreation, and their use of buildings and facilities, including nursing homes. The ADA also covers access to transportation and communication. Under the law, a *disability* can be a physical or mental impairment that substantially limits one or more major life activities.

Title III of the ADA prohibits discrimination on the basis of disability. The law requires that certain adaptations, whenever necessary, be made to provide access by the disabled. For example, no architectural barriers should prevent access to the building from sidewalks and parking areas. Adequate parking spaces must be reserved for the handicapped. Access ramps must be installed. At least one accessible entrance to the building must be protected from the weather by canopy or roof overhang. Such entrances are also required to incorporate a passenger loading zone.

Inside the building, barriers to accessibility should also be removed. Examples of things a facility can do to make its services accessible include positioning telephones, water coolers, and vending machines so that they are easy to use by people in wheelchairs; installing elevator control buttons with raised markings; using flashing fire alarm lights; installing raised toilet seats and grab bars in the bathrooms and allowing enough room to maneuver a wheelchair; and avoiding high-pile carpeting that makes steering a wheelchair difficult. All building features and equipment must be maintained in operable working condition except for temporary interruptions in services or access due to maintenance or repairs.

At least 50% of the resident rooms and toilets in LTC facilities must be designed and constructed to be accessible. In addition, all public use and common use areas must be accessible and usable by the disabled. In facilities or units of a facility where treatments and rehabilitation of conditions that affect mobility are rendered, all resident rooms and toilets must be accessible.

The ADA also requires facilities to provide auxiliary aids for effective communication. Such aids include interpreters, note takers, telecommunication and sound amplifying devices suited for the deaf, audio recordings, videotext displays, and large-print books and publications. However, the facility is not required to provide personal devices and services such as eyeglasses and hearing aids. Any segregation of residents within the facility should be based on clinical factors, not on a person's disability, because segregation based solely on disability is discriminatory. Another law, the Fair Housing Amendments Act of 1988, prohibits disability-based discrimination in public and private living quarters.

OSHA and Workplace Safety

OSHA was created under the Occupational Safety and Health Act of 1970. OSHA's primary mission is to ensure the safety and health of America's employees by setting and enforcing standards and encouraging continual improvement in workplace safety and health.

Thanks to new technology and improvement in workplace practices, worker injuries in nursing homes have been decreasing. For example, between 2012 and 2015, the incidence rate for nursing assistants (NAs) decreased from 426 per 10,000 workers to 328 per 10,000 workers (Bureau of Labor Statistics, [2013](#), [2016](#)). Nevertheless, NAs incur high rates of injury. These workers are responsible for completing the most physically demanding tasks, including lifting and moving of residents. Because of the physical demands and emotional strain of their work, combined with the significant staffing shortages, NAs are vulnerable not only to workplace injuries, but also to job dissatisfaction and turnover intent. Empirical evidence suggests that NAs who sustain job-related injuries have lower levels of job satisfaction, increased turnover intentions, and a negative opinion of the nursing home. Injury rates are correlated with employee ratings of injury prevention training, supervisor support, and employee engagement (opposite of burnout) (McCaughey et al., [2014](#)).

Nursing homes are legally required to comply with OSHA standards. However, OSHA also provides education and consultation, particularly to small- and medium-size employers such as nursing homes. For example, OSHA has developed guidelines to help reduce certain types of injuries. OSHA's educational and consultation services are available free of charge and are independent of the agency's regulatory role.

OSHA Standards and Enforcement

OSHA's general industry standards (29 CFR Part 1910) are quite exhaustive and result in the most frequently cited violations in nursing homes. These standards can be accessed at the OSHA website (<https://www.osha.gov>). Nursing Home eTool is another web-based tool developed by OSHA that provides standards and recommendations to assist employers and employees identify and control hazards. Topics covered under Nursing Home eTool include bloodborne pathogens, ergonomics, dietary, laundry, maintenance, the nurse's station, pharmacy, tuberculosis, housekeeping, whirlpool/shower, and workplace violence (see **For Further Learning**).

OSHA conducts its own independent inspections and issues citations for violations. It may assess monetary penalties and seek abatement of any hazards. In extreme cases, the matter may be referred to the Department of Justice for criminal investigation.

OSHA Recordkeeping Requirements

The nursing home should implement a policy that all workplace injuries, no matter how small, be reported on an incident report (*OSHA's Form 301-Injury and Illness Incident Report*). An injury or illness is considered work related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition.

The facility is required to maintain a log (OSHA Form 300) of all recordable injuries. In nursing facilities, the most common recordable injuries include those that require medical treatment beyond first aid, those that result in days away from work, those that require restricted work activity or job transfer, and those sustained from needlesticks and cuts from objects considered contaminated.

At the end of the calendar year, the facility must complete a summary of recordable incidents (OSHA Form 300A). This form must be posted in a visible location where the employees can see it and become aware of the injuries and illnesses occurring in their workplace. Each February through April, the employer must post the summary of the injuries and illnesses recorded the previous year. All records must be kept on file for 5 years following the year to which they pertain.

Terminology for Review

deficiency

F-Tag

Requirements of Participation

scope

severity

survey

substantial compliance

State Survey Agency

For Further Thought

1. What attitudes do you think nursing home administrators ought to have toward regulations that are often regarded as onerous?
2. As a nursing facility administrator, what would you do to ensure that your organization is in compliance with the various regulatory standards?

CASE

Conflict of Interest or Not?

Bestcare Nursing and Rehabilitation Center is a 290-bed, dually certified, four-story facility located in a large city (the average size of a nursing home in the United States is 108 beds). The facility operates at 92% occupancy, and only 15% of the residents have a private source of payment. In the past, the facility has had quality of care issues in the areas of diets and nutrition; practices in food preparation that may lead to contamination that could cause sickness; proper storage and dispensing of medications; and inadequate number, variety, and quality of recreational programs. Mona Sinclair was the RN leading the survey team for Bestcare's annual survey. Mona used to be an RN employed by Bestcare, but she left voluntarily 3 years ago for family reasons. Jonathan Husky, the dietitian on the survey team, was a consultant on contract for Bestcare, but last year he did not renew his consultancy contract. An LPN on the survey team was discharged from Bestcare approximately 2½ years ago for excessive absenteeism. Another member of the survey team had her mother as a resident in Bestcare, but she moved her mother to a different facility 6 months ago.

Questions

1. Do the four individuals identified in the case have a conflict of interest? Explain. (To answer this question, you must review Section 7202 of the *State Operations Manual, Chapter 7—Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities*.
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf>.)
2. If conflict of interest is believed to exist, what should the nursing home administrator do?

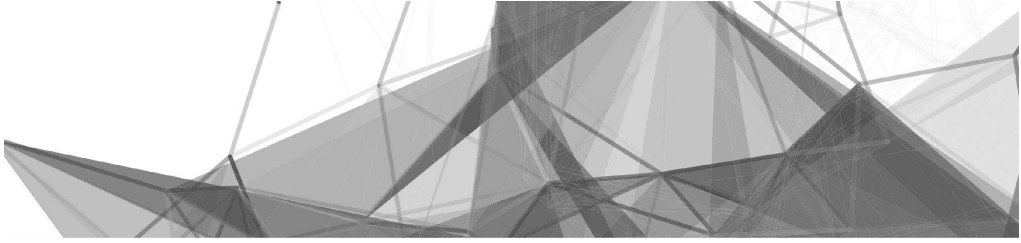
For Further Learning

OSHA, Nursing Home eTool, <https://www.osha.gov/SLTC/etools/nursinghome/index.html>.

State Operations Manual, Appendix PP: Guidance to Surveyors for Long-Term Care Facilities,
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>.

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CHAPTER 7

Financing and Reimbursement

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WHAT YOU WILL LEARN

- Financing is the mechanism by which nursing home clients pay for the services. Payers determine the method and amount of reimbursement, except for private-pay rates that are established by the facility.
- Private financing includes out-of-pocket payment for services and coverage under private long-term care insurance.
- Medicare is a federal program that is uniform across the United States. Services for eligible people in a Medicare-certified skilled nursing facility are covered under Part A.
- Medicare Part B does not pay for skilled nursing care, but certain services are covered while the resident is in a long-term care facility. Beneficiaries enrolled in Part C obtain all health care services, including skilled nursing care, through a managed care plan.
- Medicare reimburses certified nursing homes according to a Patient Driven Payment Model.
- Medicaid is a welfare program for the indigent. Unlike Medicare, the program varies from state to state. Medicaid is the largest payer for nursing home services.
- The Program of All-Inclusive Care for the Elderly aims to provide long-term care in community settings to those who risk being placed in a nursing home.
- Managed care organizations are active players in Medicaid and Medicare. Reimbursement is based on capitation.
- Collaborations between nursing homes and other health care organizations can provide new sources of revenue.
- Fraud and abuse are prosecutable under the antikickback statute and the False Claims Act.

Introduction

Financing and reimbursement are critical for sustaining internal facility operations. Higher Medicaid reimbursement may provide better resources to nursing facilities to increase their capacity to deliver services. Indeed, it may improve quality of care in nursing homes (Xu & Intrator, 2020).

Financing is the means by which residents receiving services in nursing facilities pay for those services. The national median costs of long-term care (LTC) services in the United States are furnished in **Table 7-1**. The average costs vary considerably among states.

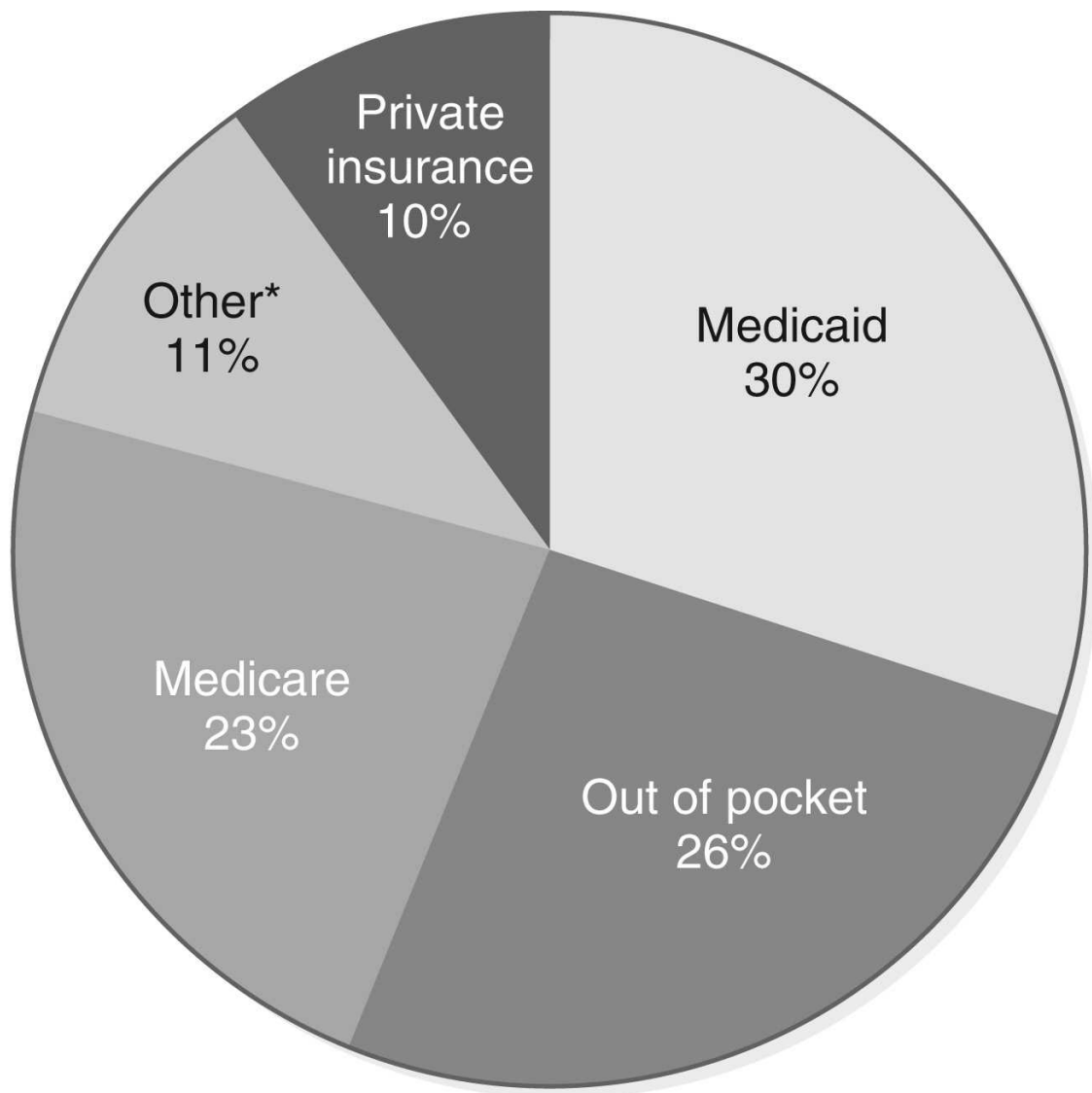
TABLE 7-1 National Daily Median Costs of LTC Services, 2019

Type of service	Cost
Nursing home (semi-private room)	\$247*
Nursing home (private room)	\$280
Assisted living facility	\$133
Home health aide	\$144
Adult day care	\$75

* Four times the national average in Alaska, and 1½ times in New York and Hawaii.

Data from Genworth cost of care survey. (2019). <https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf>.

Few people can afford such costs if they have to pay with their own funds. Indeed, trends show that people's ability to finance the cost of nursing home care has continued to decline over time. Individual LTC insurance has not been a priority for most people because premiums have been unaffordable. Hence, public financing, mainly Medicaid and Medicare, remains the predominant source of financing nursing home care, as illustrated in **Figure 7-1**.



Total expenditures: \$168.5 billion

*VA, state and local programs, other private revenues

FIGURE 7-1 Sources of payment for nursing home care, 2018.

Data from Centers for Medicare and Medicaid Services (CMS). 2019c. National health expenditure data. NHE tables (historical).

Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>. Accessed July 2020.

Reimbursement covers two aspects of financing: (1) the method used by a payer, such as Medicare or Medicaid, to determine the amount of payment and (2) the amount that is actually paid to a facility on behalf of a resident. The Centers for Medicare and Medicaid Services (CMS) establishes Medicare reimbursement rates, whereas each state sets its own rates for Medicaid payment. The actual rate-setting methodologies are quite complex.

Much of the information covered in this chapter is of value to more than just nursing home corporations and administrators. Social workers and resident accounts managers should also have a clear understanding of financing so they can furnish advice and assistance to current and prospective residents, families, and the community.

Private Financing

Of the two main types of private financing, direct out-of-pocket payment is the most common. Private LTC insurance remains a much smaller source of financing see [Figure 7–1](#).

Out-of-Pocket Financing

For some people, cash savings, stocks, bonds, or annuities may provide adequate income to pay for nursing home care. In most instances, however, assets may have to be sold to generate cash. In some situations, reverse mortgaging on a home could provide cash against the built-up equity in a home without having to sell the property. The caveat is that the owner must continue to live in the home. Hence, reverse mortgaging is an option for in-home medical and assistive services. It can also be used to purchase private LTC insurance.

Private-Pay Rate Setting

LTC facilities are free to establish their own private-pay rates or prices. For noncertified beds, a facility may label its services as “skilled care,” “intermediate care,” “personal care,” or “residential care,” which allows a tiered structure of prices depending on the level of care. Because of certification rules, however, when private-pay residents are placed in a section of the facility that is certified as SNF (skilled nursing facility) or NF (nursing facility), administrators must be careful when setting private-pay rates. They risk having the Medicare and Medicaid rates reduced if the all-inclusive private-pay rate happens to be lower than what the public programs are paying.

Even though private-pay rates may be set at any level, they are governed by market forces and competition. Additional factors such as amenities that a facility offers and a reputation for providing high-quality care can also be taken into account. Residents and their families who have sufficient private funds available are often willing to pay extra for better quality.

When private-pay residents are admitted to Medicare/Medicaid certified beds, they cannot be provided better quantity or quality of services for clinical needs that are similar to those of residents on public assistance. For example, certified beds occupied by private-pay residents cannot have extra staffing or extra amenities such as a more exclusive menu because these extra services would be construed as discriminatory against residents on public assistance. For these reasons, many facilities have a separate noncertified section to care for private-pay residents because the facility can then deliver extras and charge for them.

The general industry practice is to charge a basic room-and-board rate, which includes nursing care, meals, social services, activities, housekeeping, and maintenance services. Charges are then added for ancillaries such as pharmaceuticals; supplies such as catheters, dressings, and incontinence pads; and services such as oxygen therapy or rehabilitation therapy.

Private Insurance

General health insurance plans sponsored by employers may have limited coverage for LTC services. Some retirees may also have similar limited coverage available under their company's health insurance plan for retirees. In most instances, however, people have to buy their own LTC policies sold by some private insurance companies.

When admitting residents with private insurance coverage, the facility's business office manager should carefully review the coverage, such as the type of services covered by the insurance plan. Plans also have restrictions, such as length of coverage, amount the plan will pay each day, coverage for ancillaries such as supplies and therapies, and an elimination or waiting period during which insurance does not pay.

Medicare

Medicare—also called Title 18 of the Social Security Act—is a federal program that is uniform across the United States. It finances medical care for three categories of people: (1) persons who are age 65 and over, (2) disabled individuals who are entitled to Social Security benefits, and (3) people who have end-stage renal disease. The program is operated under the administrative oversight of the CMS. Medicare has limited benefits for skilled nursing care under Part A. Medicare does not pay for other levels of services, such as care in an assisted living facility.

Part A of Medicare

Part A—also called Hospital Insurance (HI)—includes hospital inpatient benefits as well as care in a facility certified as a SNF. Part A also covers home health services for intermittent or part-time skilled nursing care delivered through a Medicare-certified home health agency and hospice care through a Medicare-certified hospice.

SNF Coverage in a Benefit Period

The maximum coverage in a SNF-certified facility is for 100 days. Few people, however, qualify for the full 100 days of coverage. Medicare benefit for SNF is a postacute program; it requires prior hospitalization for at least 3 consecutive nights, not counting the day of discharge. The patient must be in need of skilled nursing care as certified by a physician and be admitted to a SNF within 30 days after discharge from the hospital.

Inpatient benefits in a hospital or SNF fall within a benefit period. A **benefit period** begins when a patient is hospitalized for a particular spell of illness and ends when the beneficiary has not received care in a hospital or SNF for 60 consecutive days for that particular spell of illness. The following rules apply to a benefit period:

- A spell of illness, that is, a principal condition, for which a patient is hospitalized begins a benefit period. Different spells of illness can trigger new benefit periods.
- If a spell of illness for which a patient is hospitalized subsequently requires skilled nursing care in a SNF, the benefit period continues.
- A benefit period associated with a given spell of illness ends when the patient remains out of the hospital or SNF for 60 consecutive days.
- Readmission to a hospital or SNF within the 60 days is considered the same benefit period.
- The number of benefit periods a patient can have is unlimited.

Medicare rules on inpatient SNF care are quite complex. For details, refer to the Medicare Benefit Policy Manual (see web link in **For Further Learning** section).

Part A Deductibles and Copayments

A **deductible** is the amount the patient must first pay when a benefit period begins. Medicare starts paying only after the patient has paid the required deductible (\$1,484 per benefit period in 2021). In almost all instances, however, the deductible requirement is met during the 3-day hospitalization before a patient comes to the SNF.

A **copayment** is the amount an insured patient must pay out of pocket each time a particular type of service is used. Medicare fully pays for just the first 20 days of SNF care in a benefit period. From days 21 through 100, the SNF resident must pay a copayment (\$185.50 per day in 2021). Beyond the 100 days, the resident must rely on Medicaid (discussed later) or private funds.

Part A Services: Skilled Nursing Care

The definition of skilled nursing care, as it applies to SNFs under the Medicare program, includes subacute care services and also skilled rehabilitation services. The specific criteria are summarized below:

- The services must be ordered by a physician.
- The care furnished must be for treating conditions for which the resident was hospitalized or for conditions related to the one for which the resident was hospitalized.
- Skilled nursing services must be needed and must be provided 7 days a week, except for skilled rehabilitation, which must be needed and provided 5 days a week.
- The services must require the skills of, and must be furnished directly by or under the supervision of, registered nurses (RNs), licensed practical (or vocational) nurses (LPNs or LVNs), physical therapists,

occupational therapists, or speech pathologists. Under their supervision, certain services can be delivered by paraprofessionals.

- Incidental services, such as, lodging and meals, social services, prescription medications, and nursing supplies, are part of the care furnished under Part A.

Some examples of skilled nursing services include intravenous or intramuscular injections, enteral feeding (delivery of liquid feedings through a tube), nasopharyngeal aspiration (suctioning through the nose and pharynx), tracheostomy (direct opening into the windpipe for breathing), dressings for the treatment of infections, treatment of pressure ulcers, and oxygen therapy. Examples of skilled rehabilitation include assessment of rehabilitation needs and restorative potential (probability of functional improvement), therapeutic exercises or activities, gait training, range-of-motion exercises, ultrasound treatment, whirlpool treatments, services needed for the restoration of speech or hearing, and therapy for swallowing disorders. As a general rule, preventing further deterioration is a sufficient justification for furnishing skilled care even when recovery or improvement is not possible. If an SNF contracts with a rehabilitation company to provide therapeutic services to its residents, the service company cannot bill Medicare directly for Part A services. The facility is responsible for paying that company.

Part B of Medicare

Part B of Medicare—also called Supplementary Medical Insurance (SMI)—covers outpatient services. In general, these services include physician services, X-rays, laboratory tests, and other services listed in [Exhibit 7-1](#), even when a resident is in an LTC institution. These services are generally delivered by providers other than SNFs, and the providers bill Medicare directly for the services.

Exhibit 7-1 Main Benefits and Noncovered Services Under Medicare Part B

Main Covered Benefits

Physician services
Emergency department services
Outpatient surgery
Diagnostic tests and laboratory services
Outpatient physical therapy, occupational therapy, and speech therapy
Outpatient mental health services
Limited home health care under certain conditions
Ambulance
Renal dialysis
Artificial limbs and braces
Blood transfusions and blood components
Medical equipment and supplies
Annual physical exam
Certain preventive services, such as mammography, cardiovascular screening, Pap smears, colorectal cancer screening, depression screening, diabetes screening, glaucoma tests, and vaccinations.

Noncovered Services: Dental services, hearing aids, and eyeglasses.

After the patient has met the Part B deductible, Medicare pays 80% of the cost. Courtesy of Centers for Medicare and Medicaid Services.

Medicare Part B requires voluntary enrollment and payment of a monthly premium. Unlike Part A, Part B benefits are based on an annual basis, not on a benefit period basis. Hence, annual deductibles and copayments apply. In 2021, the deductible was \$203. Copayments are paid according to an [80:20 coinsurance](#), meaning that after the deductible has been paid, Medicare pays 80% of the costs, and the beneficiary pays the remaining 20%. Copayments typically apply to physician services, outpatient rehabilitation therapies, and durable medical equipment (CMS, [2020](#)).

Part C of Medicare

Medicare offers its beneficiaries the choice to either remain in the original Medicare fee-for-service program or enroll in Part C, which is also called [Medicare Advantage \(MA\)](#). A beneficiary who chooses to enroll in MA must receive all Medicare benefits through a managed care organization (MCO) that has contracted with Medicare. The MA plan in turn contracts with various providers to deliver services to those enrolled in the plan. Hence, the MCO will pay for LTC only in a nursing home with which it has established a contract.

Part D of Medicare

Part D is the prescription drug program that is available to anyone, regardless of income, who has coverage under Part A or Part B. Like Part B, the program is voluntary because it requires payment of a monthly premium. For Medicare beneficiaries receiving services in a SNF, prescription drugs are generally covered under Part A. Medicaid beneficiaries receive drugs under the state's Medicaid program, generally without any cost to the beneficiary.

Medicare Reimbursement for SNFs

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of care. Unlike a retrospective payment system, the PPS is not based on the costs an SNF incurs in delivering services. Rather, it is based on a facility's case mix. PPS reimbursement provides for a per diem rate based on a facility's **case mix**, which is the aggregate level of clinical severity (acuity level) of residents in a facility. The payment is all inclusive, which means that it is a **bundled rate** that includes payment for all SNF and ancillary services (room and board, medications, nursing supplies, etc.) that a Medicare recipient is eligible to receive under the program.

Previously, the PPS was driven by Resource Utilization Groups (RUGs), which was a system to classify residents by their levels of resource use. It was found that SNF providers could “game” the RUG-based PPS design by delivering excessive rehabilitation therapy services, many of which were determined to be of questionable value. RUG-based payments had also incentivized longer stays in the facility. Hence, the payment mechanism was redesigned and implemented in October 2019.

The new payment system is called **Patient Driven Payment Model (PDPM)** because it incorporates many aspects of a resident's condition in establishing payments. The new payment methodology puts more emphasis on nontherapy ancillary products, such as drugs, ventilator devices, and the like. Thus, resource allocation is shifted to medically complex residents. Hence, six components—nursing, physical therapy (PT), occupational therapy (OT), speech–language pathology, nontherapy ancillaries (NTA), and room and board—are summed up to establish the daily rate (MedPAC, 2020).

Four main steps are involved in the reimbursement setting methodology, as illustrated in **Figure 7–2**:

1. Base rates are established for each of the six components according to urban and rural locations. The base rates for 2020 are shown in **Table 7–2**.
2. The base rates are adjusted for geographic variations in wages.
3. Except for the room and board component, which is not affected by a resident's need for care, each of the other five components are adjusted for case mix by using each component's case mix factor. Case mix factors are derived according to the clinical needs of residents. For example, the primary reason for treatment and functional status are used to adjust payments for physical and occupational therapy, while a resident's comorbidities and special treatments adjust the payments for NTA services (MedPAC, 2020).
4. PT, OT, and NTA components are adjusted for the day of stay, with higher payments for the resident's earlier days of stay. For example, payments for NTA services during first 3 days are three times those for NTA services during later days. Payments for PT and OT services are the same for the first 20 days of a stay, and then slowly decrease for later days (MedPAC, 2020).

TABLE 7-2 Daily Base Rates for 2020

	SNFs in Urban Areas	SNFs in Rural Areas
Nursing component base rate	\$105.92	\$101.20
Physical therapy	\$60.75	\$69.25
Occupational therapy	\$56.55	\$63.60
Speech-language pathology services	\$22.68	\$28.57
Nontherapy ancillary services	\$79.91	\$76.34
Non-case mix (room and board)	\$94.84	\$96.59

MedPAC. 2019. Skilled nursing facility services payment system. Revised October 2019. http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_snf_final_sec.pdf.

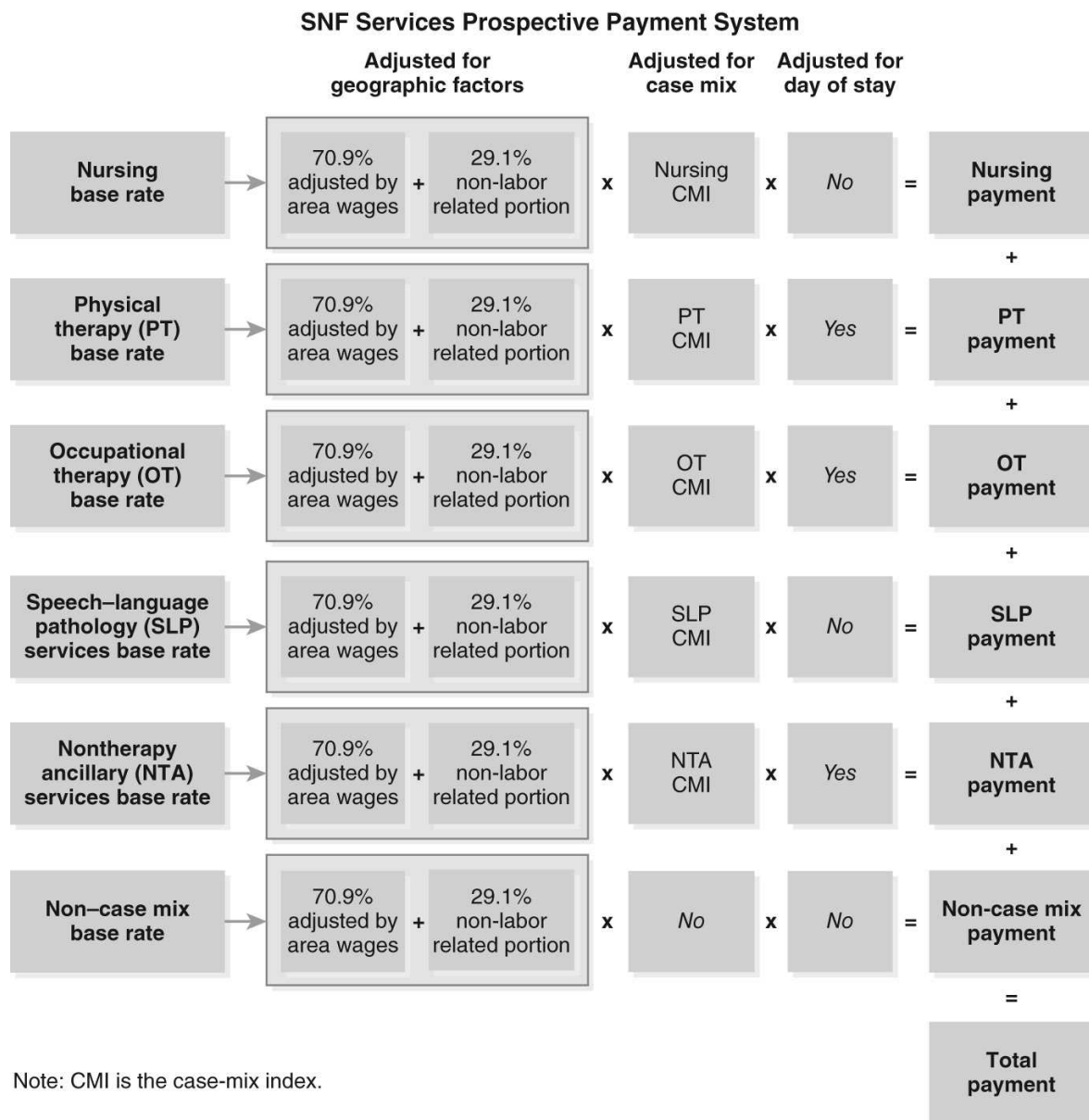


FIGURE 7-2 SNF services prospective payment system.

MedPAC. 2019. Skilled nursing facility services payment system. http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_snf_final_sec.pdf.

Role of Resident Assessment

Resident assessment is used to determine the case mix. The Minimum Data Set (MDS)¹ is a standardized assessment instrument (called resident assessment instrument—RAI) that is federally mandated to be used by all certified nursing homes. The MDS contains items that measure physical, psychological, and psychosocial functioning. Thus, the MDS provides a multidimensional view of a resident's functional capacities and clinical needs. Data collected through the MDS are used to classify Medicare residents into the PDPM components discussed previously. States may also use MDS data to determine Medicaid reimbursement.

The assessment process should involve various disciplines such as nursing, dietary, social work, rehabilitation, and activities. A trained RN in the facility must coordinate and sign the MDS once it is complete. Federal regulations require electronic transmission of the MDS to the CMS. The MDS data can be collected, maintained, and transmitted using the Resident Assessment Validation and Entry System (jRAVEN), a free software program developed by the CMS.

Medicare Value-Based Purchasing

In general, **value-based purchasing (VBP)** refers to linking payments to resident outcomes to redistribute payments from low-quality to high-quality nursing facilities. The current VBP program for SNFs mandates

financial penalties for **facilities that have** high 30-day readmissions back to hospitals and incentives for those facilities that do not. The CMS has developed an SNF 30-Day All-Cause Readmission Measure (SNFRM), which assesses SNF residents' hospital readmissions within 30 days of being discharged from a prior hospital stay. Based on their readmission rates, SNFs can earn bonuses or be penalized up to 2% of their Part A payments. The program is intended to incentivize quality improvement in nursing facilities. Early results show that for-profit SNFs that are small size, have low nurse staffing, and are located in low-income areas are more likely to incur penalties (Qi, [2020](#)). Research further confirms that SNFs serving vulnerable populations, such as blacks, were less likely to receive bonus payments and more likely to be penalized (Hefelee et al., [2019](#)). Penalties likely create a vicious cycle in which penalized facilities may end up with even fewer resources to improve quality with further negative effects for vulnerable populations.

1 MDS 3.0 is in current use and is referenced in the **For Further Learning** section.

Medicaid

Medicaid—also called Title 19 of the Social Security Act—is a jointly funded federal–state health insurance program for the indigent. People with very low incomes and those with few or no assets generally qualify. The eligibility criteria vary from state to state. However, states are also required to follow federal guidelines. Under the guidelines, Medicaid must cover people receiving Supplemental Security Income (SSI). It includes many of the elderly, the blind, and the disabled.

People who have excess income or assets to qualify for Medicaid must [spend down](#) to Medicaid eligibility thresholds by incurring medical expenses to offset their excess income and assets. The resource limits for spend down, meaning the amount of funds a person may keep in order to apply for Medicaid, generally vary between \$2,000 and \$3,000. This provision is particularly significant for nursing facilities because it allows middle-class elderly to qualify for Medicaid once they have exhausted their personal assets. An estimated one-fourth of the residents who are initially admitted to a nursing facility on a private-pay basis eventually switch over to Medicaid after their personal assets have been exhausted. If individuals who qualify for Medicaid receive income from any sources, they are required to apply most of that income toward nursing home expenses; Medicaid will then pay the rest. Under federal law, it is a felony to shelter or distribute personal assets with the intention of making oneself eligible for Medicaid coverage.

The spend-down provision of Medicaid was modified under the Medicare Catastrophic Coverage Act (MCCA) of 1988 to protect the assets of an institutionalized person's spouse if the spouse must remain at home. The law was designed to prevent the impoverishment of the spouse remaining in the community. When one spouse enters a nursing home, the spouse at home is allowed to keep a maximum amount of resources, including a basic monthly allowance for living expenses.

Unlike Medicare, Medicaid has no limit on the number of days a person may stay in a nursing facility. Hence, Medicaid pays the largest share of national expenditures for nursing home services (see [Figure 7–1](#)). Many states also periodically (generally once a year) pay for eyeglasses, hearing aids, dental care, and other needed services. Also, states have been expanding coverage of community-based LTC services under the home- and community-based services (HCBS) waiver program. The waiver program allows people to receive community-based LTC services.

Determination of reimbursement rates for nursing facilities is left up to each state. States employ diverse methods and policies to determine the per diem rates, and the amount of reimbursement can vary greatly from one state to another. Many states have adopted the PDPM or a modified method to determine reimbursement. Medicaid reimbursement is far less than what people pay privately or what Medicare pays. As a result, facilities heavily reliant on Medicaid are financially vulnerable and might not have resources for adequate staffing, training, or quality improvement (Hefelee et al., 2019).

Program of All- Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is available in most states. PACE focuses on frail elderly who have already been certified for nursing home placement under Medicare or Medicaid. It exclusively targets adults who are age 55 years and older. The main aim of the program is to provide LTC services in community settings to people who otherwise risk being placed in nursing homes. To reduce costs, PACE employs three main strategies:

- It offers the full spectrum of acute care and LTC services. For example, PACE services can include adult day care, home health care, medical care from specialists, rehabilitation, laboratory and other diagnostic services, hospitalization, and nursing home care.
- Care is integrated by an interdisciplinary team of professionals, such as physicians, nurses, rehabilitation therapists, social workers, personal care attendants, and dietitians.
- Financing is integrated through Medicare, Medicaid, and private funds. PACE organizations are paid a fixed monthly payment per enrollee (capitation). The reimbursement amount remains fixed during the contract year regardless of the services an enrollee may need.

PACE has no deductibles or copayments, which is an incentive for qualified individuals to participate. Studies have consistently shown that the rates of hospitalization and readmission are substantially lower for PACE enrollees than for comparable populations (Segelman et al., [2014](#)). Consequently, there are substantial cost savings over alternative models of LTC delivery (Wieland et al., [2013](#)).

Partnerships with Other Organizations

The growing health care burden for an aging population will, by necessity, make public financing more stringent. It means that nursing home administrators (NHAs) will have to find innovative ways to increase revenues from private sources, something that will increasingly involve other organizations for financing and delivery of care.

Managed Care Financing

MCOs are private organizations, but they contract with Medicare and Medicaid to deliver health care to beneficiaries covered by these public programs. The key to understanding the general concept of managed care financing is the delivery of all needed services to enrolled beneficiaries in exchange for a fixed monthly payment agreed to in advance. The fixed monthly payment per beneficiary that covers all services is called [capitation](#). The nursing facility must manage the cost of providing the services within the capitation amount received. Capitation is designed to control inappropriate use of services and to control the escalating costs of health care delivery.

Another type of managed care contract is for Medicare beneficiaries who are enrolled in MA (Part C) plans, discussed previously. In this case, the MCO bears the financial risk and, therefore, has an incentive to seek high-value clinical care. Contracted providers bill the MCO directly instead of submitted claims to the CMS (McGarry & Grabowski, [2019](#)).

Institutional Special Needs Plans (I-SNPs) are a specialized form of MA that is limited to Medicare beneficiaries who are long-term (≥90 days) nursing home residents or are certified as needing nursing home-level care. Some I-SNP plans waive the 3-day prior hospitalization that is otherwise required before admission to an SNF. Beneficiaries enrolled in these plans incur lower rates of hospitalizations and emergency department use (McGarry & Grabowski, [2019](#)).

A nursing facility could have contracts with several different MCOs to provide services to clients covered under private or public financial arrangements. NHAs are faced with both an opportunity and a challenge to meet higher demands for inpatient clinical care. They must develop contracting and negotiating skills to win MCO contracts, skills in costing and pricing skilled care and subacute services, and skills to manage clinical services that have become increasingly complex.

Partnerships with Hospitals and Accountable Care Organizations

The changing health care delivery landscape calls for collaboration between physicians, hospitals, and nursing facilities capable of providing postacute services. The Affordable Care Act requires reduction in reimbursement to hospitals that incur excessive Medicare readmissions for selected conditions (MedPAC, [2019](#)). A similar burden is placed on LTC facilities under Medicare value-based purchasing, discussed previously. Because of these changes, hospitals are narrowing the network of SNFs to which they discharge patients for postacute care (Chess et al., [2018](#)).

The emergence of [accountable care organizations \(ACOs\)](#) has placed increased emphasis on forming partnerships among health care delivery organizations. In an ACO, a group of health care providers work collaboratively to take responsibility for improving the overall health status, care efficiency, and satisfaction with care. Medicare's Bundled Payment for Care Improvement program provides for a single payment per episode (such as total joint replacement or treatment for complications of heart failure) to an ACO for care that must be integrated across settings. This program has resulted in cost savings to Medicare. It also demonstrates the potential of aligning incentives across providers (Hostetter & Kline, [2018](#)). Hence, it provides opportunities for NHAs to pursue new sources of revenue that did not exist before.

Veterans Health Administration Contracts

The Veterans Health Administration (VHA) is responsible for providing nursing home care to any veteran in need of such care. The care may be provided directly in VHA-owned facilities, or veterans who need care may be placed in community nursing homes because of capacity shortages within the VHA system. In 2018, the VHA contracted with approximately 1,800 community nursing homes to provide services to veterans. With the aging of veterans, nursing home use is expected to increase 16% between 2017 and 2022. The number of veterans in community nursing homes is expected increase by 37% (from 9,251 thousand in 2017 to 12,688 thousand in 2022) (Government Accountability Office, [2019](#)).

To participate in the VHA's nursing home program, community facilities must meet VHA standards and be certified to participate in Medicare and Medicaid. The VHA pays per diem rates that are tiered according to intensity of resources required to provide care. The homes are prohibited from billing any other payer for services provided to veterans.

Fraud and Abuse

The term “fraud and abuse” refers to receiving payments from Medicare, Medicaid, and other government programs through falsification, misrepresentation, or intentional deception. Because fraud and abuse siphon off resources that could otherwise be used for providing legitimate services to needy people, the government has been cracking down on providers who abuse the system. Both criminal and civil laws can be enforced, as well as exclusion from participation in federal programs.

Antikickback Statute

It is a felony to induce referrals of Medicare or Medicaid patients by offering or receiving any kind of remuneration, kickback, or bribe, regardless of whether they are in cash or kind. For example, it would be illegal for a nursing home to give gifts to physicians or other referral agents, such as hospital discharge planners, with the intent of influencing their decision to refer patients to the nursing home. Antikickback provisions may also apply to situations in which the nursing home makes referrals to external providers, such as a hospice, in exchange for benefits received. A hospice may also be owned or operated by a nursing home corporation. Common ownership or a joint venture opens the door to utilize nursing home hospice reimbursement mechanisms to inappropriately increase reimbursement to one or both facilities. Also, exclusive referral arrangements between the related facilities, the use of nursing home staff by the hospice and vice versa, or the provision of free services to the nursing home by the hospice and vice versa may invite scrutiny by the Office of Inspector General (Bureau of National Affairs, [2012](#)).

False Claims Act

The False Claims Act (FCA) is a law of general applicability that is invoked frequently in the health care context. In general, the FCA imposes civil liability on entities who knowingly submit false or fraudulent claims to defraud the federal government. False claims often arise in terms of billing, including billing for services not rendered, billing for unnecessary medical services, or double billing for the same service or equipment (Staman, [2014](#)). Another illegal practice, referred to as [upcoding](#), involves billing for services that procure a higher reimbursement than what should have been provided. The PDPM was designed to replace RUG-based reimbursement (discussed previously) to discourage upcoding. Although PDPM is likely to encourage admitting residents with higher clinical complexity to an SNF, if the nursing home is not equipped to provide the required levels of care, it could violate the FCA. The general legal theory of defrauding the government can apply when claims are submitted for Medicare and Medicaid reimbursement and the services delivered are found to be substandard.

Damages under the False Claims Act are severe. In 2016, Life Care Centers of America, Inc. (Life Care), a Tennessee-based LTC chain, had to pay \$145 million to settle allegations that it submitted false claims to defraud Medicare and TRICARE (insurance for military personnel) for rehabilitation therapy services. The United States alleged in its complaint that Life Care instituted corporate-wide policies and practices designed to classify as many residents in the highest reimbursement level irrespective of the clinical needs of the residents and to keep the residents longer in therapy than was necessary, resulting in the delivery of unreasonable and unnecessary therapy to many residents (U.S. Department of Justice, [2016](#)). In the PDPM system, certain comorbidities and services in the NTA component can greatly increase reimbursements, and they thus carry the risk of being overreported and overutilized (Unruh et al., [2020](#)).

Under the FCA, the theory of “worthless services” has been applied when the care delivered to the residents is of such poor quality that billing for such care would be tantamount to submitting false claims. One example would be grossly inadequate nutritional care and subsequent development of pressure ulcers that are inadequately treated. Claims for payment submitted to the government carry an “implied certification” that services delivered were in compliance with all legal and regulatory requirements. When such is not the case, for example, when the facility has been found to be in serious violations of Medicare/Medicaid standards, it can be prosecuted under the “implied false certification theory.”

A unique feature of the FCA that has been widely credited for its success is the *qui tam* (informer or whistleblower) provision. Any individual who has knowledge that a person or an entity is submitting false claims or otherwise defrauding the federal government can bring a lawsuit on behalf of the government and can share in the damages recovered as a result of the lawsuit. The person who brings the case is referred to as a [qui tam relator](#) or whistleblower and is often an employee or a former employee of a company. But a competitor, a subcontractor, a patient, or a family member can also be a relator if they have evidence of fraud against the government. Depending on various factors, the relators are entitled to between 15% and 30% of whatever amount the government recovers as a result of their *qui tam* lawsuits (Phillips & Cohen, [2020](#)). In the Life Care case, referred to previously, two *qui tam* cases, docketed as *United States ex rel. Taylor v. Life Care Centers of America, Inc.*, No. 1:12-cv-64 (E.D. Tenn) and *United States ex rel. Martin v. Life Care Centers of America, Inc.*, No. 1:08-cv-251 (E.D. Tenn) were filed. Taylor and Martin were the two former employees of Life Care who acted as relators and shared a reward of \$29 million. A third case, *United States v. Preston*, No. 1:16-cv-113 (E.D. Tenn) was brought against Forrest L. Preston, the owner of Life Care, who was also found

guilty. These cases demonstrate that the owners and officers of a corporation are not immune from liability when their involvement in a fraudulent scheme can be demonstrated.

The law provides certain protections to the relators. For example, the law prohibits an employer from harassing or retaliating against a relator. If retaliation occurs, the relator can recover damages including reinstatement, double the amount of back pay, and legal costs.

Terminology for Review

80:20 coinsurance

accountable care organization

benefit period

bundled rate

capitation

case mix

copayment

deductible

financing

Medicare Advantage

Patient Driven Payment Model

qui tam relator

reimbursement

spend down

upcoding

value-based purchasing

For Further Thought

1. You are preparing for a job interview for the administrator's position at a skilled nursing facility operated by a nursing home corporation. In the light of what you have learned in this chapter, what preparatory work prior to the interview would you do?
2. Suppose that three years ago the nursing facility referred to in (1) had to defend a lawsuit against it under the False Claims Act. How would you pursue this during the interview? Would you take the job if it is offered to you?

Case 1

A resident's family visits a skilled nursing facility that is dually certified. The resident's daughter meets with the administrator and inquires, "My mom, Josephine, has Medicare coverage. I am a nurse and have been taking care of her at home, but my family and a new job are putting more and more demands on my time and I cannot take care of my mom anymore. She requires tube feeding and has an indwelling urinary catheter. She is in a wheelchair because of limited mobility. She may need some physical therapy. I have heard good things about your nursing home and would like to bring her here." How should the administrator handle this inquiry?

Case 2

Mabel Brown resides in an assisted living facility and is admitted to the hospital following a stroke. After a hospital stay of 8 days, Brown returned to her apartment at the assisted living center, but she needs assistance with personal care and some speech therapy. Will Medicare pay for the personal care services and speech therapy? Explain.

Case 3

Hilda Smith, who had osteoporosis, sustained a hip fracture because of a fall in her home. After 5 nights in an acute care hospital, she is admitted to an SNF where she spends 16 days for rehabilitation, nursing care, and assistance with activities of daily living. The resident is then discharged to her own home where a physical therapist from a home health agency comes in to train her to use a walker and build strength. After being at home for 25 days, Smith develops deep venous thrombosis (blood clot in a vein) in her thigh (related to her fall) and is admitted to the hospital, from where she is transferred to the same SNF after spending 2 nights in the hospital. Assuming that Smith meets Medicare criteria for the services described here, how many days of SNF care is she entitled to during her most recent stay (assume that she qualifies for the full 100 days)? How much in deductibles and copayments does Smith have to pay? (For 2021, the Part A deductible was \$1,484 and the daily copayment for SNF was \$185.50.)

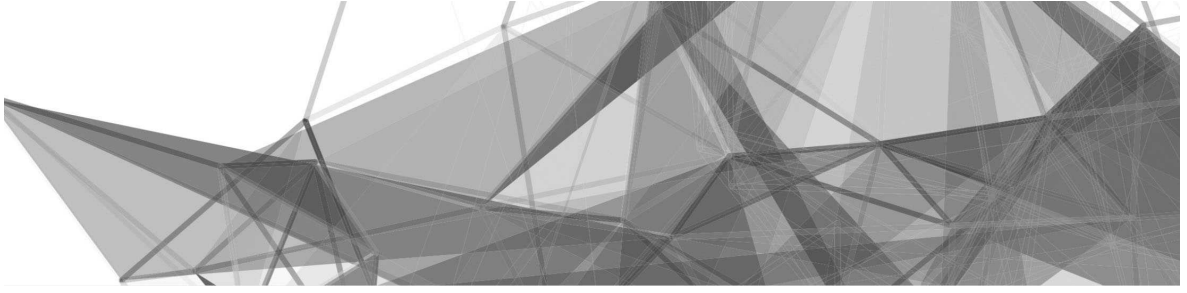
For Further Learning

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (Version 1.17.1, October 2019).
<https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1-october-2019.pdf>.

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PART III

Organization and Services

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[Chapter 8 Organization, Environment, and Culture Change](#)

[Chapter 9 Social Services, Admission, and Discharge](#)

[Chapter 10 Medical Care, Nursing, and Rehabilitation](#)

[Chapter 11 Recreation and Activities](#)

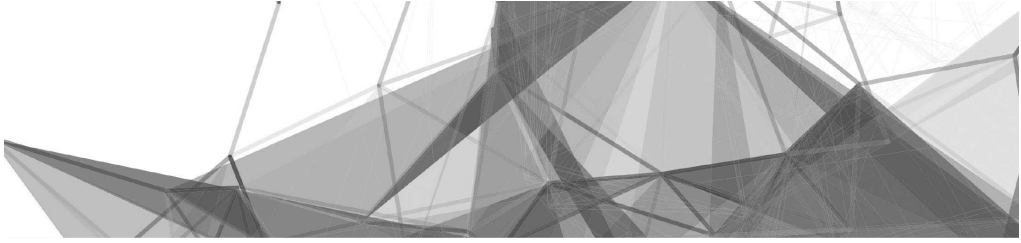
[Chapter 12 Dietary Services](#)

[Chapter 13 Plant and Environmental Services](#)

[Chapter 14 Administrative and Information Systems](#)

This section covers the organizational aspects of a nursing facility. It elaborates on the services that health facility administrators are called upon to manage; hence, their understanding is critical. It begins with an overview of current thoughts in the delivery of person-centered care, which is in sharp contrast to the outdated medical model in delivering long-term care. Subsequent chapters discuss the six main services and their departmental organization. As pointed out in these chapters, services delivered in certified facilities must comply with federal regulations. These regulations are referenced as F-Tags. However, no department ought to function in isolation. A multidisciplinary approach to planning, caregiving, and problem solving must bring the departments together to share their expertise and efforts toward common goals in delivering resident care.

- [Chapter 8](#) incorporates a comprehensive discussion of person-centered care, nursing home organization, creation of enriched environments, modern architectural designs, and the growing movement called culture change that is transforming long-term care facilities. The main ideas presented in this chapter reveal a portrait of what nursing homes of the future will look like.
- [Chapter 9](#) covers the purpose of social services; skills, roles, and competencies necessary for social workers; and the admission and discharge processes. The chapter concludes with discussions about resident council, family management, and dealing with death and terminal illness.
- [Chapter 10](#) explains medical, nursing, pharmacy, and rehabilitation services within the context of regulatory guidelines. The critical functions of assessment and care planning are explained. The roles and functions of the medical director and the director of nursing are discussed. The chapter also outlines the main features of an effective infection control program. Special areas of nursing care management include falls and fall prevention, pressure ulcers, physical restraints, and urinary incontinence. The section on pharmacy services includes controlled substances and psychotropic drugs. The chapter concludes with a discussion of rehabilitation therapies.
- [Chapter 11](#) covers recreational activities that must be individualized and designed to achieve several key goals. Sensory stimulation, reality orientation, reminiscence, validation therapy, and multisensory stimulation are explained. A special section deals with activities for residents with dementia. The main factors in the recruitment and retention of volunteers are also outlined.
- [Chapter 12](#) includes staffing and consultation in the dietary department, menu planning and meal plans, nutritional adequacy, inventory and cost control, food production and food service options, therapeutic diets and intensive nutrition techniques, and food safety. An example of cost-benefit analysis is included.
- [Chapter 13](#) explains the various plant and environmental services such as maintenance, housekeeping, laundry, security, fire and disaster planning, evacuation, waste management, and environmental safety. An example of cost-benefit analysis is included.
- [Chapter 14](#) addresses business office functions such as payroll, accounts payable, accounts receivable and the aging report, resident trust fund, medical records, and information systems.



CHAPTER 8

Organization, Environment, and Culture Change

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WHAT YOU WILL LEARN

- Delivery of care in long-term care facilities has been making a transition from the medical model used in hospitals to contemporary building designs, philosophies of care, and practices that spotlight person-centered care.
- The delivery of person-centered care necessitates the integration of socioresidential, clinical, and overarching human factors. Nursing homes encounter several challenges to a full integration of the three components, but compromises must be achieved.
- A nursing home is organized by departments, but a multidisciplinary approach that works across the various departments is essential to identify and address the individual needs of each resident.
- The socioresidential environment should emphasize opportunities for compatible relationships, personal security, safety against potential hazards, wayfinding, self-determination, and privacy.
- Modern architectural designs, such as neighborhood design and nested single rooms, emphasize many of the socioresidential factors.
- Aesthetics are an important element of homelike environments that also promote a sense of well-being. Lighting, colors, noise reduction, and furnishings require special considerations in creating therapeutic environments for nursing home residents.
- Theoretical foundations underpin enriched environments. These environments must provide a moderate degree of positive stimulation and also opportunities for silent contemplation and inner reflection.
- Culture change requires person-centered care, enriched environments, and staff empowerment.
- The Eden Alternative and Green House homes are two contemporary models of culture change.
- Environments for people with dementia are based on the modern concepts of creating enriched environments.

Introduction

Traditional nursing homes were patterned after hospitals. As hospital building codes were adapted for nursing homes during the 1960s, hospital-like long corridors, shared occupancy, and cafeteria-style dining rooms became the norm. Licensing and certification rules further reinforced the hospital design because the nursing home was viewed as a place where convalescent treatment would continue following discharge from hospitals, as laid out in Medicare rules. Clinical organization in nursing homes also followed the hospital-based medical model, with central nursing stations, buzzers, and call signals; noisy shower and bathing areas; lack of privacy; scheduled routines; and hallways cluttered with medication carts, soiled linen hampers, housekeeping carts, and similar items.

It took some time for nursing home professionals and regulators to fully grasp the fact that, unlike hospitals, a nursing facility is both a clinical and a socioresidential establishment. Many residents stay in nursing homes and assisted living facilities for extended periods of time. For some, the stay is permanent, and in a sense, the facility becomes their home. Hence, new choices and alternatives to traditional nursing home care have molded people's expectations about long-term care (LTC) and have influenced a gradual transformation from traditional hospital-inspired facilities to contemporary architectural features and furnishings that have homelike living environments. Yet, at the same time, residents' clinical needs must be addressed while improving both quality of care and quality of life.

Many nursing homes across the United States and, indeed, in many developed nations are adopting the notions of person-centered care and culture change. As a result, tomorrow's nursing facilities will be much different than what they are today.

In the above context, it should be mentioned that research to date has shown mixed results between homelike and traditional models of care with respect to clinical outcomes, quality of life, social engagement, and functional status of residents. Moreover, empirical evidence regarding the cost-effectiveness of homelike models of care is also lacking (Gray & Farrah, [2019](#)). Nevertheless, the three main stakeholders—residents, their relatives, and caregivers—all consider a homelike environment, along with residents' autonomy and self-determination, to be key aspects of modern LTC facilities (van Hoof et al., [2016](#)).

Philosophy of Care in Transition

Traditional methods of treating patients in health care institutions have been driven by the [sick-role model](#), first explained by Parsons (1972). The patient is expected to relinquish individual control to medical personnel and comply with their directives. The sick role promotes an institutional orientation to patient care, which is manifested in four ways: (1) rigid daily routines; (2) social distance between staff and the patient; (3) care practices that lend to depersonalization, such as loss of privacy; and (4) “blocking routines” that require patients to do certain things at prearranged times, mainly for the convenience of staff (Kruzich & Berg, 1985).

Although residents in skilled nursing facilities are there primarily to receive therapeutic interventions, increasing emphasis is being placed on care delivery according to the philosophy of [person-centered care](#), which integrates physical layout and design with empowerment of the residents and their families. It requires a focus away from what is best for the organization to what is best for the resident. It requires a commitment to treating each resident as an individual who has his or her own desires and values, and not categorizing every person in a set mold as if they were products in an assembly line.

The contemporary philosophy of person-centered care (also called resident-centered care or client-centered care) in modern nursing facilities is guided by three main factors ([Figure 8–1](#)):

Overarching Human Factors		
Autonomy Independence Dignity Self-esteem		
Socioresidential Component		Clinical Component
Room and Board	Amenities	Clinical Care
Accommodation • Privacy • Safety • Cleanliness • Comfort Meals • Nutrition • Choice • Adequacy • Attractiveness • Palatability	Private rooms Personal space Social space Dining rooms Layout Décor and aesthetics Barber/beauty salon Game room Gift shop Library Chapel	Medical oversight Nursing care Rehabilitation Social services Dietary services Recreational activities End-of-life care

FIGURE 8–1 Main Components of Person-Centered Care

- The socioresidential component creates the physical environment in which the residents receive room-and-board services and consider the nursing facility as their home. Various amenities are incorporated into facility designs. Privacy, opportunities to pursue individual interests, and leisure are balanced by social interaction and engagement. Meals not only meet the nutritional and therapeutic needs but are also palatable and attractively served.
- The elements of clinical care (listed in [Figure 8–1](#)) are highly individualized. Care is delivered in accordance with prevailing standards that incorporate evidence-based practices.
- The overarching human factors—autonomy, independence, dignity, and self-esteem—blend into every aspect of the resident's life and the delivery of services. Such integration is achieved through ongoing staff training.

When human factors are integrated into the other two components, it creates an environment in which a person's physical, mental, social, and spiritual needs are met. In sharp contrast to the sick-role model, person-centered care is characterized by shared control between the resident and the facility personnel. It promotes individual autonomy and decision-making, even when a resident's decision-making capacity is limited. It gives equal weight to promoting quality of care and quality of life.

Challenges to a Full Integration

Integration of the three components will continue to be a struggle for nursing home professionals because of several challenges. Successful juggling through these challenging aspects is what sets apart an effectively managed facility from the mediocre ones.

Primacy of Clinical Care

The fundamental purpose of a nursing home is defeated if it does not provide clinical care in accordance with up-to-date standards, best practices, and use of appropriate technology, while also complying with regulatory requirements. The sick-role model can be compromised but cannot be entirely dispensed with. For example, giving medications and other treatments in a resident population of any size requires certain routines based on medical directives. Medical examinations result in some loss of personal control. Necessary staff assistance with daily living activities does create some dependency and loss of autonomy.

Economic Necessity

Nursing facilities exist because of economic necessity. If it were feasible, almost every nursing home resident would prefer to be cared for in a private residence by a private-duty nurse. The reality, however, is that unless an individual is very wealthy, neither the individual nor the society can afford to incur the expense that private-duty care would entail. Expensive as it is, delivery of care in a nursing facility is highly cost effective compared with private-duty nursing.

Resident-Related Constraints

By the sheer necessity of caring for residents who may present behavioral problems, such as frequent combativeness or screaming episodes, facility environments can be disruptive. Secondly, issues such as confusion and dementia compromise a person's ability to make rational decisions. Although a conscious effort must be made to give the resident some of the responsibilities for his or her own health care in a compassionate and respectful way, yet the primacy of clinical care must be maintained.

Regulatory Burden

Nursing home professionals view the regulatory process to be onerous, adversarial, and punitive. As a result, the culture of nursing home administration has suffered from paranoia of the regulatory system. Inadequate financing under Medicaid, the largest payer for nursing home care, is also seen as a major constraint to procure needed resources. Despite these drawbacks, the industry has evolved by adopting innovative approaches to create organizations that are most desired by its clients. Culture change, discussed later in this chapter, is an effort that was adopted by the industry's leadership without any push from regulators. Yet, regulatory oversight is not likely to go away.

Conflicting Rights

In a nursing facility, each resident's desires, interests, and rights can directly affect the rights of other residents. For example, residents who wander into others' rooms, rummage through others' belongings, dip their hands into other diners' plates, make yelling noises, or display combativeness disrupt the quality of life of other residents. To deal with such conflicts in an institutional setting, the facility must try to achieve an appropriate balance among the needs and rights of different groups. No one resident's interests are legitimately outweighed by the competing interests of other residents. Hence, appropriate interventions and compromises often become necessary.

Nursing Home Organization

An organizational chart showing the main service departments in a typical skilled nursing facility is illustrated in **Figure 8–2**. In midsized facilities, each of these services is managed by a midlevel department head who reports directly to the administrator.

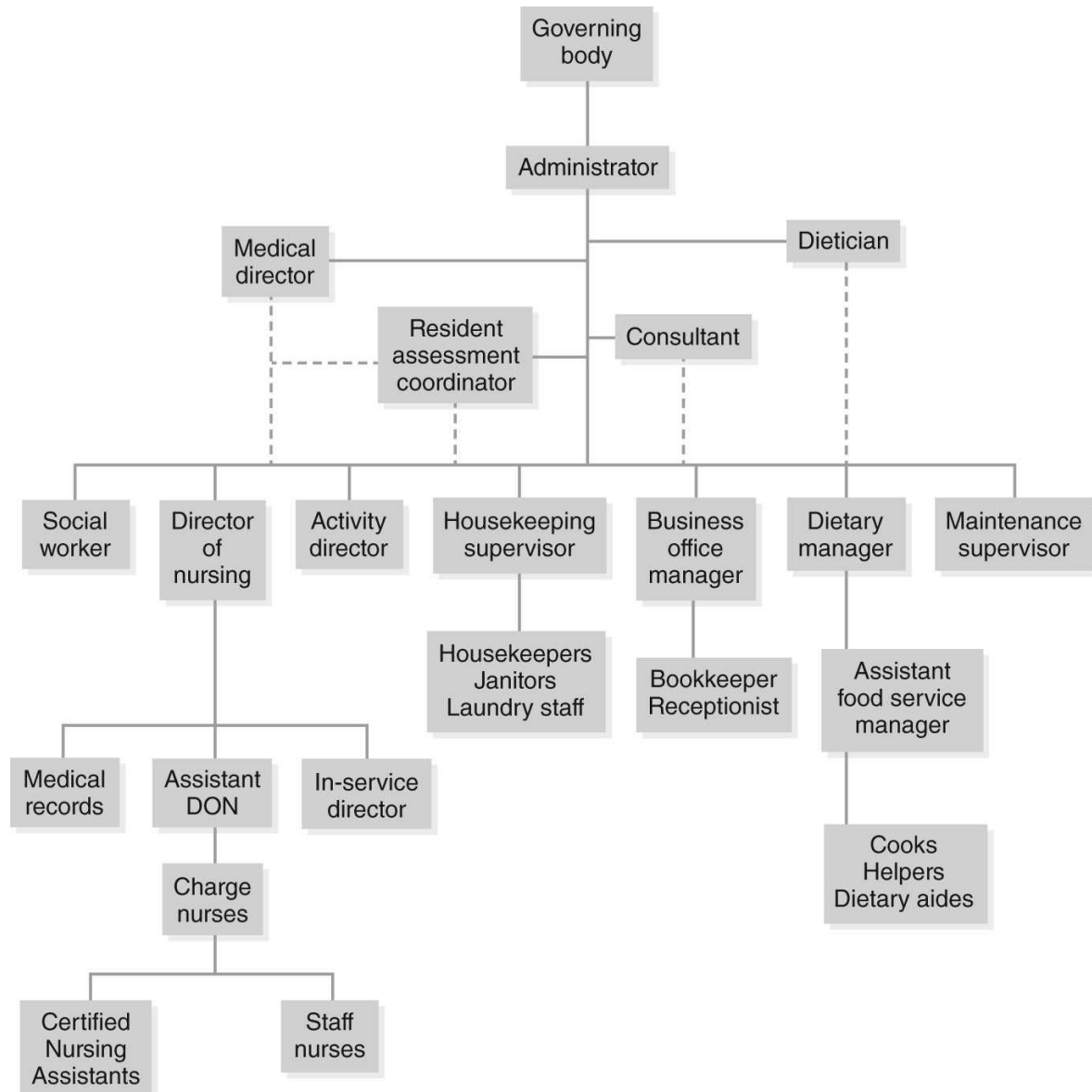


FIGURE 8–2 Organizational Chart of a Typical Skilled Nursing Facility

The various support services are adjuncts to the central nursing care process and interface with clinical care using a multidisciplinary approach that works across the various departments. Building a multidisciplinary team requires that the administrator's leadership promote an organizational culture of interdepartmental communication and cooperation to address resident needs in a holistic system of care.

In an integrated multidisciplinary approach, professionals who provide medical, nursing, and rehabilitation services, social services, recreational activities, and dietary services share their observations, discuss clinical goals, and develop interventions in which these services interface. Professionals in each discipline are aware of what others are doing to address the multifaceted needs of each resident. The overarching goal is to collaboratively address all aspects of a resident's needs.

Clinical Set-Up

The vast majority of nursing homes use a traditional clinical set-up. Many newer facilities have incorporated innovative design concepts to tone down the clinical look and feel of traditional nursing homes. Generally, a

nursing unit or wing, that is, a section of a facility that consists of a certain number of resident rooms, is served by a nursing station. A centrally located nursing station enables the staff to observe and supervise resident rooms and to respond effectively to resident needs. A nurse call system, medical records, and a locked medication room are located within the nursing station. Only licensed personnel have access to the medication room.

Depending on its size, a facility may have clinically distinct nursing units, each providing a somewhat distinct level of care, such as rehabilitation, dementia care, or specialized care. To achieve staff efficiency, most clinical units are self-contained, having their own bathing rooms, linen closets, dining or feeding rooms, and lounges for residents and visitors.

An enclosed soiled utility area, rather than a nook in the hallway, is ideal. It minimizes hallway clutter and is installed with modern ventilation and waste-elimination systems to keep odors to a minimum.

Modern wireless communication devices such as portable pagers have eliminated the need for buzzing sounds at nursing stations and frequent overhead paging, which make the environment noisy and stressful. Medical records have been switched from paper charts to electronic health records.

Socioresidential Environment

In person-centered care delivery, an LTC facility is viewed as a community in which the social and residential elements are closely intertwined. The facility's layout should enable residents to explore compatible relationships with others and engage in social interactions in accordance with personal preferences. For example, segregating residents with severe dementia and those with behavioral problems reduces stresses in an environment that can otherwise be disruptive from commotion and confusion. The socioresidential environment should also emphasize personal security, safety, wayfinding, autonomy, privacy, and opportunities for socializing.

Security

Security is a basic human need. It entails physical safety and also psychological peace of mind by giving people a sense of freedom from risk, danger, and anxiety. An LTC facility is responsible for its residents' personal security and the safekeeping of their belongings and private funds if the latter are deposited in a resident's trust account that the facility manages. For residents who may have a tendency to wander outside, a fenced-in walkway surrounded with plants and flowers provides a secure area that can also have a therapeutic effect.

Not all nursing homes are located in safe neighborhoods, particularly in large cities. The administrator must evaluate both external and internal security concerns, which include protecting residents and their property from intruders.

Safety

Building construction and practices in compliance with the *Life Safety Code*® mainly address fire safety. However, the facility must also provide an environment that is free from accident hazards. For example, fixtures such as handrails and grab bars and assistive devices such as canes, wheelchairs, and walkers must be maintained for safety. Adequate supervision is also necessary to prevent avoidable accidents.

Environmental assessment of risks and hazards must be an ongoing undertaking. Safety must be everyone's concern, and hence, must be interdisciplinary. A systems approach to safety includes the following:

- Supervision limits access to products such as drugs, lotions, and ointments on medication and treatment carts. Cleaning chemicals must not be left unattended on housekeeping carts. Sharp objects, such as certain maintenance tools, must be safeguarded. Access to areas such as the kitchen, mechanical rooms, and laundry must be adequately secured.
- Under proper supervision, cooking/baking or certain laundry activities can provide stimulating and meaningful engagement for some residents, including those with mild to moderate dementia. Ideally, small household-style kitchens can be included in the facility's design.
- Safety concerns should be incorporated into the resident's plan of care. For example, a person's medications may need to be reviewed for causing dizziness. Strength training or behavior modification may be necessary.
- Potential hazards and actual incidents should be reported and corrected without assigning blame to anyone.

Wayfinding

Wayfinding refers to features that can help people find their way through a large institution with relative ease. Residents in LTC facilities are often susceptible to disorientation because of a decline of various senses. Sameness and repetition—similar layouts, regular pattern of doors, and similar furniture throughout a facility—are the common sources of disorientation. Orientation involves much more than use of signs. In addition to clear and readable signage, wayfinding can be facilitated by using a variety of means such as employing different color schemes; change of patterns in different sections of the facility; color-coded handrails; varying furniture styles; varying layout and arrangement; and use of pictures, tapestry, hanging quilts, and window displays. On the other hand, doors leading to utility rooms and areas not meant for residents should be painted to blend with the adjacent walls.

Autonomy

Autonomy refers to several notions that include self-determination, freedom, independence, and liberty of choice and action. Autonomy results in decision-making by a person, without outside interference (Collopy, 1988). Because health care by its very nature creates dependency, caregivers must make deliberate efforts to maximize the preservation of resident autonomy. On the other hand, autonomy cannot be taken to an extent that it infringes on the rights of others or exposes the resident to harm.

Autonomy also requires that residents are allowed to personalize their rooms with familiar things, including such personal items as small television sets, family pictures, mementos, artifacts, plants, music, personal furniture, and bed accessories. Emotions and memories from past experiences and events often stimulate conversation and social interaction. Although space is almost always limited, a display shelf in each room can help people personalize their space by displaying memorabilia and other items. On the other hand, certain personal belongings may pose safety concerns. For instance, too many electrical gadgets may overload the circuits and create a fire hazard. Long extension cords and floor rugs pose a tripping hazard.

Autonomy also means that a resident must be able to make informed choices within the parameters of what is in the resident's best interest. Occasionally, conflicts may arise between a resident's autonomy and the facility's duty toward the resident. Such conflicts should be resolved by taking into consideration legal requirements, regulatory constraints, and ethics.

Privacy

Privacy of Space

In most skilled nursing facilities, shared accommodation in the form of double occupancy is the norm. For those receiving public financing, private accommodation is generally out of pocket, unless a medically determined need exists. Hence, a person's privacy rests on how much physical space each individual has, including closet and storage space. Privacy also entails the need for **intimacy**, which refers to a person's privacy during visits with family, friends, and legal or spiritual counselors. Residents can also express their sexuality in a private environment. Because privacy is generally compromised in a multiple-occupancy setting, the facility should provide secluded areas that may be used for intimate dining experiences with family and friends, for private visits, or for sexual intimacy.

Privacy of Time

Privacy of time is often compromised by clinical routines that are established for the sake of staff efficiency or convenience. Such routines tend to make residents' lives regimented. In many nursing homes, wake-up and morning hygiene chores must be completed before breakfast. Because assigning staff members to every resident at the same time is not possible, certain residents must wake up before others. Meal hours are also generally fixed. Bathing and shower routines are scheduled ahead of time. Yet, within the parameters of such scheduled routines, residents' individual preferences should be accommodated whenever possible. Privacy of time also includes the need for personal reclusion, that is, having time for oneself, being free from unwanted intrusion, and being alone for quiet reflection. For this purpose, quiet and secluded spaces such as small libraries and chapels are highly desirable.

Privacy of Person

Privacy of person can be equated with dignity. A basic rule for facilities to follow is to treat every person with dignity, regardless of whether he or she can perceive indignities (Kane, 2001). Knocking at the door before entering a resident's room, closing the door when toileting, drawing privacy curtains during treatment, providing appropriate personal covering for a trip to the common bathing and shower area, providing proper grooming during a trip to the therapy room or dining room, and giving lap robes to female residents in wheelchairs are examples of how personal privacy is respected to preserve individual dignity.

Socializing

Social interactions are primarily driven by compatibility because compatible relationships are something people naturally seek. The issue of compatibility first arises when a new resident is admitted to the facility and has to share a room with another resident who is a complete stranger. Gender compatibility has been a long-established practice. Room sharing by two individuals of the opposite sex is permitted in the case of legitimate couples. Apart from such obvious types of compatibility, the main consideration in assigning a room to two people is how well the two individuals are likely to get along and engage in a meaningful social exchange. Compatibility is also an important consideration in other situations requiring social groupings, such as dining at the same table or participating in social and recreational events.

For residents who require feeding assistance or who may have other special needs, dining may become a clinical event, but staff interaction can still help make it a social event. To the extent possible, clinical dining areas for those who cannot eat on their own should be separated from social dining areas so that those who are able to dine in a social setting, including those in wheelchairs, can enjoy the dining experience without interruption or distraction.

The facility must schedule programs that offer numerous daily opportunities for residents to socialize. Social events also enable persons with dementia and other limitations to receive sensory stimulation by just being

present. Events should be held in both interior and exterior spaces. Some modern facilities have spaces such as mini malls, ice cream parlors, and barber and beauty shops where residents can enjoy some of the social activities they once pursued. One example of modern architectural designs for senior care environments includes the concept of “main street,” in which a common area opens into large interior volume spaces that have façades with exterior building appearances (see **Figure 8–3**). In some designs, a chapel can have the look of a church, a meeting space can appear as a town hall, and food service operations can look like a sidewalk café. Such features can give residents the feeling of going out to dinner, church, or other event. The effect of such environments can be therapeutic because many residents remember such environments from their earlier days.



FIGURE 8–3 Illustration of the “Main Street” Concept. Towne Center Community Campus, Avon, Ohio
Reproduced with permission from JMM Architects, Inc., Columbus, Ohio. Courtesy of Mike Milligan.

Exterior spaces include courtyards, patios, balconies, terraces, vegetable and flower patches, gazebos, and spaces around bird feeders and fountains. The building’s design should permit all residents easy access to the exterior. The outdoor spaces should have appropriate seating arrangements so that the residents can spend time relaxing, socializing, and simply enjoying the surroundings.

Modern Architectural Designs

The average number of nursing home beds per facility has been fairly consistent at 109 beds per facility since 2009. States vary in the average size of nursing homes with eastern states seeing larger facilities as compared to other states (Harrington et al., [2018](#)). Although the larger size creates operational efficiencies, it may detract from a desirable socioresidential environment. In response, some architects have created innovative facility designs that strike a balance between the clinical and socioresidential factors. In shared accommodations, there is some evidence of territoriality and aggression between residents who share the same room (Calkins, [2018](#)). Hence, in new constructions, private rather than shared rooms are in vogue to give residents their own personal space.

High-pitched roofs, creation of neighborhoods rather than hallways, use of natural light, installation of fireplaces in lounges, and the connection of indoor to outdoor spaces can make a building seem more like a home than an institution. In some cases, the medical character of the facility can be deemphasized by even eliminating the traditional nursing station. In large facilities, smaller self-contained units can be created, each with its own household-style kitchen and a common room that can serve as a multipurpose room for dining, activities, and socializing.

Neighborhood Design

Also referred to as a cluster design, it places decentralized self-contained neighborhoods, or “household clusters,” within the larger clinical units, creating relatively small residential groupings. **Figure 8–4** illustrates adjoining 12- to 13-bed neighborhoods. Cluster designs practically eliminate the traditional long corridors and offer better flexibility in segregating residents than traditional layouts do. For instance, residents requiring heavy care could be accommodated in the same cluster. Small groupings of residents are also desirable in short-term rehabilitation units and dementia units. Neighborhoods allow food service to be more personalized with small serving kitchens adjacent to dining spaces. Food can be served on plates rather than trays. In homestyle dining, residents may even be allowed to select the type and amount of food they wish to eat (Remsburg, [2016](#)).

High construction costs for the neighborhood design is a major deterrent, although better functional efficiencies are often gained. By decentralizing staff and services and giving associates quick access to utilities, a neighborhood layout can make associates more productive because shorter walking distances save time. The self-contained clusters also have their own bathing rooms, linen closets, and soiled utility closets. Thus, services are brought to each cluster instead of transporting residents to the nursing station, dining room, or therapy room. A group of permanent caregivers assigned to each neighborhood can provide opportunities for interaction and bonding between caregivers and residents.

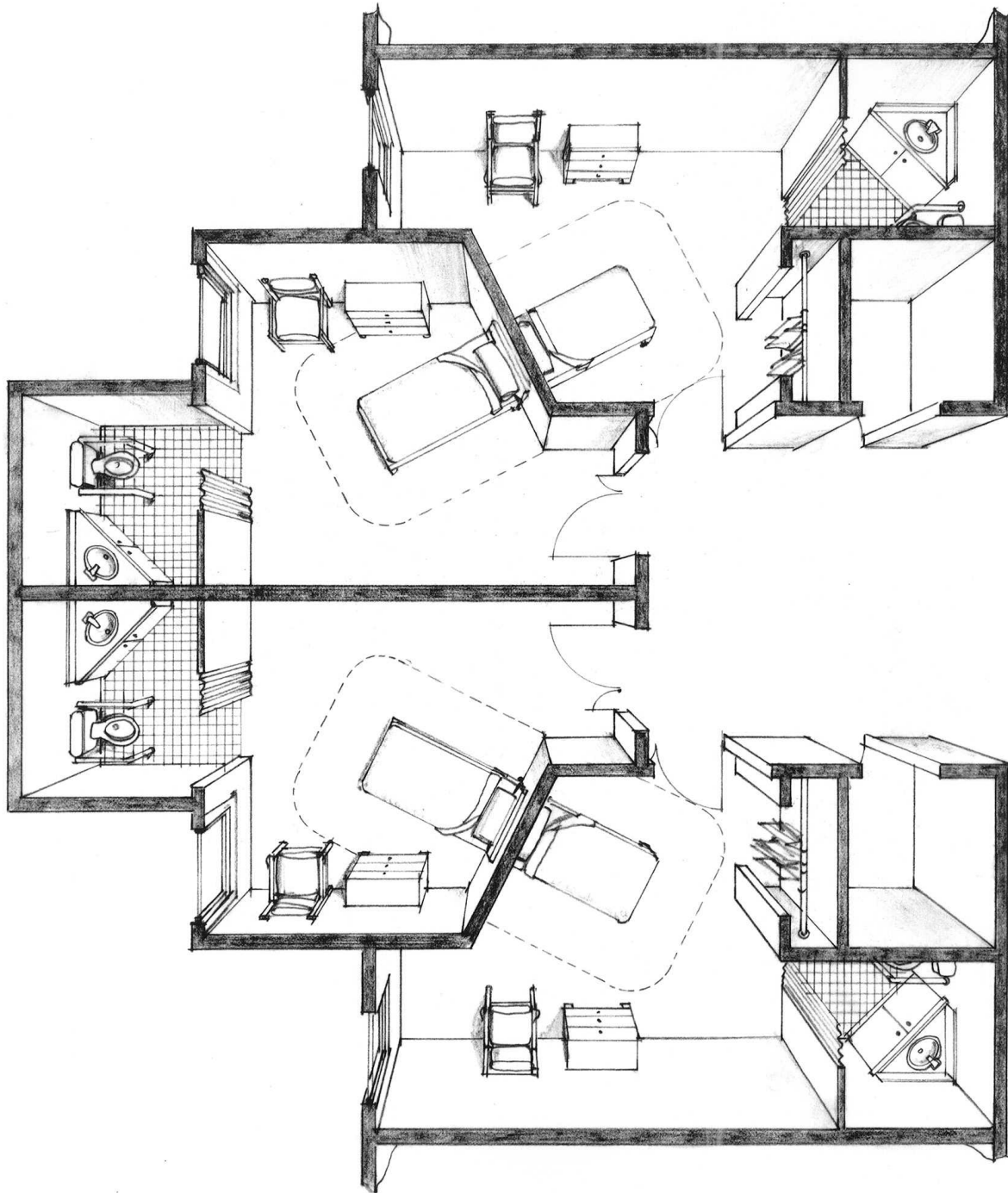
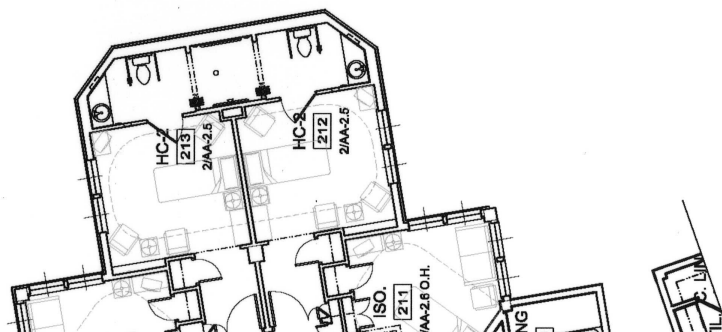


FIGURE 8-5 Overhead One-Point Interior Perspective of Nested Rooms
 Reproduced with permission from EGA, P.C. "Designs for Living."



Aesthetics

Aesthetics are necessary to promote a sense of well-being. The physical environment can also affect social behavior and certain clinical outcomes. Light and color, for example, influence residents' sleep, wakefulness, emotions, and health. Use of lighting, color, and furnishings create an environment that is both aesthetically appealing and comfortable. Conscious efforts must also be made to reduce noise levels.

Lighting

Compared with community-dwelling elders, nursing home residents suffer from far greater visual impairment. It is estimated that almost half of the residents may have vision impairment (Andersson et al., [2020](#)). Causes include cataracts, glaucoma, and diabetic retinopathy.

Today's light source of choice is fluorescent, with an electronic ballast. Appropriate lighting can compensate for poor vision and help to prevent accidents. Uneven brightness patterns can produce shadows that may be frightening for people with dementia. On the other hand, excessive brightness can cause glare, which can contribute to agitation, confusion, and anger, and also compromise safety. Maintaining an even level of lighting; using diffused and indirect lighting (such as coves and pendant fixtures), and concealing bright light sources by using valances, translucent shades, blinds, and awnings are recommended. Use of lighting control technology in tandem with daylight sensors can significantly reduce energy use and control light levels, for example, by automatically reducing light levels in the evening (Brawley, [2006](#)).

Natural sunlight has positive effects on overall health. Indeed, bright light therapy is effective and safe for Alzheimer's patients who have disorders of the circadian rhythm that regulates the sleep-wake cycle (Ferini-Strambi et al., [2020](#)). Hence, a balance between natural and artificial light is desirable.

Patios and porches enable residents to enjoy fresh air as well as direct sunlight. Because older eyes adapt much more slowly to changes in light levels (especially from bright to dim surroundings), transitional spaces between indoors and outdoors are recommended (Brawley, [2006](#)). Low windows in resident rooms, lounges, and corridors allow residents to see the exterior grounds from their beds and wheelchairs.

Color

Use of colors to promote health, or to influence people's moods and behaviors, has long been an area of contention between researchers and color theorists. Also, emotional responses to colors are culturally learned (Brawley, [2006](#)). However, it does not mean that judicious use of colors has little or no value in health care settings. For example, a monochromatic color scheme throughout the building may be perceived as institutional. It becomes monotonous and boring over an extended period of time, thus contributing to sensory deprivation (Leibrock & Harris, [2011](#), p. 89). Overuse of red can increase the heart rate and cause anxiety (Green, [2005](#)). Use of different colors can not only break up the monotony, but it can also help elderly residents to identify their own living areas in institutional settings.

Color contrasts can be used to improve safety. To compensate for the reduced visual function of aging eyes, bright colors can help distinguish grab bars from the surrounding wall and the toilet from the floor. Chrome and metallic bars may produce reflected glare or blend in with the wall, causing safety hazards (Leibrock & Harris, [2011](#), p. 95). From a durability and maintenance perspective, recent innovations in paint have improved finishes that better tolerate daily abuse and routine scrubbing (Brawley, [2006](#)).

Acoustics

Unpleasant noise jars, disrupts, and upsets because it lacks meaning and sense (Picker, [2003](#)). On the other hand, natural sounds can have a positive effect on health and well-being. As a rule of thumb, an average sound level of 50 decibels (dB) is recommended for residential communities (for comparison, a vacuum cleaner has a sound level of 80 dB) (Brawley, [2006](#)). Sound levels above 50–55 dB may cause annoyance, and higher levels may induce psychologically related stress. For example, sound is a significant predictor of agitation and stress in residents with dementia (Jousse, [2012](#)). Noisy work environments also create feelings of stress and fatigue for staff. In a busy caregiving environment, noise reduction does require a conscious effort, even though no specific noise levels have been prescribed by nursing home regulations.

Noise mitigating design features can include acoustical ceiling and wall products that reduce echoes, sound proofing resident rooms, and ventilation and heating systems with sound reduction. Other techniques include use of lined drapes, wall hung quilts or sound-absorbing panels, place mats on dining tables, and rubber tips under table and chair legs. Use of alarm and overhead paging systems should be confined to emergencies. Fire drills can be conducted silently, without the use of alarms. Visitors can be asked not to use cell phones inside the facility. Staff can be trained to use lower speaking voices. Closing of doors can also be an effective method to reduce noise.

Furnishings

Carpeting adds warmth and softens sounds. It also provides cushioning against falls and can prevent serious fractures of the hip or wrist. Today's high-performance carpets, which are resistant to stains and odors, are also cost effective. New carpets are treated with a moisture barrier and an antimicrobial coating. Appropriate carpeting can provide a smooth flooring surface that facilitates foot mobility as well as wheelchair use (Brawley, 2006).

Of course, carpeting is not appropriate for all areas in the building. Slip-resistant tile is by far the most widely used flooring material. Resilient flooring with low sheen can be used in certain high-use areas without creating an institutional appearance. For example, these hard-surface floorings also come in beautiful wood-grain patterns that add a homelike touch. Padded and easy to maintain soft-surface flooring includes vinyl and rubber products. Smooth, hard-surface flooring such as wood and ceramic tile pose a greater risk of falls than soft-surface products (Brawley, 2006). Highly polished and buffed surfaces are not recommended for elders because they produce glare, appear wet or slick, and can be a source of anxiety and confusion.

A variety of furniture is available that is specifically designed for LTC facilities. Lounge chairs, sofas, and rocking chairs can add charm and variety as well as comfort. Use of upholstered furniture has actually become quite common. Some manufacturers are producing foam cushions that are soft enough to be comfortable and yet firm enough for residents to rise easily from chairs and sofas. High-tech finishing of upholstery fabrics include soil- and stain-resistant finishes, lamination with vinyl, fluid barriers, and antimicrobial finishes. For nursing home use, these fabrics must also be flame retardant. "Super fabrics," such as Crypton, have built-in stain and moisture resistance and have been tested for fire and microbial resistance. These new fabrics have replaced vinyl coverings for chairs and sofas, and a range of colors, textures, and patterns are now available to enhance the residential environment in nursing facilities.

Enriched Environments

The environment itself should promote the healing of the body, mind, and spirit. A healing environment relieves the clinical infrastructure of pressures that might otherwise be imposed on it from social conflict or individual ill-adjustment. **Enriched environments** (or enhanced environments) are physically and psychologically supportive environments that promote positive feelings, harmony, and thriving. They also reduce boredom and stress. Conversely, impoverished environments, in which people are mainly sedentary and lonely, are thought to lead to cognitive decline. In impoverished environments, residents spend an unnecessary and excessive amount of time in bed, and when out of bed, they show mainly sedentary or completely passive behavior (Volkers & Scherder, [2011](#)).

Theoretical Foundations

Various theories have been advanced to support the concept of well-being. Seligman ([2018](#)) hypothesized that the elements of well-being constitute positive emotions, engagement, relationships, meaning, and accomplishment (PERMA), and that these five elements lead to a flourishing life. When thriving occurs, certain critical attributes are noticeable in the person: social connectedness, finding meaning in life, adaptation, and positive cognitive/affective function.

Haight et al. ([2002](#)) proposed an integrative model of **thriving**—living life to the full. They proposed that for thriving to occur, three elements must be in balance: the person, the human environment (family, friends, caregivers, etc.), and the nonhuman environment (the physical and ecological surroundings of a person).

E.O. Wilson, a biologist, coined the term **biophilia** for the human propensity to affiliate with other life forms that include people, certain animals, and nature in general. In short, it describes the human tendency to pay attention to, affiliate with, and respond positively to nature (Wilson, [1984](#)). Evidence supports that a connection between humans and nature contributes to life satisfaction, and nature often serves as a background to many of the positive memories that people have (Chang et al., [2020](#)). Berto et al. ([2018](#)) concluded that people who already have a high sense of connection to nature better perceive its restorative benefits.

From their research, Goto and colleagues ([2018](#)) concluded that experiencing a garden environment is a holistic experience rather than a solely visual stimulus. In people with dementia, garden observation not only relieves physiological stress, but it also improves verbalization and memory retrieval.

Interestingly, in a study of older adults, neither physical nor cognitive training was found to improve mental function. In contrast, those who engaged in a variety of regular leisure activities demonstrated a favorable change in cognitive performance (Küster et al., [2016](#)). The implication is clear: Enriched environments present numerous opportunities for LTC residents to engage in activities and relationships that bring enjoyment and dispel boredom.

Principles of Enrichment

Enriched environments are created by incorporating three main principles:

- All three elements of person-centered care (clinical care, socioresidential elements of the physical environment, and overarching human factors) must be integrated, as discussed earlier.
- The environment should provide a moderate degree of positive stimulation and distraction. In the absence of positive distractions, residents begin to focus on their own problems because of boredom and depression. Positive distractions elicit good feelings, hold attention, and generate interest. Happy faces, laughter, people passing by, pets, fish in aquariums, birds, flowers, trees, plants, water, pleasant aromas, and soothing music can all be positive distractions. Negative distractions, on the other hand, are stressors because it is difficult to ignore them. Visual stimulation from pictures, artwork, and television watching can be positive, but abstract art and uncontrolled loud noise from television can be irritants.
- Thriving is not entirely a function of external stimulus. Thriving also requires solitude, reflection, introspection, spiritual contemplation, study, and a sense of one's individuality and self-worth. However, a balance between passive relaxation and activity are necessary.

Culture Change

The ideas presented in this chapter are at the heart of what has been loosely referred to as “culture change.” As a working definition, [culture change](#) refers to a gradual transformation of the traditional LTC environments and care processes driven by the sick-role model to the ones that promote the delivery of person-centered care in enriched environments that are also aesthetically pleasing to the senses.

Historical Context

Beginning in 1997, nursing home professionals and advocates, referred to as “pioneers,” began informal meetings to define common areas of endeavor and opportunities for bringing about a change in traditional nursing facilities. A few nursing home professionals, who had already experimented with some innovative approaches, were invited to share their experiences with various stakeholders, which included consumer advocates, nursing home administrators, caregivers, and others. Referring to themselves as pioneers, they formed a formal organization, named the Pioneer Network, in 2000. Subsequently, it evolved into a growing national movement with formal coalitions established in several states. The network has continued to make a meaningful impact in the areas of education and advocacy to influence public policy.

Achieving Culture Change

Culture change requires a change in mindset on the part of both management and associates. As a guiding principle, administrators and department managers must first treat their associates as they would want the associates to treat the elders. There is no room for practices that devalue workers, most of whom are women who typically earn just a little above the federal minimum wage. It also requires a decentralized management approach in which the residents, their families, and caregivers are given a voice in the residents' daily routine and life.

Advocates of culture change also recommend adopting the practice of [consistent assignment](#) whereby caregivers are assigned to the same residents. It is assumed that forming a bond between residents and caregivers may bring increased satisfaction to caregivers and also lead to better quality for residents. However, research to date has shown inconsistent effects of consistent assignment on quality outcomes, which may be due to inconsistencies in the way this construct is measured in research studies (Roberts et al., [2015](#)). On the other hand, when consistent assignments are routinely adopted, they may help lower absenteeism and turnover among caregivers (Castle, [2013](#)).

There is no single way in which culture change can be achieved. Numerous possibilities exist that can differ rather substantially from one facility to another. Even at that, it remains a work in progress. Culture change is an unstoppable wave of the future. Facilities that do not adopt this growing movement will be left behind and find themselves in an uncompetitive position and perhaps out of business at some point. This is because compared with previous generations, baby boomers entering retirement are likely to be more inclined to search for LTC options that promote comfort and quality of life in an environment comparable to their own homes (Ragsdale & McDougall, [2008](#)).

For some facilities, the high cost of constructional modifications could be a deterrent. Also, many of the older buildings may present daunting challenges because of their layout and lack of available space that must be devoted to providing essential services such as nursing care and rehabilitation. However, culture change encompasses much more than architectural features and building layouts. Facilities can still enrich their existing environments by implementing person-focused changes discussed previously in this chapter.

Contemporary Models of Culture Change

The Eden Alternative

In the early 1990s, Dr. William Thomas, who worked as a physician in nursing homes, concluded that the residents often suffered from the three plagues of loneliness, helplessness, and boredom. Working with the staff in an 80-bed nursing home, which served mostly residents with dementia, Thomas developed some new ideas and a set of principles for creating a garden-like environment. Thomas explained:

I want an alternative to the institution. The best alternative I can think of is a garden. I believe when we make a place that's worthy of our elders, we make a place that enriches all of our lives—caregivers, family members, and elders alike. So the Eden Alternative provides a reinterpretation of the environment elders live in, going from an institution to a garden . . . There are kids running around and playing. There are dogs and cats and birds, and there are gardens and plants. I want people to think that this can't be a nursing home. Which it isn't—it's an alternative to a nursing home. . . . (McLeod 2002, pp. 14–15).

Eden Alternative, a trademark of its founding organization, is based on the belief that the companionship of pets, the opportunity to give meaningful care to other living creatures, and the spontaneity that marks an enlivened environment have therapeutic values. The 10 principles on which the Eden Alternative is founded are presented in **Exhibit 8–1**.

EXHIBIT 8–1 The Eden Alternative Principles

1. The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders.
2. An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.
3. Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
4. An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.
5. An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.
6. Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
7. Medical treatment should be the servant of genuine human caring, never its master.
8. An Elder-centered community honors its Elders by deemphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.
9. Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.
10. Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.

Courtesy of Eden Alternative. Available at <https://www.edenalt.org/about-the-eden-alternative/mission-vision-values>.

Eden Alternative has become an international organization. Its philosophy has been adopted in some 20 different countries that include Canada, the United Kingdom, Australia, New Zealand, and several European nations. **Edenizing** is the expression used for achieving culture change by implementing the Eden principles. Edenizing may pose some risks in the form of allergies, injuries, and illnesses. **Zoonosis** is the transmittal of infections from vertebrate animals to humans. However, the extent of zoonotic infections among the elderly remains unknown (Cherniack & Cherniack, 2014). Nevertheless, preventive steps should be undertaken by routine veterinary screening of pets. In addition, infection control policies and procedures geared toward management and prevention of zoonotic illnesses should be developed and implemented (Guay, 2001). Pets might also cause psychological harm. Humans often become attached to their pets, and when they lose them, they may undergo grief reactions similar to those with loss of other people (Beck & Katcher, 2003).

It must be emphasized that Eden Alternative is not a quick fix for serious problems. Acceptance of the Eden Alternative by staff members and their training are necessary prerequisites. Changing an organization's culture takes time, effort, and leadership skills. Implementing the Eden principles can take an estimated 3 to 5 years.

The Green House Project

An outgrowth of Eden Alternative, and also a brainchild of Dr. Thomas, the Green House Project takes Edenizing a step further by revolutionizing the way in which nursing home services are organized and delivered in small-scale settings. The term **Green House** stands for architectural renderings of small

freestanding cottages, each designed to house just 10 to 12 residents who live together in a homelike setting. The freestanding cottages are spread across a campus (**Figure 8-7**). The first Green House project in Tupelo, Mississippi, opened its doors in June 2003. Since then the model has been adopted by a number of nursing home organizations across the nation. In 2014, 167 Green House homes were in operation, with 133 licensed to provide skilled nursing care (Cohen et al., 2016).

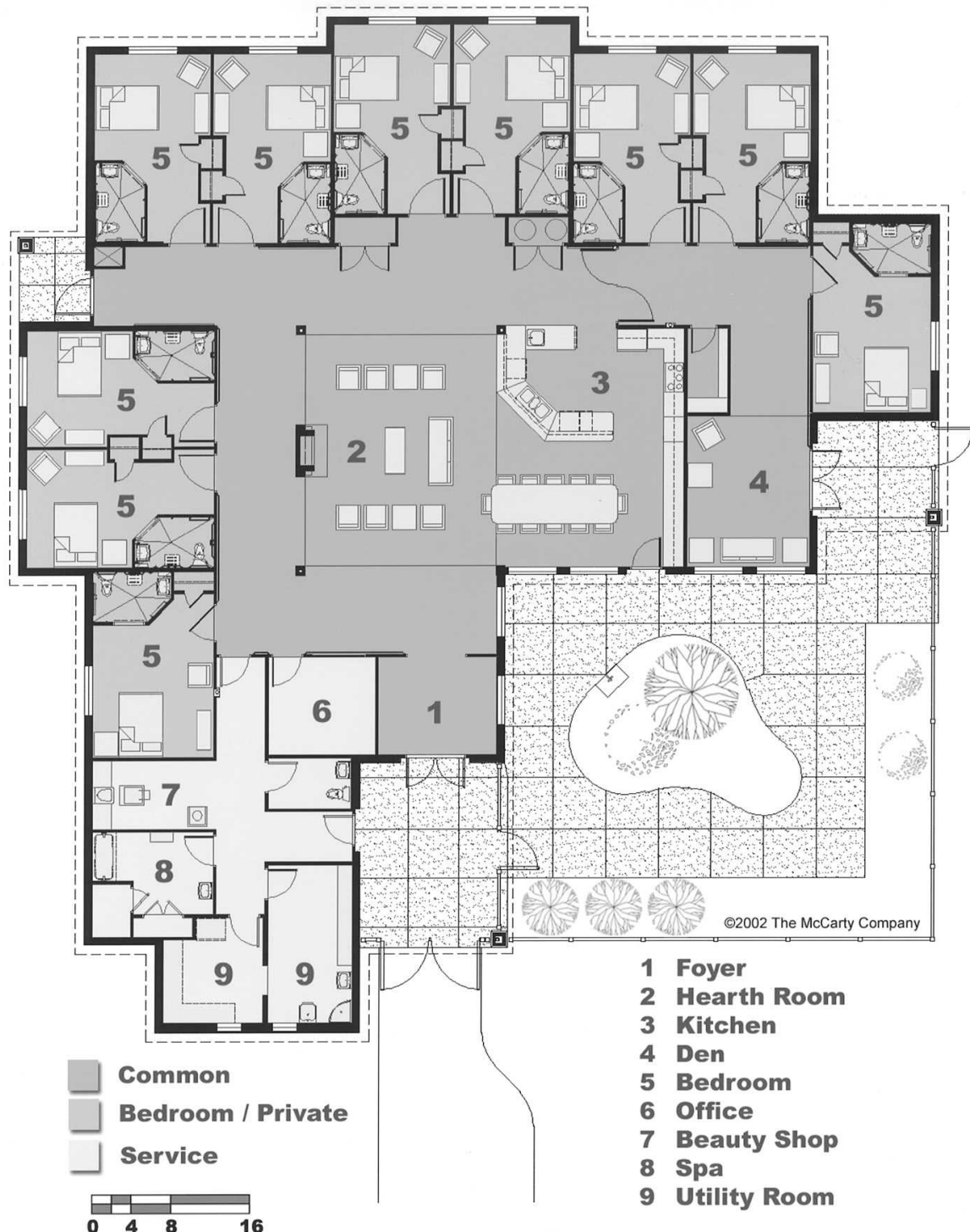


FIGURE 8-7 Ten-Bed Skilled Nursing Green House (Methodist Senior Services, Tupelo, Mississippi)

Reproduced with permission from The McCarty Company, Tupelo, Mississippi. Courtesy of Stephen Ladd.

Each Green House has self-contained private rooms that include a commode, a sink, and a shower. To accommodate even the frailest elders, rooms are equipped with ceiling lifts for transferring. The residential units are connected by short hallways to a central hearth room, open kitchen, and dining area. Other amenities

include a spa room, laundry room, alcove, and storage space (**Figure 8-8**). The small size eliminates the need for nursing stations and medication carts. The nurse call system is wireless, using silent pagers that can be activated from pendants worn by the residents.

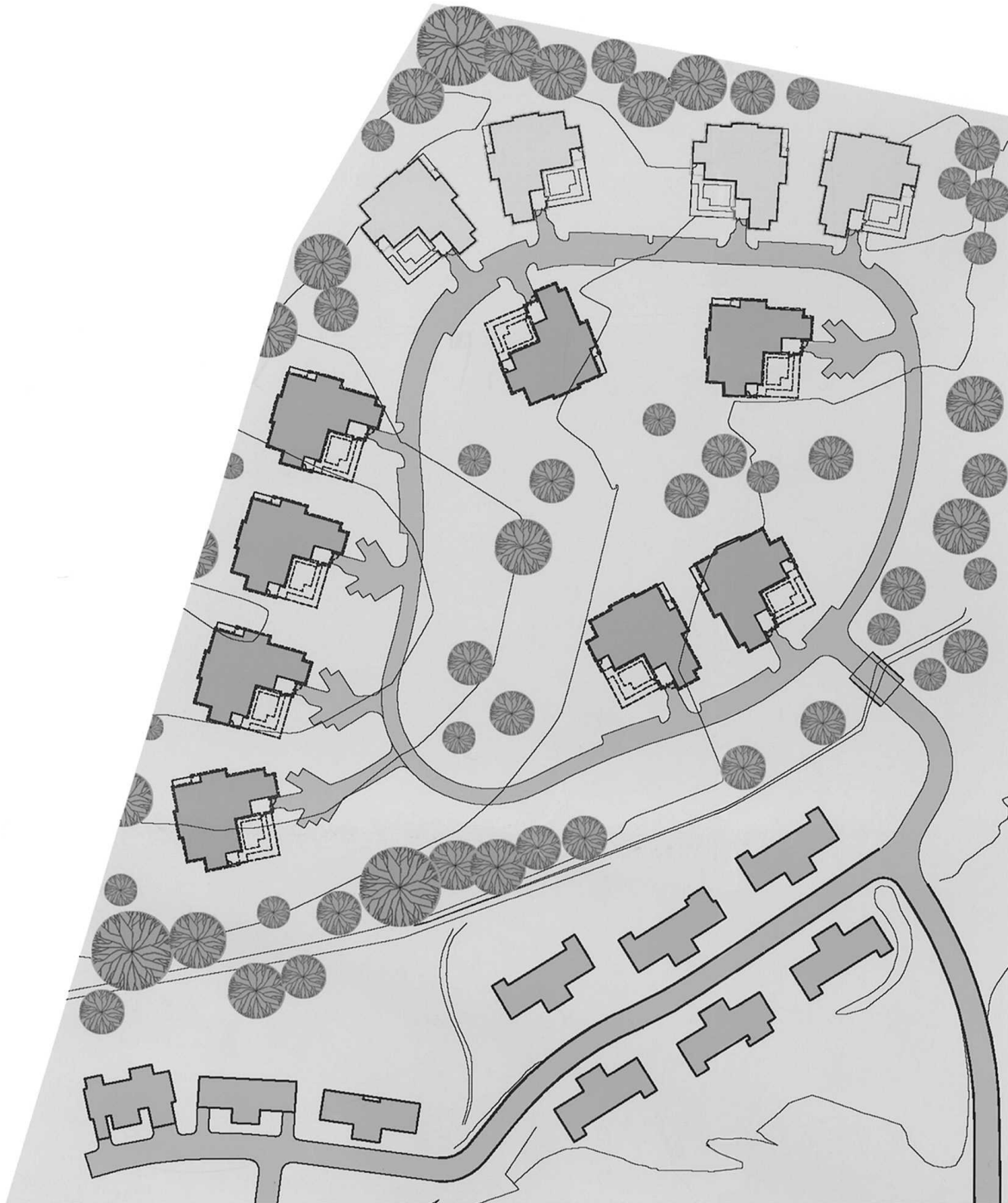


FIGURE 8-8 Overhead Perspective of Green Houses (Small Residential Structures Spread Across a Campus)
Reproduced with permission from The McCarty Company, Tupelo, Mississippi. Courtesy of Stephen Ladd.

Compared to traditional nursing homes, the Green House model requires a higher ratio of nursing assistants, but overall staff time (combined nursing and nonnursing) is slightly less (Sharkey et al., [2011](#)). The staff are cross trained to do food preparation, light housekeeping, scheduling, and activities (the concept of “universal worker”). The cross-trained, self-managed worker teams create a decentralized organizational structure that modifies the typical supervisor–subordinate relationships.

The Green Houses are supported by the traditional organization of a skilled nursing facility nearby in which functions such as professional nursing, rehabilitation therapies, medical records, accounting, billing, purchasing, and plant maintenance are located. Interdisciplinary clinical support teams carry out individualized

clinical assessment and care planning and visit the elders to meet their treatment needs. Clinical practice guidelines based on medical research and standards, as well as emergency protocols, are used by caregivers (Rabig et al., 2006).

Individual choices and preferences are preserved by allowing the elders the maximum possible latitude in establishing their own daily routines for sleep, rest, meals, personal care, and activities. Elders who can participate in meal preparation, gardening, cleaning, and laundry work are encouraged to do so.

To promote bonding between assistants and elders, the two groups sit around a large common dining table and together enjoy a family-style meal. The assistant may help feed the resident sitting in the next chair. Even tube-fed residents may be brought to the dining table for sensory stimulation from the music, the chatter, and the aroma.

Some small-scale studies have found that the family-like environment is well received by residents, visitors, and staff (Cutler & Kane, 2009). Self-reported quality of life by elders is higher and there is less decline in activities of daily living functions (Kane et al., 2007). On the other hand, the evidence to support consistent assignment and universal workers is less strong in terms of outcomes (Zimmerman & Cohen, 2010). In their research, Cohen et al. (2016) found that more than a third of residents did not have complete choice of awakening time, and nearly two-thirds reported residents could not make unrestrained choices about bathing times. Also, contrary to the model, homes excluded residents from some key decisions. Cohen and colleagues (2016) concluded that many unanswered questions remained about Green House homes, especially because there is variation between the homes in the implementation of key model elements.

Environment for Residents with Dementia

Compared to large institutions, small groupings of residents in a homelike environment provides a more effective therapeutic setting for people with dementia. Leibrock & Harris (2011, p. 27) reported a case in which people with dementia were moved into a 10-room group home from larger institutions in Sweden, where all these residents were incontinent and heavily medicated. Within 3 months, none of the residents needed diapers, sleep medications, or psychoactive sedative drugs. Moreover, these residents no longer displayed aggressive behavior, wandering, anxiety, and episodes of screaming. Cost savings of 30%–40% were realized compared to care in nursing homes. Smaller scale environments reduce stress that such residents may experience from the overwhelming effect of being placed in complex surroundings. Although there is some debate over whether segregation of residents with dementia within larger institutions is the right approach (Calkins, 2018), there is some evidence of an increased risk of elder-to-elder aggression or mistreatment in integrated environments (Lachs et al., 2016). It is critical to note, however, that a good physical environment alone cannot create a therapeutic milieu without the appropriate integration of care practices and relationships (Chaudhury et al., 2018).

Seating arrangements can make a difference in promoting meaningful engagement with others. Sitting across from or at right angles from another individual is more conducive to conversation than sitting right next to someone facing in the same direction (Calkins, 2018). Research shows that smaller-sized dining rooms with more homelike décor are associated with reduced anxiety and agitation, increased social interaction, and improved food and fluid intake (Chaudhury et al., 2018). Increased lighting and use of brightly colored dishes have also shown to increase food intake (Brush et al., 2002).

The various aesthetical factors discussed previously are applicable to environments in which residents with dementia are cared for. It should be noted, however, that sharp color contrasts and patterns can be disturbing (Calkins, 2018). Bluish light may reduce restlessness, a common behavior among people with dementia (van Hoof et al., 2009).

Safety is an important factor. Electronic guards to prevent wandering may be essential, yet dementia settings must provide easy access to the outdoors. Nature-related activities and simply being outdoors are often an essential therapeutic resource. Connection to nature extends to people's interaction with animals. Pet therapy, even the use of robotic animals, can decrease agitation and other negative behaviors and improve social interactions (Aarskog et al., 2019).

Terminology for Review

autonomy
biophilia
consistent assignment
culture change
Edenizing
enriched environments
Green House
intimacy
person-centered care
sick-role model
thriving
wayfinding
zoonosis

For Further Thought

As a nursing home administrator who has just been appointed to manage a skilled nursing facility that was built in the 1970s, how would you go about delivering person-centered care?

CASE

Edenizing Gone Awry?

In the certification survey of a facility, eight deficiencies were cited, including one for inadequate supervision of residents. The Centers for Medicare and Medicaid Services imposed penalties, and the facility appealed. On appeal, the case came before an administrative law judge. In his decision, the judge upheld the deficiencies and the fines imposed based on the care of eight residents, seven of whom had sustained repeated falls and one resident who was injured during transfer when a mechanical lift that was ordered by the resident's physician was not used. Three of the deficiencies were classified as "immediate jeopardy," which carried a penalty of more than \$3,000 per day.

Prior to the incidents, the facility had implemented the Eden Alternative program, which was supported by the facility's medical director. During the court hearing, the facility's administrator argued that Eden promotes residents' mobility and ability to express preferences, recognizing that there will be ensuing risks and that Eden promotes allowing residents to take reasonable risks and enjoy the last years of their lives. The administrator further asserted that the state's legislature had mandated that facilities employ the Eden Alternative program in care delivery. The facility's medical director testified that the facility "embraces the philosophy of a resident-centered environment. We promote residents making their preferences known. Even if these preferences are considered by some to be poor, we recognize that permitting freedom and quality of life includes risks."

Questions

1. What main lesson can you derive from this case?
2. Based on what you would have learned in previous chapters, did the facility follow the law?
3. Was Edenizing a mistake? If not, how could the nursing home administrator have prevented the deficiencies while also Edenizing the facility?

For Further Learning

Eden Alternative, <http://www.edenalt.com>

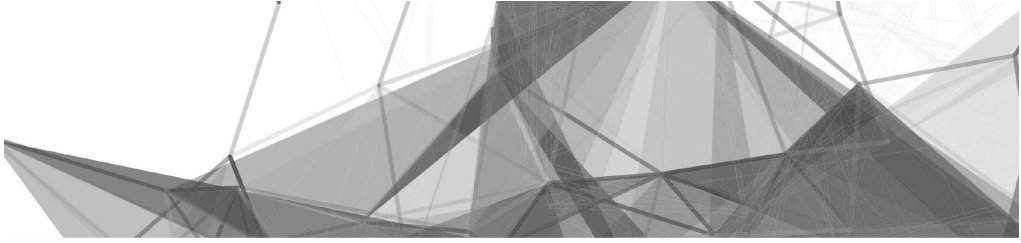
The Green House Project, <http://thegreenhouseproject.org/>

The Pioneer Network, <http://www.pioneernetwork.net>

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CHAPTER 9

Social Services, Admission, and Discharge

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WHAT YOU WILL LEARN

- Social workers in long-term care facilities coordinate admission and discharge of residents. Social services also deal with the residents' psychosocial concerns.
- The size of the facility and scope of responsibility are two main factors on which social services staffing is based.
- Skills of engagement, assessment, communication, conflict resolution, interviewing, and documentation are essential to effectively perform social service roles and tasks.
- The variety of social service tasks can be best understood through six different roles: informational, case manager, coordination, enabler, intervention, and advocacy. An ethics committee can help resolve sensitive or serious issues.
- Admission and discharge functions include preadmission inquiry, admission and orientation, and discharge planning.
- The parameters for transfers and discharges are defined by regulations.
- Regulations also provide formal guidelines for filing grievances and their resolution.
- The resident council is a self-governing forum. It gives residents a sense of control through involvement in decision-making about their quality of life.
- Family management is a proactive approach to minimize dissatisfaction and conflict. Programs should be developed to achieve productive results.
- Nursing home staff must be prepared to address certain legal, emotional, and supportive elements of death and terminal illness.

Introduction

The nature of social work in a long-term care (LTC) facility brings the social worker into extensive contact with current and potential clients. The practice of social work requires sensitivity to people's needs and an understanding of the problems and issues that people may face when they must live within social systems that can be large and complex. Hence, dealing with residents' psychosocial concerns is at the heart of good nursing home social work (Bern-Klug et al., [2010](#)). The term [psychosocial](#) refers to a constellation of social and emotional needs and the care provided to meet those needs (Vourlekis et al., [2005](#)). When psychosocial issues remain unaddressed, they can lead to depression, anxiety, and physical illness. Eventually, the person may lose touch with reality as a means of coping, and the will to live may even lessen (Bern-Klug et al., [2018](#)). The focus of social services is on supporting the coping and adaptive capacities of individuals, especially for those who may lack a primary support system of family and friends. Social services are an essential component of LTC from preadmission planning through a resident's stay in the nursing facility to the time of discharge. The social worker performs key planning and coordinating functions through these stages of change in a person's life. If the resident's family is involved, they are treated as an essential part of the team effort for the resident's benefit.

Social Services Department

Staffing and Qualifications

Federal regulations (F850¹) mandate a full-time social worker for facilities that have more than 120 beds. These social workers must have a bachelor's degree in social work (BSW) or in a human services field and have at least one year of supervised social work experience in a health care setting working directly with individuals. However, regardless of the facility size, regulations require all facilities to provide medically related social services to help residents attain or maintain their highest practicable physical, mental, and psychosocial well-being (F745). Each state may have its own requirements for social services. Apart from these minimum requirements, however, staffing considerations should be based on the overall scope of responsibilities assigned to the social services department. Larger facilities generally have a director of social services, who is in charge of one or more assistant social workers. A facility of 100 beds or more may also have an additional position of director of admissions, admissions coordinator, or director of admissions and marketing, who may report to the administrator or to the director of social services.

A national study found that a full-time social worker was typically employed to serve 80 to 90 residents, but there were considerable variations among facilities. Social services directors, on the other hand, indicated that a full-time social worker could address the needs of 60 or fewer long-stay residents or 20 or fewer subacute care residents (Bern-Klug et al., [2010](#)).

Social workers in a geriatric setting must have an understanding of the physical and psychosocial changes that accompany the aging process. They must understand the unique needs of elders and demonstrate a desire to work with the problems and issues confronting clients in nursing facilities. In LTC facilities that had qualified social workers, residents showed improved behavioral symptoms, which resulted in reduced use of antipsychotic medications (Roberts et al., [2020](#)).

Social workers should also possess certain personality traits, such as trustworthiness, compassion, patience, thoughtfulness, and ability to listen. They must be knowledgeable of community resources, and they need to establish linkages with various external agencies in order to obtain needed services for residents and their families.

¹ Federal regulations for nursing homes are identified by F-Tags.

Skills and Competencies

As discussed later in this chapter, social workers serve in a variety of roles. To carry out these roles effectively, social workers must learn and develop skills in at least six main areas:

- Engagement
- Assessment
- Communication
- Conflict resolution
- Interviewing
- Documentation

Engagement Skills

Engagement requires building rapport with residents and their families. Deficiencies in human relations skills can severely hamper a social worker's effectiveness. Skilled social workers can play an especially important role in training other staff members in effective ways to interact with the residents and their families.

Assessment Skills

Assessment requires a systematic investigation of all basic and special needs of the individual, including the resident's own perspective as well as that of his or her family or surrogates. Special attention is paid to the person's biophysical functioning in relation to psychological and social processes, such as the resident's attitudes about being in the nursing facility, economic needs, family support, and race or cultural issues. The information gathered from the assessment is used to determine how the facility's resources and services will be deployed to best address the needs of clients. Such a plan of action takes into account any limitations in resources the nursing facility may have. When a facility is unable to furnish the resources necessary to address all the identified needs of a resident, services from outside the facility must be procured or the resident should be moved to a more appropriate setting.

Communication Skills

Communicating with elders requires special skills apart from speaking, listening, writing, and making presentations. Particular attention must be paid to language use with older adults. Use of technical jargon is commonplace among nursing home associates, but such jargon should be avoided when communicating with residents and their families. For example, associates should use the term "food service" instead of "dietary," "recreation" instead of "activities," and "evaluation" instead of "assessment." Simple and straightforward language is the most effective method of verbal communication. A handshake or touch adds warmth to the communication process. Sitting in close proximity to an older client aids understanding of what is being said and is also taken as a sign of acceptance. Active listening, repeating, and feedback are essential techniques for communicating with seniors to ensure understanding. Because hearing impairment is a common problem among nursing home residents, clear diction and a slow pace of talking are important. Another good strategy is to use the residents' names frequently, so they know that they are being addressed.

Conflict Resolution Skills

More than any other staff, social workers in nursing facilities are typically called upon to intervene in conflict situations and sometimes to manage irate family members (Allen et al., [2007](#)). Conflicts can be attributed to several sources, such as disagreement or differences in values, attitudes, needs, or expectations. Conflict can also arise from miscommunication. The results can be residents who withdraw and get depressed, residents who lash out at others, or irate family members. In trying to deal with such conflicts, social workers may themselves experience resistance when they are advocating for the needs and interests of the resident, especially when those needs and interests come into conflict with the nursing home's administrative policy and practice.

A conflict-resolution model in which the social worker should evaluate four main factors is proposed (Allen et al., [2007](#)): (1) needs of the resident; (2) evidence of the urgency of the resident's need; (3) legal and ethical implications; and (4) likelihood of resistance from some entity, such as associates, management, or family. A simultaneous review of these four factors can lead to one of five possible resolutions according to the Thomas-Kilmann Conflict Model: avoiding, compromising, accommodating, collaborating (or problem solving), and forcing (or confronting).

- *Avoiding*. The social worker makes an effort toward improving the situation through education, subtle suggestions, or better relationships, but the conflict is not dealt with directly. For example, a family member may insist that caregivers help the resident dress even though the resident may be able to dress herself given adequate time. This family member may need some education about why it is important for the resident to do such tasks independently to the extent possible. Avoiding can also be accomplished by separating two individuals who cannot get along. For example, two roommates may be assigned to different rooms. In most other instances, however, avoiding is not a good strategy. When left unresolved, the underlying issue may fester and create an explosive situation later on. For example, avoiding a family member who routinely complains about the services is likely to make this person more irritable as time goes on.
- *Compromising*. This involves bargaining and taking a middle ground. Each party gives up something to get something else in return. This approach is used when the four factors play a moderate role. A resident may insist on smoking even though there are contraindications on medical grounds and the facility has a nonsmoking environment. However, for each side to gain, a compromise is struck where the resident is able to smoke in a designated area at designated times with the assistance of a staff member or family member.
- *Accommodating*. Here, the social worker can help the resident best by smoothing relationships, repairing trust, and reopening lines of communication using nonassertive cooperative behavior. This strategy is valuable when it is important to appease the other party because the facility is wrong on the issue and the issue may not be very important. An example of this would be when a piece of resident's personal laundry is missing, the social worker asks the administrator to replace the item, and the cost of doing so is reasonable.
- *Collaborating (or problem solving)*. This approach requires a careful definition of the problem, alternative solutions, evaluation of costs and effectiveness of each solution, and choosing a solution that best accommodates the needs of those involved. This approach is useful when resident needs are high and low resistance from associates or management is expected (Allen et al., [2007](#)). For example, a resident with severe dementia may have a chronic shortage of appropriate clothes to wear. A meeting with the family may involve the social worker and one or two caregivers to discuss alternatives. If the family is not inclined to purchase more new clothing for the resident, the staff may discuss alternatives, such as using the resident's personal funds to buy new clothing, asking a faith-based organization to donate clothing, or purchasing used clothing.
- *Forcing (or confronting)*. When faced with a high degree of resistance, forcing may become necessary when the resident's needs present urgency and high legal or ethical stakes are involved. Examples include flagrant violation of resident rights, negligence, or abuse. Confrontation would require that the social worker present clear and convincing evidence of the resident's compelling need (Allen et al., [2007](#)).

Interviewing Skills

Interviewing is commonly used for gathering facts about individual situations, especially when dealing with complaints and problems brought to the management's attention. As an interactive tool, interviewing involves communicating in a more focused way than usual. Effective interviewing generally requires some prior preparation, such as gathering background or other preliminary information that is used as the basis for further probing to obtain more pertinent and detailed information. When preparing for the interview, the social worker needs to think through what specific questions to ask.

The actual interview requires a private and quiet place and adequate uninterrupted time. Effective interviewing employs the skills of engagement and communication described previously. But it goes beyond a mere use of those skills. An interview should get to the main point of the issue and begin with a summary of the issue and the purpose of the interview. It is important to pose questions that get to facts and feelings. Questions posed accusingly or in a suspicious manner would only make the person erect defensive barriers. During the interview, particular attention must be paid to special cues that may require further probing. For example, the individual may try to dodge an issue or may be hesitant to respond to a question. A victim of abuse may be reluctant to discuss it because of embarrassment or fear of retaliation. The interview should conclude with a summary that puts the total interview in perspective for the individual, who should then be asked if any information is incorrect or missing. The social worker should also explain what follow up will take place.

Documentation Skills

Documentation often requires the use of prescribed forms and formats, but much of this work is now computerized. Documentation must be timely, accurate, complete, and descriptive—but concise. In this manner, social service documentation should provide a complete record of the resident's initial history, assessment, care planning, progress (or lack thereof), interventions, and discharge.

Social Service Roles

Social workers perform a variety of different tasks that are too numerous to describe. Most situations that require social work intervention cannot be foreseen and must be dealt with as they arise. The roles discussed in this section paint a general portrait of what a social worker employed in a nursing facility does. These roles also highlight the importance of the social worker's position. The various roles and functions can be classified into six main categories:

- Informational
- Case manager
- Coordination
- Enabler
- Intervention
- Advocacy

Informational Role

The social worker is generally the main source of information for prospective clients on several fronts: the facility and its services, eligibility for public financing and the services covered under programs such as Medicare and Medicaid, resources and services available in the community and their suitability for a particular client, and various issues related to LTC. A social worker must acquire comprehensive knowledge in all these areas.

Although prospective clients are the primary recipients of information about the facility, professionals in other health care and social service agencies also need to be educated about the facility's services. One skilled nursing facility can differ substantially from another on the level of specialization, philosophy of care, socioresidential environment, and so forth. Such differentiating factors should be used in marketing the facility to potential sources of client referrals.

Case Manager Role

As a case manager, the social worker generally coordinates external resources to meet the total care needs of each resident. Upon a resident's admission, the facility takes on the responsibility of providing or procuring all appropriate services that the resident may need—a concept called "total care." Services not provided by the facility are obtained from external sources. For example, a resident may require eyeglasses or dental care or may need a psychiatric evaluation. A referral for such services may require obtaining orders from a physician, involving family or other responsible party, following up on financing, making an appointment with an appropriate professional, arranging transportation, and following up to ensure that the resident has actually received the service and if any return visits would be necessary.

Coordination Role

The social worker's coordination role goes beyond case management. Each admission and discharge requires careful coordination with both key staff members within the facility and with relevant parties outside the facility. The social worker is generally the facilitator of the resident council within the facility or a family support group sponsored by the facility. The social worker is also generally called upon to assist the facility administrator in sharing the facility's expertise with the community through well-coordinated programs on geriatric issues and financing for LTC. Examples include sponsoring a support group for dementia-related issues or a support group on handling personal guilt and anxiety associated with institutional placement, sponsoring a seminar on Medicare and Medicaid coverage for LTC, and disseminating information on respite care.

Enabler Role

In this role the social worker functions as a facilitator. For example, new residents require adjustment to the new surroundings and the unfamiliar routines of the facility. The process and time required for adjustment varies from one resident to another. Social workers help residents adjust by frequently visiting them and by encouraging them to express their fears, anxieties, and feelings. Social adjustment is also facilitated by assessing compatibilities and introducing residents to others to encourage social bonding.

The resident's family also requires adjustment. Family members often carry feelings of guilt from putting a close relative in a nursing home. There may be conflict among family members over the decision. The social worker can help family members explore their own feelings, clarify areas of disagreement, and confront the realities of the situation.

Intervention Role

The social worker is called upon to address a variety of problems that nursing home residents may face. It often requires good communication and conflict resolution skills, discussed earlier. In most instances, the resident has a conflict or lacks the ability to cope with his or her environment. Examples of this type of conflict include a resident repeatedly losing her eyeglasses or not having enough clothes to wear. The conflict may involve other people, such as an associate or family. For instance, the family may find it too expensive to replace lost items and may not favor purchasing new eyeglasses or hearing aids. The family may blame the facility for losing items of clothing and decline to replace them, with the result that the resident has insufficient or inappropriate items to wear. There may be conflict between two residents who may or may not be sharing a room or a dining table. Some conflicts arise from psychosocial problems or dementia and may require therapeutic intervention. Activity personnel as well as nursing personnel may be called upon to assist with these therapies.

Advocacy Role

The social worker is an advocate for the resident. It is the social worker's responsibility to inform residents of their rights. The social worker also monitors the enforcement of resident rights in the facility and educates the staff on the meaning and importance of resident rights. Many residents cannot express their desires and cannot determine on their own what is best for them. In the advocacy role, the social worker does not try to guess the resident's wishes; rather he or she is responsible for bringing resident-related issues to the attention of appropriate department heads, the administrator, or any other parties whose involvement may be necessary for decision-making and initiating action. For instance, a resident may have already lost two hearing aids and may be unable to express whether he or she needs a new one. The family may resist investing money in a third hearing device because, within reason, the facility has a responsibility to safeguard residents' personal property. This resident needs someone to stand up as an advocate on his or her behalf.

The Ethics Committee

Effectively managed nursing homes have ethics committees to address issues that may present a dilemma. The social worker brings issues to the attention of the committee for decision and resolution. An [ethics committee](#) is a multidisciplinary forum that may include the administrator, a nurse, a physician, social worker, activity director, and others as necessary. Depending on the issue, the committee may also include a member of the clergy, an ethicist, a legal representative, a dietitian, or a therapist. Generally, family members are also invited to attend and to provide their input. The committee's purpose is to discuss the situation brought before it and resolve issues in view of what is best for the resident. A multidisciplinary forum allows for different insights and viewpoints. It relieves the social worker of the responsibility for making complex decisions independently. When the consequences of a decision turn out to be negative, blame cannot be assigned to one person. Finally, the decision of a committee is more likely to be accepted by individuals, such as family or staff members, whose action or support is necessary for carrying out that decision.

The Admission Process

The facility must have a written admissions policy outlining certain preconditions of admission. For certified facilities, the policy must comply with federal regulations. For example, F620 outlines admission expectations related to (1) preserving resident rights (for instance, the facility cannot ask potential residents to waive the facility's liability for losses of personal property), (2) payment requirements and protection from discrimination based on payer source, such as Medicaid, and (3) any service restrictions, such as religious affiliation, that guides the facility's practices and routines.

Preadmission Inquiry

The social worker is generally the one to first meet a prospective client, unless the facility has a separate director of admissions, who would then be the one to take most inquiries. A prospective client or a referral agency may call the facility and make arrangements for a family to visit the facility. In other instances, an inquirer may walk in unannounced. The facility must be prepared at all times to handle either situation promptly and professionally because in today's competitive environment, an inquiry delayed is an admission lost.

Handling an inquiry is akin to making a sale, but using a social service approach. This approach requires the intake worker to function as an information disseminator and case manager. The focus is not simply on finding new residents for admission to the facility but also on determining whether the nursing home is appropriately suited to meet the resident's needs.

PASRR Compliance

PASRR stands for Preadmission Screening and Resident Review. One of the provisions of the Nursing Home Reform Act (OBRA-87) was to eliminate inappropriate placement of people with serious mental illness, or intellectual and/or developmental disabilities in Medicaid-certified (NF) nursing homes. The federal law required the states to establish procedures to screen Medicaid-eligible individuals before admission to a nursing home. These screening procedures vary from state to state. In some states, the nursing home may have the responsibility to do the PASRR. A review is also required when there is a significant change in the resident's condition. Only when a resident is admitted for less than 30 days based on a physician's certification is the PASRR not required.

There are two levels of PASRR screenings. Level I screening is required before admission. A person with mental illness or intellectual and/or developmental disabilities may be admitted as long as the resident's needs cannot be adequately met by community-based services. Level II screening provides for a more detailed assessment and serves as the basis for determining whether the nursing home setting is appropriate for individuals just described, whether their rehabilitative needs can be met in the nursing home setting, and if so, what specialized rehabilitation services related to their mental illness or intellectual/developmental disability are necessary.

Once the resident is admitted, the nursing facility is obligated to provide the necessary care and services the resident requires to attain or maintain the highest practicable physical, mental, and psychosocial well-being. For example, the facility may have to obtain specialized mental health services for the resident.

Written Procedure

The facility should have a written procedure for handling inquiries. The procedure should include a list, in descending order of preference, of backup personnel in case the primary intake worker is not available. For instance, the list of personnel could start with the director of admissions and include the social worker, a second social worker (if the facility has one), the administrator (or an administrative staff member such as an assistant administrator, if the facility has one), the director of nursing, and the activity director. The point here is that the facility should always have someone to provide complete information, regardless of whether the inquiry is initiated over the phone or in person.

All personnel assigned to this task must be properly trained in inquiry handling procedures. The facility should also have a plan for handling inquiries after regular business hours and on weekends. For example, many well-run nursing facilities designate a weekend manager. This role is carried out by the primary and secondary intake professionals mentioned above, who cover the role of weekend manager in rotation. An evening charge nurse or nurse supervisor should also be trained to handle the occasional inquiry that may come in after regular business hours.

Initial Interview

The interview should always take place in a private location free from any distractions. Handling an inquiry is an art, which is perfected with time and practice. A preprinted inquiry checklist can greatly facilitate the interview. Even if the intake process is computerized, making entries during the interview should be avoided because it depersonalizes the process.

The objective of the interview is to obtain essential information about the potential resident, starting with his or her name, age, gender, current location such as hospital or home, name of referring agency (if any), attending physician, when accommodation may be needed, diagnosis, activities of daily living (ADL) status,

hobbies and interests, any special needs, and so forth. The inquiry checklist should also have space for the inquirer's name, relationship, phone number, and address. Even though all pertinent information is obtained at this time to make a judgment about the resident's needs, this is not a formal assessment, nor should an attempt be made at this juncture to make one.

Once the basic information has been obtained, the interview moves on to a discussion of the facility's services that can best meet the resident's needs based on the information provided. The intake worker may call in the director of nursing, a specialized nurse, a therapist, or the dietitian to provide additional expertise if specific questions arise during the interview. The facility should evaluate the case objectively. Admitting someone and then not providing adequate services because the facility is not equipped to handle the care that the person's condition demands would be a mistake. On the other hand, if a community-based LTC program or a residential institution is determined to be more suitable for a prospective client, a referral should be made. Establishing exchange partnerships with external agencies can result in two-way referrals, creating a win-win situation for both parties.

Facility Tour

Prospective clients seldom decline to tour the facility, but it can happen if the initial interview turns them off. This phase of the inquiry process consists of a guided tour, during which the inquiring party is accompanied by the intake worker. Well-managed facilities have a written tour plan, which is used for training staff members who may be called upon to conduct facility tours.

The tour should highlight the various elements of the internal environment and caregiving philosophy from the standpoint of person-centered care. Some of the main areas of the facility to include in the tour are dining rooms, lounges, social and private spaces, rehabilitation settings, and the activity calendar. Many facilities have a large, wall-size calendar of activities and events. A stop at the posted activity calendar and some comments on the variety and substance of the activities must be part of the facility tour. In addition, safety features and practices, comfort factors, privacy aspects of care, and enrichment of the environment and culture change should be emphasized in the conversation while touring the facility. The visitor must be able to observe and feel the caregiving environment to the fullest extent possible without compromising the privacy of residents receiving care. For example, activity sessions and certain therapies, such as gait training, can be observed without compromising privacy. It is inappropriate to take visitors into occupied resident rooms unless permission to see their rooms has been obtained in advance. Some facilities set apart one or two furnished model rooms for visitors to see and to get some ideas about how a room may be personalized by bringing items such as small television sets, memorabilia, plants, personal furniture, and bed accessories (personal pillows, comforters, etc.). Visitors should not be taken into the kitchen because it violates sanitation regulations.

Concluding Interview

The conclusion of a tour always brings the inquirer back to the place where the initial interview was conducted. The intake worker now continues to assess the client's reactions and provides an opportunity for questions and answers. At this point, financing should be discussed. If appropriate, the accounts manager may join the conversation to answer questions about financing. For instance, the resident may be eligible for Medicare, Medicaid, or both. In some cases, an application may have to be made for Medicaid coverage. If the resident would come in under Medicare, an approximate length of stay and out-of-pocket costs should be discussed. Private-pay rates should be furnished if that is appropriate. If the resident has private insurance, coverage under a managed care plan, or veterans' benefits, all necessary information should be obtained. Bed availability, wait-list status, or a tentative date of admission should also be discussed at this time.

Information Packet

Before the prospective client leaves, he or she must receive an information packet, and the intake worker should briefly go over some of the materials contained in the packet. The information packet should be professionally designed and should contain all relevant information that may be needed for making a decision about placing someone in the facility. If the client has no further questions, the client should be courteously escorted to the main lobby and given a personal send-off.

Follow-Up

When different personnel are involved in handling separate inquiries, all inquiries should be channeled to the person who has the primary responsibility for inquiry intake, such as the director of social services or the director of admissions. This individual should follow up on all inquiries, and the final disposition should be noted. If a prospective resident was considered an appropriate client for the facility but was not admitted, an attempt should be made to find out the reason the facility was not selected. Inquiry dispositions should be periodically reviewed with the administrator. Over time, this information can be useful in identifying weak spots and taking appropriate measures to improve operational policies, procedures, and services.

Admission and Orientation

Nursing home admission trauma is common and affects most residents. But the social worker can take steps to minimize a resident's fear and anxiety. One source of anxiety for the resident, and of guilt for the family, is

stereotyped and unpleasant images of nursing homes. Despite efforts made by industry leaders to change the gloomy portrayal of nursing homes, the effect of these images has not been fully overcome. Hence, the adoption of culture change and enriched environments can pay rich dividends over time.

Planning and Preparation

Sometimes, it may be possible for the social worker to visit a prospective resident at his or her current location. The purpose of such a visit would be to attempt to allay unfounded fears that the prospective resident may have. A sizable number of residents are admitted to nursing facilities on a short-term basis for rehabilitation and convalescence. If that is the case, the fact that it will be a short-term stay must be emphasized to the resident, who otherwise may be thinking that admission to the facility may be his or her final living arrangement before death. If a long stay is contemplated, the social worker should emphasize the vibrant living environment of the facility and the opportunity to pursue one's own interests and to make new friends. Autonomy, privacy, and other features should be highlighted. This is also an appropriate time for the social worker to discuss with the family which personal belongings may or may not be brought to the facility.

Any special instructions from the family should be passed on to the staff members who will be involved in the resident's care. Associates can be better prepared if they know in advance the resident's requirements, such as assistance with specific ADLs, incontinence, resident's preferences, or other special needs. In case of shared accommodation, compatibility with the roommate must be evaluated in advance.

Before admission, the resident's room must be given special attention to ensure that everything is in order. Paying attention to minute details is critical. For example, a corner of the room may need additional cleaning, a wall may need some touch-up paint, or a leaky faucet in the bathroom may need fixing.

On the day of admission, a flower arrangement in the room is always a welcoming sign. The administrator may also stop by for a welcoming handshake. If the admission takes place close to meal time, the family or friends who are accompanying the resident should be invited to dine with the resident in a private area. The resident may, however, express a preference to dine alone in the room or go to the dining room.

Admission Records

An important part of the admission process is ensuring all pertinent medical records have been forwarded to the facility at the time of admission, either from the hospital or another facility. If the resident is coming from home or a residential facility, medical records must be obtained from the admitting physician's office. Records must include current physician's orders certifying the need for admission to the facility and orders for medications, nursing treatments, rehabilitation therapies, therapeutic diets, etc.

The social worker should also complete the admission paperwork. The resident or the responsible party must sign an admission agreement, which is a contract between the facility and the resident (or his or her representative). Another important document contains the rights and responsibilities of residents. Other documents should also be completed as required by regulations and the facility's policies. Packets of admission forms should be prepared in advance to ensure that all paperwork gets completed. A monetary deposit may also be required from private-pay clients or if deductibles or copayments are involved. The social worker also completes a social history of the resident. A social history includes pertinent background information on the resident, such as previous occupation, family relationships, cultural background, religious preferences, personal interests, etc.

Orientation

The purpose of orientation is to help new residents adjust to the facility and its routines. The new resident should be introduced to a handful of key staff members, such as the unit's charge nurse, direct caregivers, the activity director, and the dietitian or food service director.

During the first week, the social worker should contact the resident and staff regularly to find out how the resident is adjusting to his or her new surroundings. Communication with the family should also be maintained to ensure satisfaction with the services or to simply stay in touch. Such ongoing contact can prevent conflicts down the road because it enables the facility to address minor issues as they arise. It also projects a caring attitude and allays family's anxiety.

An integral part of orientation is educating new residents about their rights and the decisions and choices they can make. Residents should be encouraged to participate in decision-making so that they do not fall into a pattern of "learned helplessness" because of their dependent position.

Discharge Planning

Discharge planning is a process, not an event. The process includes decisions about when a resident may need to be discharged from the facility and what may be needed to make a smooth transition from one level of care to another or from the facility to living independently. Discharge planning is more appropriately described as continuity-of-care planning. According to the continuity-of-care model (**Figure 9-1**), discharge planning begins when a resident is admitted to the nursing facility. Upon admission, assessment and care planning are approached with discharge outcomes in mind.

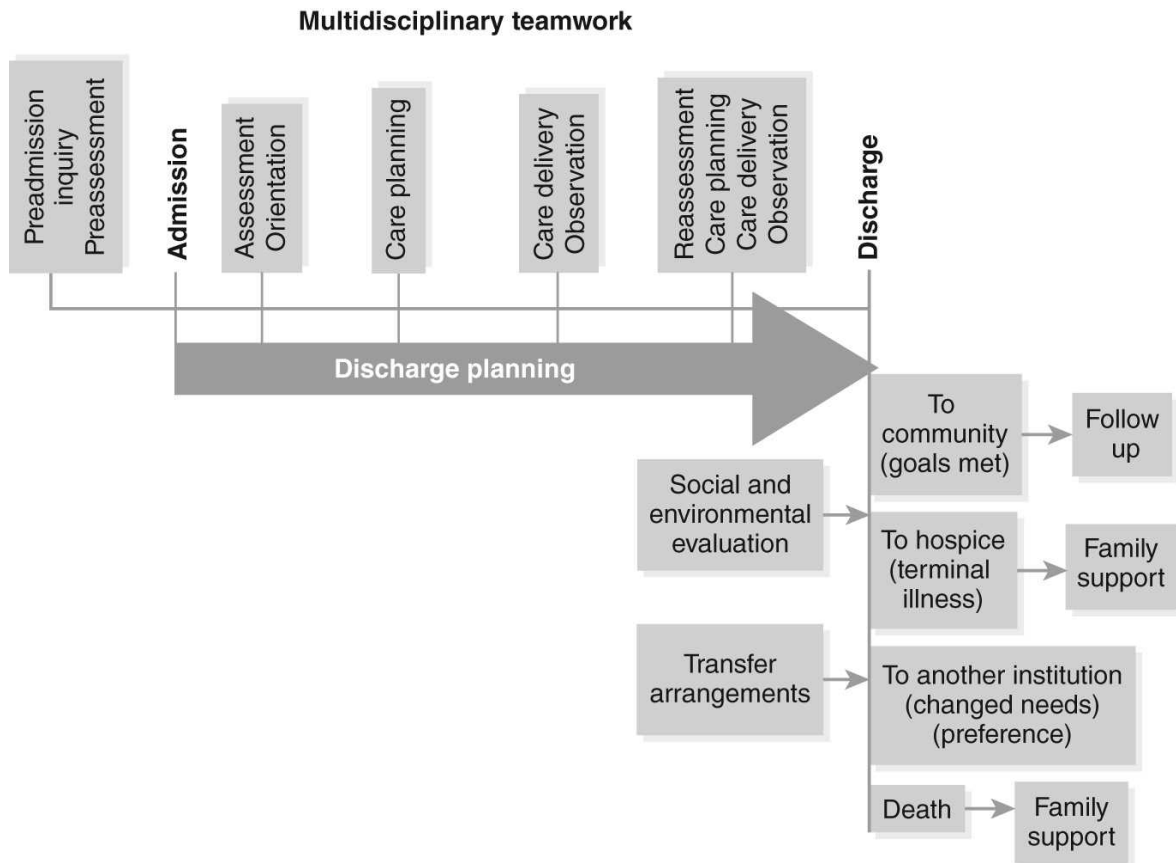


Figure 9-1 Continuity-of-care model

Financial considerations, such as coverage under Medicare, are an important consideration in discharge planning. Medicare does not cover long-term stays in a skilled nursing facility. Length of stay depends on the resident's diagnosis, assessment, and rehabilitation potential. If additional length of stay in the facility is necessary after Medicare benefits have been exhausted, the resident must pay privately or, if he or she is eligible, apply for Medicaid. Otherwise, the multidisciplinary team must prepare for the resident's discharge from the facility.

Ensuring access to services after discharge is a primary consideration in the facility's decision about where the resident will be discharged to and what ongoing services the resident may still need. If a resident will go back to his or her home, the social worker will do a social evaluation to determine whether adequate support services will be available. The facility may refer the resident to a home health agency, in which case the follow-up tasks are turned over to that agency.

Regulations Governing Transfers and Discharges

Federal regulations govern the circumstances under which transfers and discharges can occur in certified facilities (F622): (1) A resident's needs cannot be met at the facility or the resident no longer needs the facility's services, (2) the clinical or behavioral status of the resident endangers the health or safety of others, (3) nonpayment for services by the resident or a third party, including Medicaid and Medicare, or (4) the facility ceases its operations.

Prior to a transfer or discharge, the facility is required to provide written notice (F623) to the resident and his or her representative explaining the reason for the move. A copy must be sent to the state's LTC ombudsman.

Grievances (F585)

Residents have the right to file grievances to the facility or to an external agency without fear of discrimination or reprisal. The facility must provide the residents adequate information on how and where to file grievances. The facility must establish policies and procedures to ensure the prompt resolution of all grievances. The policy must designate an official in the facility who is responsible for overseeing the grievance process through to its conclusion. The facility must notify the resident of the outcome. When grievances are filed with external agencies, the facility must cooperate and facilitate any investigations. The facility is required to maintain documentation on all grievances for at least 3 years.

Resident Council

A resident council is an independent semiformal body made up of all residents who are able and willing to participate. The purpose of this forum is to empower the residents so they can have a say in the facility's operations. An active resident council in the nursing facility helps promote resident autonomy and gives the residents a sense of control. Participation in the council can promote self-esteem among residents who are able to participate in decision-making concerning their own quality of life. The council can also serve as an informal outlet to air grievances before they become larger issues.

The social worker generally assists the residents in organizing a council and to facilitate their regular meetings. For example, the social worker can assist the residents in electing council officers, such as a president, a secretary, and a liaison for special events. Space should be designated where regular meetings can be held in privacy. Although all residents are encouraged to participate, individual involvement is voluntary.

Because the resident council is a self-governing forum, the administrator and other associates attend the meetings only when invited. However, the administrator or other associates may ask the president for time when they can address the council on important issues and policies and provide follow-up reports on any previous concerns expressed or recommendations made by the council.

Family Management

Family management is a proactive approach to minimize dissatisfaction and conflict by addressing family members' emotions about placing someone in a nursing home. The resident's family becomes a secondary client whose well-being is often tied to the resident's own well-being. Maintaining the resident's family ties becomes an important task of social work. The first step in this process is for the facility's administration to promote a policy of unrestricted visiting hours for family members, barring any unusual circumstances, which are often dictated by preservation of the health and well-being of the residents.

Families often do not anticipate placing a loved one in a nursing facility and are not prepared for it. In many instances, admission to a nursing home is preceded by a family crisis, such as the death of the resident's spouse or that of some other informal caregiver, sudden hospitalization for some unforeseen complication, an accident such as a fall that results in a fracture, or the relocation of adult children who may have been providing informal care. Such events can trigger rapid deterioration of a person's physical and mental health. In such situations, families may show signs of desperation, frustration, anger, guilt, or conflict. The social worker's role is to show acceptance and empathy and to provide a supportive outlet for family members to express their true feelings but also face the realities of institutionalization. Also, some families have had a history of internal dissension and resentment. Such dysfunctional family relationships can greatly complicate the staff's ability to adequately deal with the resident's needs because family members may perpetuate disagreements and interference with the facility's practices.

During and after admission, reemphasizing the family's responsibility to stay involved is important provided, of course, that the relationship between the resident and the family has been positive. If a family is no longer involved in the resident's life, the resident may feel rejected. Most families, fortunately, continue to visit, phone, write, and care for residents following institutionalization.

The social worker's task becomes daunting indeed when bitterness and resentment are present between the resident and family members. Trying appropriate interventions and setting reasonable goals and expectations with family members is essential to minimizing negative family dynamics. Otherwise, facility staff may have to accept the fact that tenuous family relationships exist and that staff members should be prepared for occasional tensions between the staff and family. On such occasions, it is critical for the facility's associates to remain politely and pleasantly communicative with the family members. Occasional flare ups also present an opportunity for the social worker to provide training to other staff on how to deal with dicey situations that could turn into unwarranted hostility.

The social worker can also assist families with making their visits with the resident more meaningful and enjoyable, especially when the resident is disoriented, confused, or bedridden. Sometimes, family members of long-stay residents may become volunteers or informally adopt some resident who does not have a family.

The nursing home can also help families by scheduling formal support group meetings and educational seminars. Programs and seminars about visiting skills, understanding physical and psychosocial changes that may accompany aging, nursing home financing, facility policies, the relative merits of assistance and independence, roles and functions of different departments in the facility, volunteering opportunities, relationships with caregivers, and other topics can be informative and productive. Such educational programs can also provide an opportunity for families to meet key facility associates, some of whom they would otherwise never get to meet. These events help families better understand the challenges faced by the facility, and they also help family members form more realistic expectations of what the facility can and cannot do. Although family members, on an individual basis, should be encouraged to express their dissatisfactions and complaints, family seminars help focus on more productive issues. When creatively managed, these seminars can prevent family group sessions from turning into gripe sessions.

Death and Terminal Illness

Death is a reality in health care facilities. Many LTC residents spend their final days in a nursing facility and die there. Nevertheless, the association of nursing homes with death is an unfortunate stereotype. Yet, how a nursing home addresses end-of-life issues and how it provides appropriate services for the dying and their families is an important concern.

Depending on state laws, a death may also have to be reported to the police and coroner or medical examiner. At the time of admission, many nursing homes obtain information about advance directives, end-of-life wishes, and funeral arrangements in case of death. If such information exists in the resident's medical record, the funeral home should be notified for the removal of the remains.

People may perceive death in a nursing home to be a normative event, meaning it is normal for old people to die. Such an overgeneralization, however, can become a stereotype. Even for the geriatric resident, death is an individual event. Geriatric residents have the same tensions, fears, and despair as any other age group facing death. Also, the family's reactions to death are not homogeneous (Ewen et al., 2016).

Social workers, nurses, and even physicians are not always prepared to react to death and dying. Yet, the social worker must be prepared to lend support to family members who have lost a loved one and also to caregivers who often feel the loss of a resident they have been intimately involved in caring for.

Hospice care is an appropriate end-of-life service for many terminally ill residents. Although the decision to pursue or not to pursue this alternative is left strictly up to the residents and their families, the social worker should provide adequate counseling so that an informed decision can be made. If the hospice option is chosen, a written consent is required that any attempts to cure terminal illness or active interventions to save life will not be pursued. In many instances, hospice services will be brought to the facility.

Social workers can help terminally ill residents and their families by simply being present and using kind words. Terminally ill residents generally go through the stages of denial and isolation as initial defense mechanisms; anger and resentment because of frustration and helplessness; depression emanating from feelings of guilt, failure, and despair; and, finally, acceptance of one's fate and gradual detachment from the surroundings, including close loved ones. Family members also go through similar stages (Kübler-Ross, 1997). Throughout this process, feelings of fear and anxiety may be expressed. Family members, on the other hand, may carry feelings of guilt. Stress and contention among family members may be observed. Social workers and other associates can do very little to help people overcome these emotions. But they can be supportive and understanding throughout the process.

Terminology for Review

discharge planning
ethics committee
family management
PASRR
psychosocial
resident council

For Further Thought

Why should a health facility administrator become familiar with social services? Make a list of the various topics in this chapter that will be helpful to the administrator, and explain how these topics can be helpful.

CASE

The Pajama Man

A male resident insists on wearing his night pajamas throughout the day. When asked about it, the resident said, "I feel more comfortable in my pajamas than in pants and shirt. I do dress up when I go out though, but at home I can wear what I want." The staff has been trained to assist residents with their grooming needs in accordance with the time of day. The nurses know that the annual certification survey would take place at any time, and the facility could be cited for not dressing this resident appropriately. Besides, the activity director has stated to the nurses that the ladies are particularly offended when this resident shows up at social functions. "They refer to him as 'the pajama man,'" she said. The situation was turned over to the social worker who explained to the resident the facility's policy on grooming and that dressing up was good for his self-esteem. The resident simply retorted, "Leave me alone. I will not wear pants and a shirt."

Questions

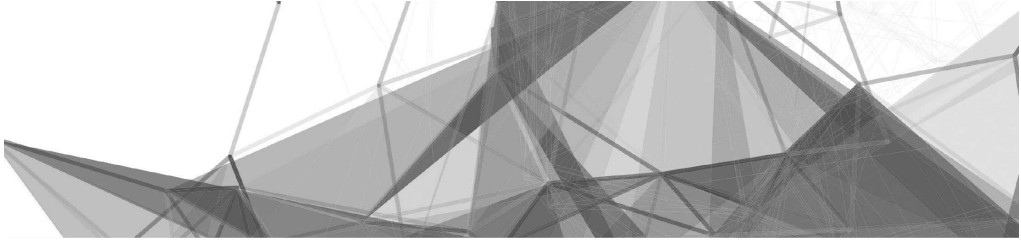
1. Did the social worker handle the conflict appropriately? How should she have approached the issue?

For Further Learning

National Association of Social Workers. <https://www.socialworkers.org>. Social Work Policy Institute. <https://www.naswfoundation.org/Our-Work/Social-Work-Policy-Institute>.

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CHAPTER 10

Medical Care, Nursing, and Rehabilitation

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WHAT YOU WILL LEARN

- Medical care in a nursing facility is akin to primary care office-based practice. Nurse practitioners and physician assistants fill some of the gaps in medical care.
- A licensed physician must be appointed as the medical director, who should help implement best practice standards of care, offer medical advice and training, and represent the facility to the medical community.
- The director of nursing is responsible for ensuring adequate staffing by trained personnel, for updating resident care policies, and for addressing numerous nursing care issues.
- Assessment is essential for evaluating the resident's strengths and needs for care. A plan of care for each resident is developed by a multidisciplinary team to specify goals and interventions.
- An effective infection control program focuses on prevention. It requires policies and procedures for early detection, education, and prompt control when outbreaks occur.
- Antibiotic stewardship is necessary to control infections from drug-resistant microorganisms.
- Falls can be caused by environmental hazards, physical effects of aging, and certain medical conditions and side effects of drugs. Several steps can be taken to prevent falls.
- Pressure ulcers can be traced to a number of causes. Preventive measures and early treatment are essential.
- In most instances, use of restraints does not promote safety. Their use is illegal, except when they are temporarily used according to a physician's orders.
- Many causes of urinary incontinence are reversible and transient. Catheters are indicated only when other measures have failed.
- The facility must arrange for pharmacy services and regular consultation. Controlled substances must be safeguarded and accounted for. Use of psychotropic drugs presents special challenges.
- Rehabilitation therapies can be restorative, maintenance, and adaptive.

Introduction

The need for medical care, nursing services, and rehabilitation therapies is the main reason patients are admitted to nursing homes, particularly when comorbidities prevent a person from receiving these services in community-based settings. Hence, these services form the core of care delivery in a long-term care (LTC) facility. The other services interface with this clinical core.

Medical care has been traditionally delivered by physicians. Increasingly, however, nurse practitioners (NPs) and physician assistants (PAs) with advanced qualifications and training who work closely with physicians are employed to take over some of the responsibilities of physicians, such as making regular rounds to see nursing home residents. Indeed, visits in nursing homes by NPs and PAs exceed those made by physicians. Research also suggests that services provided by these professionals have resulted in improved quality of care. Family members have also expressed greater satisfaction with the care delivered by these nonphysician practitioners (Intrator et al., 2015).

Medical Care

Federal regulations, identified by their F-Tags, that govern physician services in certified facilities are summarized in **Exhibit 10–1**.

Exhibit 10–1 Regulations for Physician Services (Summarized)

F- Regulatory Requirements

Tag

- F710 The care of each resident must be under the supervision of a physician. Medical orders for the resident's care and needs are provided throughout the resident's stay.
- F711 Physician visits must include an evaluation of the resident's condition and total program of care, including medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen.
- F712 The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits in skilled nursing facilities (SNFs), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist.
- F713 The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.
- F714 A physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist unless a regulation specifies that the physician must perform a task personally, or when the delegation is prohibited under state law or by the facility's own policies.
- F715 A physician may delegate to a qualified dietitian/other clinically qualified nutrition professional the task of writing dietary orders, and to delegate to a qualified therapist the task of writing therapy orders.
- F540 A certified facility (SNF or nursing facility [NF]) must have a designated medical director who is responsible for implementing care policies and coordinating medical care.
- F841 The medical director is responsible for overseeing and coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

Note: This exhibit is illustrative only. The reader must consult the cited source for a full description of the regulations.

Excerpted and summarized from Centers for Medicare and Medicaid Services. (2017). *State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities* (Rev. 173, 11-22-17). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf.

Physicians and Specialized Clinicians

Each resident's care is under the direction of an attending physician, who is a general internist or family practitioner having his or her own private practice. If a resident's personal physician does not practice in nursing homes, the resident is given the option of selecting a physician from among those who make regular nursing home visits.

Time constraints, rigid regulatory requirements, negative perceptions of nursing homes, and litigation are some of the main reasons many physicians do not participate in nursing home care. Despite these barriers, however, a small number of physicians are devoting more of their practice hours to nursing home care (Kuo et al., [2013](#)). Utilization of NPs and PAs compensates for the shortage of primary care physicians in the United States. Utilization of NPs and PAs who specialize in LTC practice has also increased the level of clinical services in LTC settings (Ryskina et al., [2019](#)). NPs, for example, provide timely access to primary care, address medication reconciliation, decrease transfers to hospitals, and take part in collaborative practice (Campbell et al., [2020](#)). Hence, specialized clinicians play an integral role in improving the quality of clinical care.

Medical care in a nursing facility is akin to primary care office-based practice in which physicians diagnose medical problems and prescribe treatment and medications. The actual treatments are rendered by the facility's nursing staff. To collect their fees, the physician bills a third-party payer, such as Medicare or Medicaid, not the nursing home. Nurses routinely monitor the resident's condition. Any substantial changes, nonresponse to treatments, or other negative observations are immediately relayed to the attending physician who then decides on the course of action to pursue.

The attending physician also makes referrals when specialized services are needed. For example, referrals can be made to medical specialists such as cardiologists, nephrologists, and orthopedists. Nursing facilities generally provide the more common types of specialty services through contracts with independent practitioners, such as podiatrists, dermatologists, and ophthalmologists who may do routine screenings and evaluations in addition to receiving sporadic referrals.

Primary care clinicians are not generally available after normal workweek hours. Telemedicine-enabled physician services, although currently used sporadically in LTC settings, can fill in the gaps. A demonstration project showed that such a service can effectively reduce unnecessary hospitalizations, thus reducing costs and increased staff performance (Chess et al., [2018](#)).

Medical Director

Nursing home regulations require the appointment of a licensed physician to function as the medical director. In all but a handful of large nursing homes, the administrator contracts with a community physician to fill the position on a part-time basis. In an average-sized facility, the medical director can be expected to spend 2 to 4 hours per week (Krein, 2003).

The medical director reports to the administrator but has an advisory relationship with the rest of the organization. Through regular communications with the medical director, the administrator can keep abreast of major resident care issues in the facility. On the other hand, by regularly communicating with the administrator, the medical director can remain in touch with administrative policies and management issues that may have a bearing on care delivery.

Not uncommonly, the medical director is also the attending physician for most residents in a facility. The medical director's involvement as an attending physician must be a completely separate practice as far as reimbursement and compensation are concerned.

Personal Traits and Qualifications

The medical director should have good interpersonal and conflict-resolution skills that will enable him or her to work effectively with the multidisciplinary team. He or she should also have the patience to work with and teach mostly licensed practical (vocational) nurses (LPN/LVN) and nursing assistants who predominate in the nursing department.

The medical director may have either the MD or the DO degree. Ideally, he or she should be a geriatrician, or have training and experience in geriatric medicine. [Geriatrics](#) is a specialized area of medicine that deals with the special health problems faced by the elderly. Knowledge of geriatrics is essential for effectively treating a wide array of medical conditions in a diverse elderly population residing in nursing homes.

The Society for Post-Acute and Long-Term Care Medicine, formerly called the American Medical Directors Association (AMDA), has developed a core curriculum on medical direction and a competencies curriculum for post-acute and long-term care practice of medicine to train physicians in both administrative and clinical management. Also, the American Board of Internal Medicine and the American Board of Family Practice jointly confer a Certificate of Added Qualification in Geriatric Medicine on physicians who complete a training program and pass an examination. However, only a few physicians hold such certification.

Functions

The medical director functions as a key consultant to the nursing facility on almost all aspects of resident care. As an attending physician, the medical director is in a position to obtain firsthand knowledge of the adequacy and appropriateness of clinical care provided to the residents and to become involved in consultations to improve quality of care for all residents.

The main functions of the medical director can be classified into four essential roles:

- Oversight
- Advisory
- Teaching
- Representative

Oversight Role.

The medical director helps ensure that clinical services meet or exceed established standards in the practice of medicine. Use of evidence-based practices must be incorporated in the delivery of care. [Evidence-based practices](#) (also known as best practices) incorporate clinical research evidence in delivering both medical and nursing care. For example, evidence-based practices result in the potential for fall reduction and in the prevention of pressure ulcers (Mäki-Turja-Rostedt et al., 2019; Teresi et al., 2013). Regular rounds, observations, and attentiveness to any resident care concerns are generally the means of monitoring the adequacy of clinical care. Any breakdowns in the facility's skill capacity must be addressed with the administrator. Such breakdowns generally occur when the facility experiences turnover of key staff or when it adds a new service.

Advisory Role.

The medical director's advisory role directly stems from his or her effectiveness in carrying out the oversight role. The medical director functions as an advisor to the various committees, such as the infection control committee, quality improvement committee, utilization review committee, medical records committee, pharmaceutical review committee, safety committee, and ethics committee. Most of these committees meet once a quarter, and for the sake of efficiency, meetings of the various committees are often combined.

Teaching Role.

This role is mostly carried out informally during routine interactions with caregivers or while making bedside rounds with nurses. However, formal training sessions become necessary when special issues arise. For

example, enhanced infection control practices became paramount during the pandemic of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2; also known as the Wuhan Virus, based on its place of origin) that caused coronavirus disease, COVID-19, and resulted in the deaths of thousands of residents in U.S. LTC facilities from 2020 onward.

Representative Role.

The medical director is the facility's representative to the medical community. During interactions with colleagues, he or she should function as the facility's advocate and as an expert on medical care issues in LTC in general. A medical director's collegial influence can also go a long way to ensure that attending physicians are in compliance with nursing home regulations. The medical director can also help smooth out any transfer-related issues with the hospital.

Nursing Services

Nursing is the largest department, employing about 70% of the nursing home associates. Nursing services are also the central hub, and the nursing staff generally has the most interaction with residents and their families. But nursing's central role should not be interpreted as dominant over other services. The best resident care can be delivered only when each discipline—including nursing—recognizes the interdependency between the various departments and services. The main federal regulations governing nursing services in certified facilities are summarized in **Exhibit 10–2**.

Exhibit 10–2 Regulations for Nursing Services and Nurse Aide Training (Summarized)

F-Tags Regulatory Requirements

F725F726	The facility must have sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population.
F727F731	The facility must designate a registered nurse to serve as the director of nursing (DON) on a full time basis. The DON may serve as a charge nurse if the facility has an average daily occupancy of 60 or fewer residents. In addition, the facility must use the services of an RN for at least 8 consecutive hours a day, 7 days a week. The state may grant a waiver, if in spite of best efforts the facility is unable to meet this requirement and if it will not endanger the health and safety of residents.
F728	A facility must not employ for more than 4 months on a full-time basis a nurse aide unless he or she has completed a training and competency evaluation program.
F729	Before employing a nurse aide, a facility must receive registry verification that the individual has met competency evaluation. Retraining is necessary if an individual has not worked continuously in nursing services for 24 consecutive months.
F730F947	The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. Nurse aides must receive at least 12 hours of in-service training per year. The training must include dementia management and resident abuse prevention.
F732	The facility must post in a prominent place staffing data, and upon request make this data available to the public.

Note: This table is illustrative only. The reader must consult the cited source for a full description of the regulations.

Excerpted and summarized from Centers for Medicare and Medicaid Services. (2017). *State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities* (Rev. 173, 11-22-17). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Nursing Administration

The director of nursing (DON) may be supported by an assistant director of nursing (ADON), who may be responsible for staffing and also function as the inservice director (director of training) in average-size nursing homes. In larger facilities, an alternative to the ADON is to have a nursing supervisor on each shift—three supervisors covering the three shifts—in which case, a separate inservice director's position would be necessary. Because resident assessment has become a critical driver of the Medicare prospective payment system, most average-size facilities also have a registered nurse (RN) in the position of resident assessment coordinator. This position, as well as the inservice director, may report to either the DON or the administrator.

Director of Nursing

The DON is a key member of the top management team and has a position of substantial responsibility. In most facilities, the position is second only to that of the administrator. The DON is often in charge of the facility during the administrator's absence. In large nursing homes where an assistant administrator may be employed, there is sometimes a direct chain of command between the administrator and the DON, whereas the assistant administrator may have direct responsibility for the remaining departments. Effectively managed nursing facilities have a triad relationship among the administrator, the medical director, and the DON, and this triad is involved in making many top-level evaluations and decisions regarding the facility's operation.

Research shows that job tenure of a DON in a nursing facility is associated with higher quality ratings on the five-star system developed by the Centers for Medicare and Medicaid Services (CMS). The DON's stability also helps retention of other RNs (Hunt et al., 2012). These findings highlight the need for owners and administrators to support DONs in their leadership roles (Krause, 2012).

Skills, Qualifications, and Functions

The DON must be an RN, and the position requires a composite of clinical and management skills. However, DONs who have formal training in both nursing and management are rare. Most acquire management skills through a combination of experience, continuing education, and seminars. On the clinical side, some DONs

possess a bachelor's degree in nursing, but many have nursing preparation through a 2-year associate's degree or an RN diploma. A small number have master's degrees. Some have completed certification requirements in gerontology, but many have not.

The DON is not a direct caregiver but mainly performs administrative and supervisory functions, which at times can be quite challenging. The main responsibilities of this position can be summarized under five main categories:

- Staffing
- Training
- Resident care
- Policy
- Administration

Staffing.

Staffing can pose some daunting challenges because, depending on labor-market conditions, nurses may be in short supply. Recruiting and retaining qualified staff members is often difficult, and a typical facility experiences high turnover and absenteeism among certified nursing assistants (CNAs, also referred to as nurse aides). Hence, the DON should have some training in human resource management. Staff shortages coupled with the need to have adequate 24/7 staff coverage present special challenges in staffing and scheduling. Large facilities often designate a full-time person to the tasks of recruiting and scheduling CNAs.

Training.

The DON must ensure adequate levels of skill competency among the nursing staff. Needs for individual as well as group training should be evaluated periodically. Many facilities also operate CNA training programs. Regulations require that these programs be under the DON's general supervision. The DON, however, is not permitted to do the actual training, which should be delegated to a nurse instructor who must be an RN. The required number of training hours vary by state. However, states that require clinical training hours (in relation to didactic hours) above and beyond the federal minimum of 16 hours achieve better resident outcomes (Trinkoff et al., [2017](#)). Federal law prohibits states from approving nurse aide training programs at facilities found to have substandard quality of care or that have been subject to certain enforcement actions such as civil monetary penalties.

Resident Care.

The DON oversees timely execution of resident assessments, development of care plans, and the delivery of nursing care. The nursing staff looks to the DON for leadership and expertise when care-related problems arise. The DON also plays a vital coordinating role with attending physicians by facilitating timely visits and ensuring that they receive the necessary nursing support.

Policy.

The DON is an active participant in the various resident care committees mentioned earlier (infection control committee, quality improvement committee, etc.). The DON generally provides information, data, and other key input for evaluation and deliberation by the various committees. The facility's nursing care policies, procedures, and practice guidelines constitute the standards of resident care delivery that staff members must follow. The nursing policies and procedures manual becomes a reference guide and training resource for new associates. This manual is updated as policies and practices are revised.

Administration.

The DON is responsible for the effective management of the nursing department. Although, as a matter of routine, the DON is in the facility during regular business hours, some variation from routine is necessary so that the DON has some ongoing contact with the staff, residents, and families during evenings, nights, and weekends. Many families can visit the facility only during evenings or weekends. Therefore, charge nurses on the evening and weekend shifts should be trained to address family concerns. A communication system should be implemented so that family complaints and concerns regarding resident care are related to the DON. On the other hand, periodic availability of the DON during nonroutine hours can lend support to the nursing staff, and contact with families can help resolve issues before they turn into bigger problems. Having a large staff, and a preponderance of LPNs/LVNs in relation to RNs, the DON is frequently involved in ongoing training and consultation and in handling staff-related issues that include disciplinary action for nonperformance of duties. The DON is also responsible for ensuring regulatory compliance related to nursing services.

Nursing Organization

Charge nurses are responsible for supervising resident care delivery and communicating with physicians and family members regarding resident care issues. Charge nurses report to the nursing supervisors, the ADON, or the DON, depending on how the nursing department is organized.

The number of nurses on each nursing unit, skill mix of nurses (ratio of RNs to LPNs/LVNs), and the ratio of CNAs to residents on each shift are dictated by the number of residents and the level of clinical care required by them. More than 70% of RNs working in LTC are graduates of hospital-based diploma programs or 2-year associate's degree (ADN) programs (Jones et al., 2019). RNs are generally responsible for resident assessment, care planning, and quality assessment. LPNs render treatments and administer medications. Several states allow the routine administration of medications by specially trained medication aides (or medication technicians) under the general supervision of licensed nurses. Use of qualified medication aides/technicians can relieve nurses, enabling them to devote their time to other nursing care and monitoring functions.

CNAs provide most of the hands-on nursing care to residents. To deliver effective care, CNAs must possess basic nursing skills in four main areas:

1. Clinical skills, such as taking vital signs (temperature, pulse rate, and blood pressure), measuring height and weight, recognizing abnormal changes in body functions such as urine output and bowel function, and reporting changes in resident's condition to the charge nurse.
2. Personal care skills to assist residents with bathing, dressing, grooming, oral hygiene, eating, hydration, transferring, positioning, turning, toileting, and cleaning up and drying after incontinence.
3. Rehabilitation skills to do range of motion exercises, bowel and bladder training, and use of assistive devices to promote independence.
4. Documentation skills to record what they do and what they observe.

CNAs should also receive appropriate training in how to communicate with residents and visiting family members. In addition, CNAs must be trained in infection control practices; they must be prepared to use fire and safety procedures in case of an emergency; and they must understand how to preserve and promote the residents' rights to privacy, confidentiality, autonomy, dignity, and freedom from abuse and neglect.

Resident Assessment and Care Planning

Assessment is defined as the process through which health care professionals attempt to reliably characterize the resident's physical health, functional abilities, cognitive functioning, psychological state, social well-being, and past and current use of formal services (Kane, 1995). Assessment can be regarded as the first step in care planning and delivery. It is a multidisciplinary process that must be headed by an RN. The primary tool used in resident assessment is the Minimum Data Set (MDS). The main federal regulations on assessment and care planning are summarized in **Exhibit 10–3**.

Exhibit 10–3 Resident Assessment and Care Planning (Summarized)

F-Tags	Regulatory Requirements
F636	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity, using the Minimum Data Set (MDS). A comprehensive assessment must be completed within 14 days of a resident's admission. A reassessment must be done at least once every 12 months while the person is still a resident.
F637	Within 14 days after the determination of a significant change (either a major improvement or decline) in the resident's physical or mental condition, a comprehensive assessment must be completed.
F638	A non-comprehensive quarterly assessment must be completed, using the quarterly review assessment tool, to monitor critical indicators of gradual change in a resident's status.
F639	Maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.
F640	The facility must electronically transmit the assessment data to the CMS within 14 days of its completion.
F642	An RN must conduct or coordinate each assessment with the appropriate participation of health professionals.
F655F656F660	Within 48 hours of admission, the facility must develop and implement a baseline care plan for the resident that includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care. Within 7 days after completion of the comprehensive assessment, a comprehensive care plan must be developed which also includes discharge planning.
F657	Care plans must be reviewed and revised by the interdisciplinary team after each assessment.

Note: This table is illustrative only. The reader must consult the cited source for a full description of the regulations.

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Resident assessment serves two major purposes:

1. The process helps the facility staff to learn about the resident's strengths, problems, needs, and preferences. This information is subsequently used for developing the individualized plan of care for the resident.
2. It enables the staff to track important changes in the resident's overall status and to revise care plans accordingly.

Plan of Care

A **plan of care** (care plan) is a written plan developed through team participation of various disciplines to clearly outline how each assessed need of a given resident will be addressed and what specific goals will be accomplished. It is like a blueprint that guides the staff in providing routine interventions necessary for accomplishing clinical goals for a specific resident. Examples of intervention include nursing treatments, medications, special diets, rehabilitation therapies, social interventions, and participation in recreational activities. The RN responsible for assessments is the one who also schedules care plan meetings—a multidisciplinary forum for addressing each resident's comprehensive needs.

As the plan of care is carried out, each member of the multidisciplinary team adds progress notes to the resident's medical record. Progress made, or lack thereof, in achieving the established goals is evaluated over time and is carefully documented. The progress evaluations provide further guidance in establishing new goals and in deciding which interventions should be discontinued, modified, or added.

Infection Prevention and Control

Infections are a common problem in health care settings. Elders in particular are predisposed to various types of infections because of weakened immune systems. In addition, cognitive impairments among many nursing home residents may compromise their basic sanitary habits such as hand washing and personal hygiene, passing disease-causing bacteria to other people. Also, residents live in close proximity to others, come in contact with staff and visitors, and are served food and beverages from a common source. Such an environment facilitates both the introduction and subsequent transmission of certain infectious agents in a vulnerable population (Strausbaugh et al., 2003).

In nursing homes, most infections affect the urinary tract, respiratory tract, skin and soft tissues, or gastrointestinal tract. The Centers for Disease Control and Prevention (CDC) estimates that 1 to 3 million serious infections occur annually in LTC facilities throughout the United States (CDC, 2020a). Complications resulting from infections constitute the main reason for transferring residents to an acute care hospital. Hence, preventing and containing infections should be a primary concern. Federal regulations pertaining to infection control in certified facilities are summarized in **Exhibit 10–4**.

Exhibit 10–4 Infection Prevention and Control (Summarized)

F- Regulatory Requirements

Tags

F603	The facility's policies must identify the type and duration of the transmission-based precautions required, depending upon the infectious agent or organism involved; and the precautions should be the least restrictive possible for the resident based on his/her clinical situation. Furthermore, the resident's record must contain the rationale for the selected transmission-based precautions. Once the resident is no longer a risk for transmitting the infection, transmission-based precautions must be removed to avoid unnecessary involuntary seclusion.
F880	The facility must maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and other individuals who come into contact with the facility. Written standards, policies, and procedures are essential for accomplishing these goals.
F882	The facility must appoint one or more individuals to function as infection preventionist(s) who have primary responsibility for infection control. The professional(s) must be qualified by education, training, experience or certification, and work at least part-time at the facility.
F883	Influenza and pneumococcal immunizations must be offered to residents in accordance with the facility's policies and procedures. The residents must be given an informed choice regarding immunizations.

Note: This table is illustrative only. The reader must consult the cited source for a full description of the regulations.

Excerpted and summarized from Centers for Medicare and Medicaid Services. (2017). *State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17)*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf.

Infection prevention and control (IPC) is a comprehensive program to prevent, recognize, and control the onset and spread of infections with the objective of protecting the residents, the staff, and visitors from contracting infections while in the facility. An effective IPC program requires the involvement of all departments. In the following sections, the main features of an effective infection control program are described:

- Policies and procedures
- Screening
- Infection control practices
- Surveillance
- Education
- Control of infectious outbreaks

Policies and Procedures

The policies should be developed and reviewed in consultation with the infection control committee and cover areas such as admission and transfer of residents, employee health, immunizations, guidelines for visitors, housekeeping practices, laundry procedures, food preparation, food poisoning, procedures for cleaning and sterilizing equipment, isolation procedures, waste disposal, removal of biohazardous waste, pest control, detection and control of infection outbreaks, and staff education. Nursing practices such as caring for wounds, inserting catheters, and collecting urine specimens require sterile techniques, which should also be outlined in the facility's written policies and procedures.

Screening

The resident's history and physical at the time of admission should be carefully reviewed for the presence of any infections or contagious disease. Associates who show symptoms of transmissible infections, such as influenza or staphylococcus infection, should not come to work until they are declared safe to return.

Tuberculosis (TB) is caused by the bacteria called *mycobacterium tuberculosis*. Although TB cases in the United States have declined, slightly more than 9,000 cases were reported in 2017, of which 25% were among older adults (CDC, 2018). Also, people living with human immunodeficiency virus (HIV) are more likely than others to become sick with TB. Worldwide, TB is one of the leading causes of death among people living with HIV (CDC, 2016). Furthermore, African Americans continue to be impacted by TB at a greater rate compared to other racial and ethnic minority group (CDC, 2020b).

All residents admitted to nursing homes must be screened for TB in accordance with state health department guidelines. All associates must have an initial physical examination at the time of employment and subsequent annual physicals to screen for any infectious diseases.

Infection Control Practices

Asepsis, the absence of harmful microorganisms called **pathogens**, requires practicing clean procedures. The primary goal of asepsis is to prevent cross-contamination, that is, transferring pathogens from soiled surfaces to clean ones. Frequent hand washing with soap and clean water is among the most important aseptic practices that must not be neglected. Examples of other aseptic practices include washing food and utensils in the kitchen before cooking, cleaning food preparation surfaces, separating and properly handling clean and soiled linens, and using appropriate techniques for trash removal.

Hand hygiene should also incorporate hand **antisepsis**: removing or destroying microorganisms. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands (CDC, 2020c).

Nursing and housekeeping staff are frequently exposed to soil and body wastes. Without frequent hand washing and sanitizing in between clean and soiled contact, they can spread disease-causing pathogens. The environment should also be protected while transporting trash or soiled linens. All trash must be properly bagged and placed in sealed containers. Similarly, soiled linens should be placed in sealed containers when they are transported through the facility. High-touch surfaces in common areas and resident rooms require routine cleaning and disinfection. Resident care equipment (blood pressure cuffs, rehabilitation therapy equipment, blood glucose meters, etc.) must be regularly cleaned and disinfected.

Isolation precautions constitute another important aspect of infection control. Two types of isolation precautions are used:

- Standard precautions
- Transmission-based precautions

Standard precautions (SPs) are used when caring for all residents, regardless of whether or not they have an infectious disease. SPs are designed to protect caregivers from infection through exposure to blood, body fluids, and body substances. It is assumed that all body fluids are potentially infectious. The precautions include the use of personal protective equipment (PPE): wearing gloves during resident care, wearing gowns when the caregiver's clothing may come in contact with body fluids, wearing masks when people are coughing and sneezing, and using protective eye wear when body fluids may splash. SPs also include preventing injuries and infections from sharps, such as needles and blades, which must be disposed of in appropriately marked sharps containers.

Transmission-based precautions must be used during care for residents who may have a communicable disease, such as HIV or influenza. Transmission-based precautions are used in addition to standard precautions. The facility must establish procedures for visitors to report to the nursing station before visiting residents for whom transmission-based precautions are indicated.

Surveillance

Surveillance refers to identifying and reporting all cases of infection in the facility and identifying all infected residents and staff. Infections can be identified during a resident's stay by screening a variety of data sources, such as laboratory, pharmacy, medication regimen review, admission/discharge/transfer reports, and medical records. These data sources are monitored for signs and/or symptoms of an infection event (for example, urinary tract infection event) (CDC, 2020d).

Surveillance includes process surveillance and outcome surveillance. **Process surveillance** includes reviewing staff practices to identify whether facility IPC policies and procedures are being followed. **Outcome surveillance** is used to verify whether staff are using the protocols to identify and report evidence of a suspected or confirmed infection or communicable disease. Examples of outcome surveillance include

monitoring a resident who has a fever, diarrhea, or other symptoms that may indicate an infection, laboratory cultures to detect clusters and trends, etc.

Education

Ongoing education of all staff about infection control is a critical preventive measure. These educational programs should be repeated often, particularly given the high staff turnover common in nursing homes.

Control of Infectious Outbreaks

An [outbreak](#) occurs when more cases of an infection than expected are identified among a specific group of people, such as residents or staff, over a given period. Among residents, outbreaks are identified by clustered cases of symptoms such as diarrhea, urinary tract infections, influenza, or scabies. Influenza outbreaks can be prevented by annual flu shots for residents and associates. Many health care organizations have made an annual flu shot mandatory for their associates.

Prompt control of any outbreaks is essential. The medical director should work closely with the nursing staff in identifying the pathogen, preventing its spread, treating the affected residents and staff members, and, if necessary, reporting and coordinating recommended measures with the appropriate public health agency. For example, the local health department may be involved in assisting the facility with a systematic approach to controlling an infectious outbreak. Access to a laboratory must be available to perform rapid antigen testing. The medical director should recommend appropriate treatment options.

The Case of COVID-19

At the time of this writing, of the more than 110,000 COVID-19 deaths in the United States, almost 36% occurred in nursing homes. Most states were found to be unprepared to deal with the pandemic, and so were the nation's nursing homes. To make matters even worse, some misguided state governors forced nursing homes to admit COVID-19 patients (Brown, [2020](#)). According to various news sources, in New York alone more than 4,500 infected patients were sent to vulnerable nursing homes, which accelerated the spread of disease and death. The state departments of health in several states stood silently by as such misinformed edicts were issued. In New York and elsewhere, PPE were not used, which exposed the caregivers to the infection.

There is plenty of blame to go around, but the pandemic provides an important lesson for LTC facilities on the critical role of IPC practices. Regrettably, even state officials may not always act in the best interest of vulnerable groups. Hence, it is incumbent upon each nursing facility to protect its own residents and staff.

Antibiotic Stewardship

Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents receiving one or more courses of systemic antibiotics during a year. Similar to the findings in hospitals, studies have shown that 40%–75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults (CDC, [2017](#)). Although antibiotics are necessary to treat certain infections, their misuse has led to antibiotic resistance and reduced efficacy within just a few years of introduction of each new antibiotic (Wall, [2019](#)). A number of multidrug resistant organisms (MDROs) have become common in health care facilities. Main examples include methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE). MRSA can cause serious and potentially life-threatening infections, such as bloodstream infections and pneumonia. VRE bacteria become resistant to the antibiotic vancomycin. These bacteria can cause infections of the urinary tract, the bloodstream, or wounds. The main mode of transmission to other patients for both MRSA and VRE is through unwashed hands. Hence, hand hygiene is the primary preventive vehicle.

Antibiotic stewardship (also called antimicrobial stewardship) is the effort to evaluate and improve how antibiotics are prescribed by clinicians and used by residents. Improving antibiotic prescribing and use is critical to effectively treat infections, protect residents from harm caused by unnecessary antibiotic use, and combat antibiotic resistance (CDC, [2019](#)). The medical director should take the lead in setting standards for antibiotic prescribing practices. The DON and nurses should set practice standards for accurately communicating changes in a resident's condition to clinicians who prescribe antibiotics. The consultant pharmacist should incorporate antibiotic use in his or her drug regimen review and compile data on antibiotic use (CDC, [2017](#)).

Special Areas of Nursing Care Management

Nursing care deals with numerous health conditions found in a diverse elderly population. Some of these conditions require special attention from caregivers and nursing managers. The topics discussed in this section also have a great deal of relevance for improving the quality of resident care.

Falls and Fall Prevention

Falls are the leading cause of fatal and nonfatal injuries among adults aged 65 and older. During 2014, approximately 27,000 older adults died because of falls; 2.8 million were treated in emergency departments for fall-related injuries, and approximately 800,000 of these patients were subsequently hospitalized (Bergen et al., 2016). Many of the injuries are hip fractures with mortality estimated at 36% within 6 months (Zubkoff et al., 2019). Among fallers, 20% to 30% experience moderate to serious fall-related injuries, such as fractures or serious lacerations that require visits to the emergency department and hospitalization (Rubenstein & Josephson, 2002). Subsequent decline in functioning frequently has long-term consequences. Fall-related injuries also pose substantial legal liability for the nursing facility. A history of falls in an individual is associated with a two- to sixfold increased risk for future falls (Moncada & Mire, 2017). Psychological factors such as anxiety from the fear of falling and depression often follow one or more falls resulting in additional risk factors (Choi et al., 2018). Hence, fall prevention becomes even more crucial for those who have already fallen before.

Approximately 60% of falls can be attributed to multiple-cause factors, including environmental factors (Moncada & Mire, 2017) such as poor lighting, wet floors, loose objects, incorrect bed height, and improperly fitted or maintained wheelchairs. Other common causes include gait problems, balance disorders, weakness, cognitive deficits, poor vision, and drug side effects.

To prevent falls, each resident's risk factors and potential for falls should be assessed. Appropriate resident-centered interventions should be incorporated in the care plan. Working with new residents until they become properly oriented to where the bed is in relation to the chair and the bathroom, teaching residents how to safely navigate from the bed to the bathroom and back, engaging residents in strength training to improve gait and balance, use of assistive devices for ambulation, appropriate footwear, and monitoring and supervising of residents by the nursing staff can all play a role in preventing falls. Toileting schedules are appropriate for some residents so they are assisted to use the bathroom at established time intervals.

Safety of the environment is another key element in fall prevention. Nursing facilities, as a rule, already have railings in hallways, grab bars in bathrooms, and other required safety adaptations. However, these devices should be routinely checked for proper maintenance and repairs. Janitorial procedures should be evaluated for resident safety during cleaning and mopping floors and during carpet vacuuming or floor buffing, when long electric cords running through hallways can become a tripping hazard. Episodes of incontinence can leave urine puddles, which may not be easy for other residents to see. The staff should be trained to observe such hazardous conditions and promptly clean up the affected areas. Safety should be everyone's business.

In resident rooms, bed height should be adjusted or protective floor pads used for those who may roll over and fall during sleep. For high-risk residents, it may be necessary to put the mattress on the floor. High-risk residents may also be fitted with hip pads to prevent hip fractures from falls. An alarm system can be installed to alert staff when a high-risk resident tries to get out of bed. For example, weight-sensitive floor mats are available that can be placed next to the bed; an alert sounds when someone steps on the mat.

Pressure Ulcers

A **pressure ulcer**, also called a pressure sore or decubitus ulcer, is localized damage to the skin or underlying soft-tissue, usually over a bony prominence. Pressure on the skin is normal when a person is sitting or lying down. With aging, however, the skin tissue develops reduced tolerance for pressure. Limited ability to change position while in bed or wheelchair that causes prolonged pressure against bony prominences, friction against wrinkled bed sheets or objects such as casts and braces, exposure to moisture from urine or feces, and poor nutrition (especially low calorie and protein intake) can all play a part in forming pressure ulcers. Some risk factors, such as lack of sensation in an area, are not modifiable. Others, such as uncontrolled blood sugar, would take time to correct.

Once formed, pressure ulcers are slow to heal. They are also susceptible to infections, a vulnerability that can lead to further complications such as permanent disability and even death. Therefore, prevention and early treatment are essential features of pressure ulcer management. Pressure ulcer prevention begins with proper nutrition and hydration. Basic care routines such as proper bed making, positioning the resident properly while sitting or lying down, use of pads and pillows to relieve pressure, repositioning at least once every 2 hours, keeping the resident clean and dry, and skin care are important in preventing pressure ulcers. At least once a day, skin should be systematically inspected in residents at risk. The skin should be cleansed at regular intervals and whenever it is soiled. Hot water and drying soaps should be avoided for skin care. Areas of redness over bony prominences should not be massaged or rubbed. To treat dry, flaky, scaly skin, optimum

environmental humidity should be maintained and moisturizers used. Mobility through rehabilitation should be encouraged.

Pressure ulcers are categorized into four stages according to the depth of tissue destruction (**Exhibit 10–5**). Once developed, there can be rapid deterioration. Stage I is the beginning stage with a notable discoloration of the skin. In darker skin, it may have red, blue, or purple hues. This stage is actually not a true ulcer because the skin is intact. However, a stage I pressure area increases the risk of ulcers tenfold (Allman, 1999). At stage IV, the most advanced stage, muscle or bone becomes exposed. Depending on the stage, treatment may include bed rest in a special pressure-relieving bed, use of anti-inflammatory drugs, antibiotics, special dressings called occlusive dressings that keep tissue hydrated, whirlpool treatment, removal of dead tissue by surgical debridement, and skin grafting.

Exhibit 10–5 Pressure Ulcer Stages

Stage 1	A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
Stage 2	A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
Stage 3	A full thickness of skin is lost, exposing the subcutaneous tissues. It presents as a deep crater with or without undermining adjacent tissue.
Stage 4	A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Courtesy of Centers for Medicare and Medicaid Services.

In skilled nursing facilities, complete elimination of pressure ulcers is often an unrealistic goal because residents are often admitted with preexisting pressure ulcers. Hence, the facility must undertake a two-pronged approach that focuses on treatment of existing pressure ulcers and prevention of skin breakdown, as discussed previously.

Use and Misuse of Physical Restraints

A **restraint** can be any device that is used to restrict a person's freedom of movement and cannot be easily removed by the resident (Grubbs & Blasband, 2000). Examples of physical restraints include waist belts or chest jackets to prevent people from getting out of a chair or bed, geri-chairs with secured tray tables, bed side rails, roller bars for wheelchairs, mitts, and wrist ties. In the past, these restraints were in common use because of a widespread assumption that restraining was necessary to keep residents from falling or otherwise hurting themselves. Restraints were also widely used to control behavioral disorders such as agitation and aggression.

Later, studies found that the value of using restraints in promoting resident safety was, at best, marginal. Contrary to what was earlier believed, restraint use often caused injuries and promoted a number of negative physical outcomes—such as falls, decline in activities of daily living, pressure ulcers, and asphyxiation—as well as psychological problems, such as anger and increased agitation (Chaves et al., 2007).

Bed rails and side rails may or may not be regarded as restraints. Bed rails are considered a restraint if the resident is not able to put the side rail down in the same manner as the staff. On the other hand, the use of partial bed rails may assist a resident to enter and exit the bed independently and would not be considered a physical restraint. Bed rails may also be used by the resident as an assistive device for support during repositioning. When used as a restraint, bed rails could result in serious injury and even death when a resident falls over the rails or gets entrapped in the rails.

Federal regulations (F700) require the facility to use appropriate alternatives prior to installing a bed rail. The resident's risk of entrapment must be assessed. An informed consent must be obtained prior to installation.

Physical restraints, in general, are addressed in federal regulation F604. The regulation limits the use of any physical restraint to circumstances in which the resident has medical symptoms that warrant the use of restraints. When medically necessary, restraints should only be used temporarily and under physician's orders and in close supervision by the nursing staff. Otherwise, their use is illegal.

Urinary Incontinence and Catheters

Urinary incontinence is highly prevalent in nursing homes. The starting point for addressing this problem is to maintain a bladder record over a period of 5 to 7 days to determine the type and frequency of incontinence. A clinical evaluation and treatment of reversible causes is the next step. Reversible or transient causes include urinary tract infection, urinary retention, delirium, restricted mobility, atrophic vaginitis, urethritis, fecal impaction, and pharmaceuticals. Other serious conditions—such as bladder cancer, prostate cancer in men, stones or other types of blockages—may also lead to incontinence. Once the underlying reversible causes have been treated, therapeutic programs should be instituted as the next step. Developing toileting schedules has been a common approach. The schedule is based on the voiding patterns observed; some residents

require staff assistance for toileting more frequently than others. Low-intensity exercise programs to strengthen the pelvic muscles can be combined with the toileting program.

Use of a catheter would be indicated only when other measures have failed to control incontinence. Some of the highest infection rates among nursing home residents are attributed to indwelling catheters. Hence, their use should be minimized. Regulations (F690) mandate that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary. A resident who enters the facility with an indwelling catheter, or subsequently receives one, must be assessed for removal of the catheter.

Condom catheters are used for men who have difficulty retaining urine. An [indwelling catheter](#), that is, a catheter that remains in the bladder to drain urine into a bag, is used in both men and women when medically indicated and approved by the attending physician. When medically indicated, the insertion, ongoing care, and removal of catheters must be done in accordance with professional standards of practice and IPC procedures.

Pharmacy Services

A nursing facility is required by regulations to provide pharmaceutical services and to have consultation from a licensed pharmacist. Federal regulations are summarized in **Exhibit 10–6**. LTC pharmacies specialize in meeting the special needs of nursing homes.

Exhibit 10–6 Pharmacy Services (Summarized)

F-Tag Regulatory Requirements

F755	The facility must provide routine and emergency drugs and biologicals to meet the needs of each resident. A licensed pharmacist must provide consultation in all aspects of pharmacy services.
F756	The drug regimen of each resident must be reviewed at least once a month. The pharmacist must report any irregularities to the attending physician, the medical director, and the DON.
F757	Each resident's drug regimen must be free from unnecessary drugs, which is indicated by excessive dose, duplication, excessive duration of use, lack of adequate monitoring, or inadequate indication for use, and when adverse consequences indicate that the dose should be reduced or discontinued.
F758	Residents must be free from the use of unnecessary psychotropic drugs.
F759F760	The medication error rate in the facility must not exceed 5%. Resident status, actual or potential resident response to the error, and frequency of error could cause such error to be classified as significant, i.e., one that causes discomfort or jeopardizes the resident's health and safety.
F761	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional standards, and include the appropriate accessory and cautionary instructions, and the expiration date. All drugs and biologicals must be stored in locked compartments under proper temperature controls, and access given to only authorized personnel.

Note: This table is illustrative only. The reader must consult the cited source for a full description of the regulations.

Excerpted and summarized from Centers for Medicare and Medicaid Services. (2017). *State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities* (Rev. 173, 11-22-17). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf.

The facility should have a written agreement with the consultant pharmacist, who should also be an active member of the multidisciplinary team. The pharmacist assists the facility in developing policies and procedures for the dispensing, storage, administration, review, discontinuation, and disposal of drugs and biologicals (or biologics). **Biologicals** are made from natural sources, which may be human, animal, or microorganisms. They include a wide range of products such as vaccines, blood and blood components, allergenics, tissues, etc.

The consultant pharmacist plays an important role in promoting safe and effective medication use because preventable medication-related adverse consequences and events are a serious concern in nursing homes. A government report found that one in three Medicare residents in SNFs experienced an adverse event or temporary harm event; 37% of these adverse events were related to medications, and 66% of all medication-related events were preventable (Office of Inspector General, 2014).

Medication errors include timing errors (e.g., one prescribed to be given before a meal, but is given after the meal), medications given without a valid prescriber's order, and dose omissions.

$$\text{Medication error rate (\%)} = \frac{\text{Number of errors observed}}{(\text{Doses given} + \text{doses ordered but not given})} \times 100$$

A system that allows separate storage of medications for each resident should be used. The unit-dose medication dispensing system is the industry standard. In a **unit-dose system**, medications are prepackaged and labeled in unit-of-use form and are ready to be given to the resident. This eliminates the need for a nurse to take out the medication from a bottle and prepare medicine cups for each resident. Internet-based drug ordering systems have become common. These systems save time, reduce medication errors, and minimize drug waste.

Controlled Substances

Controlled substances include various narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals. Their prescription, dispensing, use, and safeguarding are governed by federal and state laws. Controlled substances are governed by the Controlled Substances Act (CSA), Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Except as provided under the law, possession or use of controlled substances is illegal. Controlled substances are listed in Schedules I through V of the CSA:

Schedule I. These substances are illegal because they have no currently accepted medical use in the United States. Examples include heroin and LSD.

Schedule II. These substances have a currently accepted medical use in the United States but have severe restrictions and may be illegal in certain jurisdictions. Examples include morphine, cocaine, and methamphetamine.

Schedule III. These substances have a medical use and also have less potential for abuse than substances in Schedules I and II. Examples include anabolic steroids and painkillers containing codeine or hydrocodone.

Schedule IV. These substances have less potential for abuse than substances in Schedule III. Examples include Tramadol used for pain and Valium prescribed for anxiety disorders.

Schedule V. These substances have the least potential for abuse. Examples include cough medicines containing codeine.

Schedule II through V substances must be appropriately prescribed by a physician, but their abuse generally has a substantial and detrimental effect on health and general welfare—hence the need for strict control. Schedule II–V medications must be maintained in separately locked, permanently affixed compartments. The access system (e.g., key, security codes) used to lock these medications and other medications subject to abuse cannot be the same access system used to obtain the nonscheduled medications. The facility must implement proper recordkeeping and verification systems to prevent unauthorized use and diversion.

Emergency Drug Kit

Facility procedures and applicable state laws may allow the facility to maintain a limited supply of medications for use during emergency or after-hours situations. The pharmaceutical review committee should determine its contents. In general, the emergency kit contains drugs needed during life-threatening emergencies such as cardiac arrest, severe allergic reaction, or seizures. The drugs in the emergency kit are the responsibility of the pharmacist who should monitor the use, replacement, and disposition of the drugs. The kit is kept sealed (not locked), and records are kept whenever anything is used from the kit.

Psychotropic Drugs

A **psychotropic drug** (or psychoactive drug) is any drug that affects brain activities associated with mental processes and behavior. These drugs include antipsychotics, antidepressants, anxiolytics (antianxiety), sedatives, and hypnotics. In the past, these drugs were overprescribed for nursing home residents, sometimes as chemical restraints to sedate residents who displayed aggressive, disruptive, or assaultive behaviors that are common among residents who have dementia. Now these drugs can be used only when certain specified conditions have been documented, along with efforts to gradually reduce the dosage. Otherwise, their use is illegal. Their use may produce effects that are opposite to the ones they were intended to control. For example, antipsychotics have been shown to result in more intense psychotic symptoms and agitation among people with dementia, and sedative-hypnotic drugs may result in more intense anxiety and agitation (Maust et al., 2017). Hence, whenever appropriate, behavioral interventions should be tried first, such as modifying the environment and implementing approaches to care delivery that would accommodate the resident's behavior to the largest degree possible.

In 2012, the CMS instituted the National Partnership to Improve Dementia Care in Nursing Homes. The main focus of the partnership was to reduce the use of antipsychotic medications and to enhance the use of nonpharmacologic approaches and person-centered dementia care practices. This initiative successfully reduced the prevalence of antipsychotic medication use by 34% between 2011 and 2017 (CMS, 2017).

Rehabilitation Services

In the geriatric context, [rehabilitation](#) focuses on evaluation of physical function and interventions to achieve the highest possible level of function and independence. Rehabilitation has three main objectives: (1) to restore functional status lost through disease, injury, or surgical intervention; (2) to maintain residual function and prevent further decline; and (3) to help disabled individuals adapt to their functional deficits. Hence, rehabilitation therapies can be restorative, maintenance, and adaptive in design. In many instances, restoring an individual to his or her former functional status may not be possible. In that case, maintaining or maximizing remaining function would be the goal.

Federal regulations require that the facility must provide or arrange for the provision of specialized rehabilitative services (herein referred to as restorative rehabilitation) to all residents that require these services for the appropriate length of time as assessed in their comprehensive plan of care (F825). Qualified personnel must care for mechanically ventilated residents who must be knowledgeable of risk factors for ventilator-associated pneumonia.

Restorative Rehabilitation

[Restorative rehabilitation](#) is designed to help regain or improve function. It requires intensive short-term treatments. Restorative therapy is generally provided immediately after the onset of a disability. Examples of cases requiring short-term restorative therapy include orthopedic surgery, stroke, limb amputation, and prolonged illness. Frequently, the goal of intensive short-term rehabilitation is to enable the resident to return to independent living. In other cases, especially when a resident must continue receiving LTC because of other chronic needs, longer term maintenance rehabilitation is necessary after short-term restorative care has ceased.

The attending physician must authorize in writing all short-term rehabilitation treatments. Short-term treatments are carried out by professionally trained therapists—mainly, registered physical therapists (PTs), physical therapy assistants (PTAs), registered occupational therapists (OTs), certified occupational therapy assistants (COTAs), and speech/language pathologists (SLPs).

[Physical therapy](#) treatments are geared toward improving ambulation, range of motion, physical strength, flexibility, coordination, balance, and endurance. PTs also specialize in fitting and training a resident to use artificial limbs, canes, and walkers. PTs are also trained to give treatment modalities such as hot packs, cold packs, massage, ultrasound, paraffin bath, electrical stimulation, compression therapy, and hydrotherapy. PTs can assist and train the nursing staff in techniques for preventing falls.

[Occupational therapy](#) is tailored for the adaptive use of the upper extremities for performing various tasks. OTs address fine motor skills, adaptive equipment, splints, and other support mechanisms to facilitate the performance of daily tasks. OTs also play a vital role in evaluating the independent living environment when the resident is scheduled for discharge to home.

[Speech/language pathology](#) encompasses evaluation and treatment of speech, language, and communication disorders. Speech/language pathologists treat several kinds of disorders such as [aphasia](#), in which a person's ability to communicate is impaired; [dysarthria](#), in which speech is slurred or unintelligible because of muscle weakness; or motor speech disorders such as [apraxia](#), in which the tongue, lips, and vocal cords are unable to work together. As a result, the person is unable to say what he or she wants to say. [Dysphagia](#), or the inability to swallow, is another common problem SLPs are called upon to treat in nursing facilities.

Maintenance Rehabilitation

In many LTC facilities, maintenance therapies are incorrectly referred to as restorative. [Maintenance rehabilitation](#) has the goal of preserving the present level of function and preventing secondary complications. Certain capabilities cannot be recovered, but residents should be assisted to do for themselves as much as they possibly can in their daily activities. Without maintenance therapy, complications such as pressure ulcers, contractures, muscle atrophy, constipation, fecal impaction, and edema can result. Ambulation and range of motion are two common types of exercise programs. These programs often continue restorative treatments initiated by PTs and OTs. The treatment is generally less intense and of longer duration than restorative therapy. Long-term maintenance therapy is carried out by paraprofessionals, such as specially trained rehabilitation aides or CNAs.

Adaptive Rehabilitation

[Adaptive rehabilitation](#) deals with an evaluation by a licensed therapist to prescribe adaptive equipment and devices, and training the resident on their proper use. For example, an OT can prescribe commercial devices that can enable a person to independently dress, eat, or brush teeth. OTs can also make splints so that a person can use his or her hands and arms to perform certain ADLs, or adapt a person's living environment to

improve safety. A PT can prescribe braces or orthotics to support the knee or foot so a person can ambulate safely.

Terminology for Review

adaptive rehabilitation
antibiotic stewardship
antisepsis
aphasia
apraxia
asepsis
assessment
biologicals
controlled substance
dysarthria
dysphagia
evidence-based practice
geriatrics
indwelling catheter
infection prevention and control
maintenance rehabilitation
occupational therapy
outbreak
outcome surveillance
pathogen
physical therapy
plan of care
pressure ulcer
process surveillance
psychotropic drug
rehabilitation
restorative rehabilitation
restraint
speech/language pathology
standard precaution
surveillance
transmission-based precautions
unit-dose system

For Further Thought

1. Discuss the ways in which nursing plays a central role in a nursing facility. How can the centrality of nursing sometime result in conflict with other departments? As an administrator, how would you prevent such conflicts?
2. As a nursing home administrator, you are recruiting a new medical director. What are some of the main elements you should discuss during the interview?

CASES

Case 1: Fallen Out of Bed

Both cases were contributed by Laura M. Wagner, PhD, RN, GNP, FAAN, and Katerina Melino, RN, BA, MS, University of California, San Francisco, School of Nursing.

Mary Branscombe is an 83-year-old woman who was admitted a week ago to an SNF. She was transferred from an acute care hospital, where she was treated for 2 weeks following her first stroke. Before her recent hospitalization, Mrs. Branscombe lived at home with her adult daughter, son-in-law, and their four children. She required little to no help with activities of daily living. Now, with the change in her condition, the family does not think that she can return home to live with them. Mrs. Branscombe's gait remains unsteady. The physical therapist at the hospital tried to have her use a wheelchair, which she refused and insisted on ambulating independently.

Mrs. Branscombe's other medical conditions include glaucoma (diagnosed 3 years ago), osteoporosis (diagnosed 22 years ago), and depression (diagnosed 14 years ago, after death of her husband). Her prescriptions include alendronate (for osteoporosis), fluoxetine (an antidepressant), warfarin (a blood thinner), and timolol eye drops (prescribed for glaucoma).

During the 7:30 a.m. nursing rounds, Mrs. Branscombe is found on the floor beside her bed. She is confused, disoriented, and in a lot of pain. She tells the nurse that she attempted to get out of bed to use the bathroom and fell as she was climbing out of bed. It is unknown if she hit her head. Mrs. Branscombe is transferred to the emergency room where it is determined that she has sustained a hairline hip fracture.

Questions

1. What nonmodifiable and modifiable risk factors does Mrs. Branscombe have for falls?
2. What steps would you recommend to reduce the likelihood of this type of falls?
3. Which staff members should be involved in the planning process, and what should their roles be?

Case 2: Oh, Please Authorize Restraint Use!

You are the administrator of a 75-bed nursing home. Two CNAs approach you regarding their concerns about a resident, Mr. Valdez, who is an 86-year-old long-stay resident with Alzheimer's. Having been diagnosed and treated early in the disease process, his dementia has followed a fairly slow course but has worsened more recently. Over the last few weeks, Mr. Valdez's behavior has become aggressive, particularly in the late afternoon and early evening. He has struck several caregivers when they attempted to serve his dinner tray. He has also started wandering into other residents' rooms, creating disturbances. Last week, he attempted to escape from the facility and was combative when brought back to his room. The associates have expressed concerns about their own safety when around him, and other residents have complained that Mr. Valdez is intrusive and dangerous. The two staff members have learned about restraint use for aggressive residents. They have just walked into your office and asked you to authorize the use of restraints for Mr. Valdez so that the safety of staff and residents could be ensured.

Questions

1. As the administrator, how would you address the situation?
2. Name some interventions other than restraint use that may help to decrease Mr. Valdez's agitation.
3. Would using restraints for Mr. Valdez be appropriate?
4. In situations where restraints must be used, what is the role of each health care professional in ensuring that they are used as safely as possible?

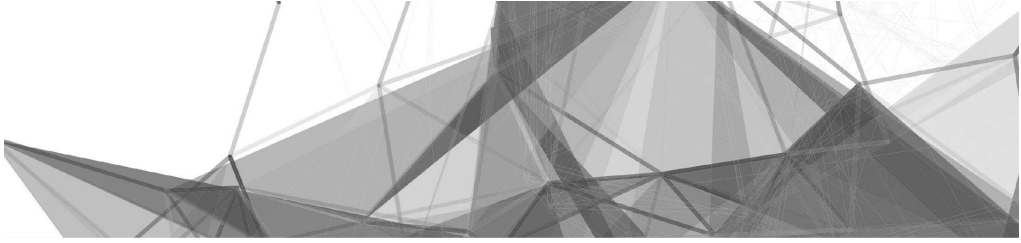
For Further Learning

- The American Geriatrics Society is the premier professional organization of health care providers dedicated to improving the health and well-being of older adults. <http://www.americangeriatrics.org/>
- American Medical Directors Association (now named the Society for Post-Acute and Long-Term Care Medicine) is the professional association of medical directors and physicians practicing in LTC, dedicated to excellence in patient care by providing education, advocacy, information, and professional development. <https://paltc.org/>
- National Association of Directors of Nursing Administration in Long Term Care is a professional organization of directors and assistant directors of nursing in LTC. It has established standards of practice for directors of nursing and also has a certification program for directors of nursing. <http://www.nadona.org>

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CHAPTER 11

Recreation and Activities

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WHAT YOU WILL LEARN

- Activities must be viewed as essential for a person's overall holistic healing in a person-centered environment. Activity programming differs from the roles of social services and rehabilitation therapies.
- Broad regulations govern residents' participation in activities. Federal regulations also provide for different ways in which activity personnel can qualify.
- Activity professionals must have a variety of skills in areas such as engagement, communication, innovation, resourcefulness, and planning.
- Activities programming must strive to achieve goals that satisfy physical, cognitive, social, affective, integrational, and spiritual needs.
- Basic planning considerations include the age of participants, nature and extent of their disabilities, space availability, supplies and equipment, staffing, and use of community resources.
- Activity calendars are not only planning and informational tools, but they are also useful for marketing the facility's services.
- Activities need to be spaced out during the day. Some evening and weekend activities should also be scheduled. Participation may be active or passive.
- Intervention approaches include sensory stimulation, reality orientation, reminiscence, validation therapy, multisensory stimulation, and cognitive stimulation.
- Continuous activity programming, various stimuli, and person-centered approach have been shown to benefit residents with dementia.
- Achievement of expected outcomes should be the focus of program evaluation.
- Various approaches are necessary to recruit and retain volunteers.

Introduction

In this chapter, the term **activity** means active or passive involvement of residents in any activities—outside the activities of daily living (ADLs)—that provide meaning and personal enrichment. Such activities are intended to enhance the resident's physical, cognitive, and emotional health, and to promote self-esteem, pleasure, education, creativity, accomplishment, and independence. Activities must be viewed as part of a person's overall holistic healing in a person-centered environment. A wide variety of programs must be offered to enable individuals to pursue their personal interests and to develop new interests, with the objective of finding meaning and purpose in life despite chronic illness, frailty, and functional impairment. The broad regulatory requirements¹ governing residents' participation in activities in certified facilities are summarized in **Exhibit 11-1**.

Exhibit 11-1 Federal Regulations on Resident Activities (Summarized)

F- Activities and Resident Participation Tags

- F550 Prohibiting a resident from participating in group activities (without clinical justification or evaluation of the impact the resident's participation has on the group) is a form of reprisal or discrimination.
- F561 The resident has a right to choose activities consistent with his or her interests, assessments, and plan of care, including participation in community activities both inside and outside the facility, and in social, religious, and community activities that do not interfere with the rights of other residents in the facility.
- F636 A resident's activity pursuits must be included in his or her comprehensive assessment.
- F679 The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Activities must be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts.
- F740 The facility must provide behavioral health care to all residents. Such care includes activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community.
- F907 The facility must provide sufficient space and equipment for the various services, including space to accommodate all resident activities.

Excerpted and summarized from State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities (rev. 11/22/17). <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>.

Meaningful activities call for a great deal of skill and resourcefulness because personal interests can vary substantially across the resident population in a nursing facility. Perhaps the biggest challenge for activity directors is to make sure that the programs meet the needs of individual residents regardless of their physical, mental, social, or emotional status. Such a focus necessitates that both individual and group activity programs should be based on residents' individual characteristics and preferences. In addition, such programs provide numerous opportunities for staff-resident interactions. Person-centered activity programs motivate residents, induce voluntary participation, and have been shown to improve self-esteem and reduce depressive symptoms (Jung et al., 2018).

A person-centered approach becomes even more important because not everyone can benefit from certain programs. For example, intergenerational programming (discussed later in this chapter) has generally proven to be beneficial; however, some adults demonstrate higher levels of frustration and impatience when participating in programs involving children (Gigliotti et al., 2007).

¹ Federal regulations for nursing homes are identified by F-Tags (e.g., F550).

Distinctive Orientation and Approach

Although some of the goals of social services and rehabilitation therapies overlap those of activities, these three services are quite distinct. For instance, maximizing independent functioning, promoting self-esteem, meeting psychosocial needs, and enhancing quality of life are the overarching goals pursued by all three disciplines. Yet, there are two main differences: (1) each is a specialized discipline that addresses resident care issues that other disciplines do not address, and (2) the approach used for achieving the common goals just mentioned is different in each discipline.

Therapeutic recreation is the primary approach used in activities; social services focus mainly on coping and social adaptation; and rehabilitation therapies employ a clinical approach to specific functional deficits, mainly by using established therapeutic modalities. By their nature, social services and rehabilitation are intervention oriented. They deal with problems and issues that are clearly defined. *Intervention orientation* respects autonomy and choice to a degree, but participation is generally nonvoluntary. For example, when a rehabilitation therapy is ordered by the resident's attending physician, refusing treatment requires a signed release from the resident. For the most part, activities are program oriented rather than intervention oriented. *Program orientation* means that programs are structured with the needs of various residents taken into consideration. In activities, intervention may be used but only to a limited degree. Compared with intervention-oriented therapies, participation in activities allows the residents a much greater degree of voluntary choice, personal control, and autonomy to pursue their own interests.

Social adaptation and maintenance rehabilitation are often the by-products of activities, although they may not be specifically pursued. For example, group activities provide opportunities for socializing, and exercise programs have rehabilitative value. Activities allow residents freedom of expression, which, from a holistic viewpoint, adds a necessary dimension to nursing home services that no other discipline in the facility can furnish.

Activity Department

Staffing

Because of the unique nature of activities, a facility needs a separate activities department headed by an activity director or activity coordinator. The director/coordinator reports to the administrator. In small facilities, one full-time person may be assigned the responsibilities of both social work and activities. However, in facilities with more than 50 beds, a full-time activity director is generally needed. Additional personnel are necessary in facilities of more than 100 beds. Part-time activity assistants may be used to fill in as needed.

Qualifications

Federal regulations require that activity programs be directed by qualified professionals. The qualifications can be met in several different ways. For example, after completing a bachelor's degree in therapeutic recreation, a person can obtain the Certified Therapeutic Recreation Specialist (CTRS) credential through the National Council for Therapeutic Recreation Certification (NCTRC). Certification requires a supervised internship and passing an examination (NCTRC, 2021). Another organization, the National Certification Council for Activity Professionals (NCCAP), offers certifications for activity directors and activity assistants. Federally mandated qualifications are also met by completing a training program approved by the state, by having recent 2 years of experience in a social or recreational program with one year of full-time work in therapeutic activities, or by being an occupational therapist or occupational therapy assistant.

Skills and Competencies

Particularly relevant for activity directors are skills in the areas of engagement, communication, assessment, innovation, resourcefulness, planning, and program evaluation. They must also have knowledge of aging and issues that accompany aging.

The skills of engagement and communication are necessary for conducting resident assessments to determine needs and interests and for motivating residents to participate in activities determined to be beneficial for them. A comprehensive assessment yields valuable information that forms the basis for planning and developing appropriate programs. During assessments, vital information may also have to be obtained from the residents' family members, for instance, when the resident has severe cognitive impairment.

Activity professionals must be innovative in designing appropriate programs to meet individual needs, resourceful in using community resources and engaging family members and volunteers to enhance the activity programming, skilled in planning and coordinating a wide variety of programs at different times of the day, and able to evaluate the effectiveness of the different programs. Activity staff are members of the multidisciplinary team to carry out assessments, participate in care planning, and document residents' activity goals and progress.

Program Development

The various factors discussed in this section should be evaluated carefully to generate ideas that can add variety, novelty, appeal, and meaning to resident activities. **Programming** refers to structured methods of delivering needed services.

Goals of Activity Programming

Activity programs should provide “stimulation or solace; promote physical, cognitive and/or emotional health; enhance to the extent practicable each resident’s self-respect by providing, for instance, activities that allow for self-expression, personal responsibility, and choice” (Lanza, 1997). Overall, activities must promote a sense of well-being and create a sense of personal fulfillment or accomplishment.

Multifaceted programming must cover the main human needs in a holistic context, and every need category is associated with goal achievement:

Need	Goal Achievement
Physical	Build strength and balance
Cognitive	Stimulate the mind
Social	Promote interaction
Affective	Express one’s individuality
Integrational	Build self-esteem
Spiritual	Provide spiritual fulfillment

Activities that provide movement and general physical stimulation of the body, such as dance therapy, exercise programs, and indoor or outdoor walks, specifically address physical needs. Research shows that physical activity also improves cognitive function as well as sleep duration and sleep quality in older adults (Bademli et al., 2019; Štefan et al., 2018). Physical activity and quality of life and health satisfaction are positively correlated in older adults, regardless of whether they are institutionalized or live independently (Crnković et al., 2019). One study reported that a ballroom dancing program for elders living in long-term care (LTC) institutions improved balance and reduced the number of falls (Borges da Silva et al., 2014). Exercises and sports programs often require simulation. For example, balloon volleyball, in which residents toss a balloon among themselves while seated in a circle, can simulate the real game.

Cognitive and educational needs can be met through word games, puzzles, discussion of current events, and book reviews. Nursing facilities must also provide residents with computers, Internet access, and other self-directed pastimes. Social needs call for activities that provide opportunities for active and passive interaction and companionship with others. Examples of such programs include coffee klatches, functions, room visits, sing-alongs, and birthday parties and other celebrations.

Affective needs require activities that enable residents to express their feelings, emotions, and creativity. Art therapy, music therapy, touch therapy, pet therapy, bird feeding, and other types of programs that provide sensory stimulation and foster reminiscence are some examples. Art therapy activities, for example, have been shown to improve depressive symptoms and self-esteem in older adults (Ching-Teng et al., 2019). Another form of therapeutic art is poetry, which can help residents find comfort, meaning, and relief in daily life (Tobia, 2020). Poetry, songs, and music often capture and release people’s emotions. Affect-related activities also include movies, puppet shows, fashion parades, magic shows, live bands, chamber music, plays and skits, art exhibits, and cooking demonstrations. Some residents may be interested in journal writing to reminisce their past.

Integrational needs call for programs that include roles in which the resident is needed by others, such as mail delivery, folding linens in the laundry, participation in resident council, acting as surrogate grandparents to children from the local day care center, and telling stories to children.

Spiritual needs are answered in the lives of many elders by religious and spiritual pursuits considered important in their lives for achieving personal satisfaction, well-being, and self-realization and as a means of coping with stressful situations. Private devotions, quiet meditation, reading, and congregational religious programs brought in by local churches and synagogues are examples of activities in which many elders like to engage to find personal fulfillment and peace.

Activity Program Planning

Planning an effective program requires that the activity professional consider (1) the kind of service to deliver, (2) the manner in which it will be delivered, and (3) its anticipated effect on the residents involved (Lanza, 1997). Six basic considerations are valuable in developing a well-rounded activity program (Greenblatt, 1988; Lanza, 1997):

1. *Age of participants.* Nursing facilities generally have substantial age differences among residents, and individual interests often vary according to a person’s age group.

2. *Nature and extent of disabilities.* Disabilities must be assessed because active participation requires a certain level of functioning. Certain activities are suitable for passive participation by those who may not be able to have active involvement. Abilities and skills required for participation may be limited by disorders in any of these three behavioral arenas (Greenblatt, 1988):

- Motor skills are affected by poor ambulation, strength, range of motion, vision, or hearing.
- Cognitive functioning is affected by disorders such as inability to recognize, store, or retrieve information, make judgments, or maintain attention span.
- Affective functioning is impaired by depression, anxiety, anger, agitation, fear, or frustration.

Regardless of the type of limitation, therapeutic activities should use residents' unaffected capabilities; otherwise, functional loss in the remaining areas can occur. This additional functional loss, called **secondary disability**, can be reversed or prevented. For example, an elderly person with the primary condition of hearing loss may tend to isolate herself, which can lead to deterioration of other types of functional capabilities (Greenblatt, 1988).

3. *Space availability.* Availability of space is an important consideration for group programs. Certain individual pursuits such as knitting, crocheting, reading, drawing, painting, or listening to music can be carried out in the resident's own room. Medium to large facilities often have an activity room for group activities. This room is generally equipped for crafts, cooking, and baking and can accommodate small- to medium-size groups. Large facilities may also have a chapel for religious services. Other activities generally require some ingenuity in adapting existing common spaces. For example, dining rooms, day rooms, lounges, lobby areas, open spaces near nursing stations, and alcoves can, with some improvisation, all be used for different activities. Use of common areas for activities requires proper planning and coordination to minimize interference with other services. For instance, activities should not interfere with the use of dining areas for meals. Only a limited number of programs should be conducted at a given time so that space is also available for individual leisure or private visiting. When weather conditions permit it, outdoor spaces such as patios, gazebos, and balconies should be used for certain types of activities. Outdoor gardening, tending to flowers and shrubs, and bird-feeding are therapeutic for many residents.

4. *Supplies and equipment.* Reusable supplies and equipment are acquired over time. Simple, inexpensive equipment is generally quite sufficient for most activities. Additional needs can be met by seeking donations or purchasing things in good condition at garage sales. Any remaining needs should be met by allocating adequate financial resources in the annual budget. In most facilities, a multipurpose, folding mobile cart is essential for bringing games, crafts, magazines, books, and other items to residents in their rooms. The same cart can be used for serving refreshments and distributing items, such as prizes, at parties and other social gatherings. Some equipment commonly used for activity programs includes folding tables and chairs; adjustable over-the-bed tables for use with wheelchairs; computers; portable screens; compact disk and cassette players; DVD equipment; movable organs or pianos; cameras; woodworking tools; garden tools; ceramic kilns; cooking utensils; microwave ovens; ice cream makers; popcorn makers; barbecue grills; Christmas ornaments and other festival or seasonal decorations; and a variety of games, puzzles, and large-print books.

5. *Staffing.* The number of associates and their qualifications, training, experience, and personality traits are key factors in developing and implementing high-quality programs. Building strong volunteer support is often necessary to supplement staffing in the activity department because additional hands are often needed for programs such as parties, shows, and outings. Involvement of families can also be successfully pursued; many of the residents' family members are retired but in good health, and family and friends often would like to stay involved in the lives of their loved ones.

6. *Community resources.* Maintaining a link with the outside community is vital to enhancing the residents' quality of life. Local religious establishments; civic organizations, such as Rotary and Kiwanis clubs; schools; Boy and Girl Scouts; nonprofit social service agencies; businesses; libraries; shopping malls; and many other types of organizations and establishments can support a facility's activity programs by offering their resources. Using community resources does not always mean bringing the resources into the facility.

Community resources are also used when residents are taken for outings. For example, a trip to the mall may require making advance arrangements to accommodate a relatively large group of residents at the ice-cream parlor, or a group visit to a department store would require some coordinating so that residents could be taken at an appropriate time to look at preselected merchandise display areas.

Activity Calendars

Activity calendars provide the most effective means for planning. A master calendar is prepared to earmark the main activities for an entire year. This calendar helps the activity staff plan and prepare for major events, special celebrations, and seasonal festivities well in advance. The master calendar is also used to identify programs of wide appeal that would be offered on a regular basis and programs for which some lead-time is necessary.

A weekly calendar of activities shows the activities planned for each day of the week. Many facilities display a large, wall-size activity calendar in a prominent place to be easily seen by residents and visitors. The activity calendar is also useful in marketing the facility to prospective clients during the facility tour.

Activity Scheduling

Activity schedules should take into account possible conflict with meal times and nursing care routines. Activities should also be planned for evenings, weekends, and holidays.

High-quality activity programming calls for a variety of scheduling patterns. As a rule of thumb, scheduling should attempt to mirror the residents' usual patterns of rest and recreation before they were institutionalized. In this regard, Greenblatt (1988) proposes that holidays, to the extent possible, should be celebrated on the days they actually occur. Crafts and hobbies ought to be pursued in late morning before lunch; the elderly often take naps or just like to rest after lunch. Parties normally take place in late afternoon or early evening. Residents like to have leisure time after dinner, which is generally over by 6:30 p.m. As a rule of thumb, some morning activities should be offered starting at around 10:00 a.m.; then afternoon activities, starting at around 2:30 p.m.; and evening activities, starting at around 7:00 p.m. Within these guidelines, residents' own preferences for activity times should be accommodated (Lanza, 1997).

On weekends, family visits are common; hence, fewer activities may be needed. On the other hand, it is also an irony that activity programming is often curtailed during periods when the residents have the most leisure time available. Hence, scheduling of activities poses some challenges, but striving for balance is the key.

Active and Passive Stimulation

Residents can get active and passive stimulation during individual activities as well as group activities. Some residents are intimidated by small-group settings, in which more active participation is generally required, whereas others may not like being in large groups. Small groups often form spontaneously as friendships between people develop. The activity staff can help such groups find something meaningful to do together. Structured group activities, as opposed to informal group activities, are particularly beneficial for depressed residents (Meeks et al., 2007).

Passivity is characterized by a decline in human emotions, withdrawal from interactions with others and surroundings, and a decrease in motor activity (Colling, 1999). Passivity can lead to isolation and cognitive and functional decline (Kolanowski & Buettner, 2008). Residents who cannot actively participate can simply be passive "bystanders" and receive stimulation from listening and watching other active participants.

Intergenerational Programming

Children's interactions with elders are enriching and have universal appeal. Eyes brighten up, smiles begin to form, and muffled laughter is often heard when the elders are exposed to little children. Children also get a special sense of fulfillment when they can sit in an elder's lap, tell a tale, show the elder their favorite toy, or ask the elder some question.

By working with local schools, child day care centers, and parents, many facilities across the country have developed formal programs that allow children to make regular visits to LTC facilities and to participate in activities with the elders. One study noted that residents with dementia who took part in intergenerational programming consistently showed higher levels of positive engagement and lower levels of negative forms of engagement than levels seen in standard activities programs (Lee et al., 2007). Constructive engagement that promotes more hands-on involvement with the children, particularly in the form of helping behaviors, keep elders better engaged in the activity with a lesser likelihood of being inattentive (e.g., sleeping/nonengagement, self-engaged). Such engagements also provide elders with the opportunity to feel productive and to be doing something meaningful, which can help maintain a sense of self-worth and improved quality of life (Janke et al., 2019).

Intervention Approaches

In contrast to most other types of activity programming, therapeutic services for cognitive disorders generally require an intervention approach. In many instances, residents who need therapeutic services are unable to express their wishes. However, the residents' past practices and habits are taken into account to develop appropriate interventions. This section categorizes activities that are specifically designed for sensory and cognitive stimulation.

Sensory Stimulation

Sensory stimulation incorporates therapies that stimulate the senses in residents with dementia or in those in comatose or vegetative states. It can benefit residents who have cognitive, visual, or hearing impairments, or those who are bedridden and are likely to undergo sensory deprivation over time. Sensory deprivation speeds up degenerative changes in mind and body and accelerates the loss of functional cells in the central nervous system. Hence, sensory deprivation affects the way people relate to their environment, and it causes biological, psychological, and social consequences (Kozlowski et al., [2017](#)). A resident's perception and alertness can be improved by eliciting responses to stimuli in the five sensory areas: vision, hearing, smell, taste, and touch. Use of objects with bright colors, lighted objects, music therapy, aroma therapy, and pet therapy are some of the means of providing sensory stimulation.

Reality Orientation

Reality orientation is a form of therapy for people who show symptoms of confusion, disorientation, or dementia. The therapy consists of reiteration of the person's identity, orientation to time and place, and reinforcement of consistency in daily routine. Repeated attempts are made to draw the person into conversation, using simple questions, pictures, or whatever may spark their interest. Simple, straightforward, factual information on a regular basis can help residents with substantial cognitive disabilities or those experiencing delirium to remain oriented and communicative. Facts such as the resident's name, the name of the facility, the day, the date, and the season are presented to the resident one at a time, and the resident is encouraged to verbalize the information and drawn into conversation. Use of calendars, clocks, pictures, and information boards are used as aids (Buettner & Martin, [1995](#); Lanza, [1997](#)).

Reminiscence

Reminiscence refers to remembering and in some way reliving past experiences to promote emotional well-being. Engaging in certain activities can help bring back "the good old days" and pleasant events that a person experienced in the past. Such activities include singing or listening to old-time favorite songs, seeing clips of old TV shows, watching old movies, going through photo albums, or discussing memorabilia from a certain era.

Validation Therapy

In validation therapy, a person's belief that he or she is actually living in the past is accepted and validated by the staff members working with the resident. Many elders, especially before death, want to return to the past to wrap up loose ends. People with dementia often "live in the past." The theory behind this therapeutic approach is that validation or acceptance of the values and beliefs of a person, even if they have no basis in current reality, helps the individual come to grips with the past. The therapy involves listening with empathy. In the absence of such therapy, the person is likely to withdraw. Hence, if a 70-year-old man says that he is a senior in high school and has to go to school so he can run the 100-yard dash, it is accepted as real. Validation therapy may be a viable treatment strategy to curtail problematic behaviors among residents with borderline personality disorders (Jall et al., [2012](#)). This therapeutic approach, however, has remained controversial regarding its effectiveness for people with dementia (Neal & Barton Wright, [2003](#)).

Multisensory Stimulation

Multisensory stimulation (MSS), also known as multisensory behavior therapy (MSBT), is commonly known as Snoezelen in European countries, and it is becoming increasingly popular in the United States. The objective of MSS is to stimulate all of the primary senses—touch, hearing, sight, smell, and taste—through a combined effect of textured objects, soft music, colored lighting, aromas, and favorite foods. Sensory experiences are manipulated, intensified, or reduced in relation to the needs and desires of the individual (Botts et al., [2008](#)). MSS procedures have not been standardized, but according to Baker and colleagues ([2001](#)), three main characteristics differentiate MSS from other therapies:

- Visual, auditory, tactile, olfactory, and gustatory stimulation is offered to residents, often in a specially designed room—sometimes called a Snoezelen room or multisensory environment.
- Associates work one on one with residents, adopting a nondirective, enabling approach in which they follow the residents' lead. Residents are encouraged to engage with sensory stimuli of their choice.
- Stimuli used are nonsequential and unpatterned, experienced moment by moment without relying on short-term memory to link them to previous events. They present few specific attentional or intellectual demands on residents with dementia.

MSS therapy has been used with autistic children, people who have developmental disabilities, and people with dementia. Generally, Snoezelen therapy has shown only mixed results in alleviating behavioral symptoms of dementia, such as restlessness, wandering, and agitation.

Cognitive Stimulation

Cognitive stimulation is preventive in nature because cognitive decline can progress rapidly in the elderly population. Studies show that it is possible to slow down cognitive degradation through stimulation programs. Such interventions include activities that promote (1) simple logical reasoning, for example, in a table of 100 squares with filled and unfilled numbers, a resident can be asked to supply the missing numbers, (2) memory, for example, remembering and repeating two or three words in the right sequence, (3) attention and concentration, for example, the game of bingo, (4) learning and sequencing, for example, the order of historical events, (5) expressive activity, such as, describing oneself, and (6) temporal and spatial orientation, which is similar to reality orientation, discussed previously (de Lima Neto et al., [2017](#)).

Activities for Residents with Dementia

Behavioral problems of dementia are often more distressing than mere cognitive and functional decline. Behavioral problems are also a main reason for institutionalization (Phillips & Diwan, 2003). Hence, both agitated and aggressive behaviors are common in nursing home residents with dementia. Generally, these residents possess a lot of nervous energy that must be channeled into more constructive outlets. Otherwise, the resulting noisy and chaotic environment can provoke a sense of bewilderment and anxiety, which, in turn, reinforces disruptive patterns of behavior, such as combativeness and other aggressive manifestations. Studies show that residents in dementia care units are unoccupied most of the time (Cohen-Mansfield et al., 2007). Passive behaviors are also among the most common behavioral symptoms of people with dementia.

Continuous activity programming has been shown to reduce negative behaviors and also decrease the need for psychotropic medications and improve nutritional intake (Volicer et al., 2006). In [continuous activity programming](#), a resident with dementia is always in the presence of a staff person who engages the resident in meaningful activities. This can be structured activity like exercise or unstructured activity like casual conversation (Volicer et al., 2006).

As cognitive and physical abilities change, individuals with dementia may not be able to engage in activities they once found enjoyable. Some activities may lead to extreme frustration because of a mismatch with the individual's current skill level (Kolanowski & Buettner, 2008). People in mid- to late-stage dementia may not be able to tolerate the stimulation of group activity. Taking an individualized approach to each person and formulating activities based on a resident's current preferences—rather than past preferences—are potent in engaging the resident; hence the importance of finding out a person's current interests (Cohen-Mansfield et al., 2010). Even brief individualized activities led by certified nursing assistants (CNAs) bring pleasure and engagement in persons with dementia (Van Haitsma et al., 2013).

Small-group programming may be more appropriate for residents with mild to moderate dementia. Under a grant from the New York State Department of Health, one facility discovered that a small-group program may best address the needs of those with dementia. This model proposes a staff-to-resident ratio of 1:8 (Hutson & Hewner, 2001). Further research suggests that small-scale dementia care in group living environments results in greater involvement in preferred activities (Smit et al., 2012). The small-group program requires cross-trained staff teams consisting of social workers, activity assistants, and CNAs. One associate works with a small group of 6 to 10 residents at a time, and practitioners of the three disciplines rotate among the groups. Group composition is roughly homogeneous; for example, wanderers are in one group, and residents displaying disruptive behaviors are in another group (Hutson & Hewner, 2001).

Various interventional approaches discussed earlier in this chapter are appropriate for people with dementia. For example, reality orientation can be modified to provide cognitive stimulation (Woods et al., 2012). Cognitive function and behavior can be improved with reminiscence therapy (Nawate et al., 2008), especially in residents who have problems communicating (Mileski et al., 2018). Some residents with dementia can also be involved in constructive activities, such as folding towels and other simple “household” chores. Cognitive activities, such as matching painted rocks with colors painted inside an egg carton, can also be employed.

Research generally supports sensory focused approaches that are tailored to the individual (Legere et al., 2018). Such activities can also meet the residents' affective needs. Arts-based interventions are increasingly being employed in LTC settings with the goals of promoting positive engagement and social inclusion for the residents (Canning & Blakeborough, 2019). Using music to soothe anxiety can be an effective intervention to assist with lessening of agitation during certain ADLs, such as bathing (Ray & Fitzsimmons, 2014). However, given the vast music repertoire, music regimens provide the best outcomes when they are individualized to the resident's preferences (Leggieri et al., 2019), for instance, to capture the person's language, culture, music genre, etc. Research also demonstrates that animal assisted activities, such as interaction with a dog and its handler, can promote engagement in persons with dementia (Olsen et al., 2019). Although Snoezelen has shown mixed results, certain combined interventional approaches, such as music therapy combined with reminiscence therapy and reality orientation techniques, have shown valuable effects for depression in residents with mild Alzheimer's disease (Onieva-Zafra et al., 2018).

Residents with cognitive impairment have been found to be significantly more engaged during visits with children and youth between the ages of 1 and 24. Also, these young visitors did not develop any negative attitudes toward the elders (Baker et al., 2017). Coloring books and scrapbooks can engage both children and adults.

Program Implementation and Evaluation

Implementation

The actual implementation of an activity is greatly facilitated by how well a program is planned. Nursing staff members generally help with transporting or assisting the residents to the activity area. Cooperation from nurses is also needed for dressing residents appropriately, helping residents use the toilet before activities, and dispensing medications and treatments in a way that will not interfere with a resident's ability to participate in activity programs. The dietary staff may be involved when refreshments are a part of the activity. Housekeeping and maintenance staff members are needed for special setups that require moving and arranging furniture and cleaning up after activities.

Execution of most routine programs simply requires bringing together the planned resources. But for larger programs such as parties, functions, and outings, efforts and resources must be coordinated, and follow up is necessary to make sure that everything proceeds smoothly. Each program should be carried out in accordance with the plan, while allowing for any unforeseen circumstances that may occur. Whenever possible, if a planned program must be canceled, an appropriate substitute activity should be provided in accordance with a contingency plan. Hence, some backup programs that can be carried out on short notice are necessary.

Resident Participation

Maintaining a resident profile can greatly facilitate matching residents with activities from which they can derive the most benefit. The profile should include any risks and clinical contraindications. A risk profile incorporates a resident's limitations as well as cautionary information about things such as allergies or other health conditions or treatments that may require associates to observe certain precautions. For example, residents with serious cardiovascular conditions, asthma, or respiratory problems may require medical clearance for participation in certain types of activities. Use of certain medications produce side effects such as dizziness, drowsiness, and sensitivity to sunlight that require necessary precautions, such as assisting residents on certain medications to move slowly or using sunscreen for outdoor activities. Others may have dietary restrictions which require substitutions when food and drinks are served in certain activities.

Program Evaluation

Program evaluation is the process of systematically appraising a program to determine whether expected results are being achieved. Evaluating activity programs is a prerequisite for improving their quality. An outside activity consultant may be employed to either do the program evaluation or to train the activity staff on how to do the evaluation. When the evaluation validates the effectiveness of programs that associates have helped create, their morale is improved. Program evaluation, however, should not be used to criticize or penalize activity personnel.

As discussed previously, program goals and expected resident outcomes must be established at the planning stage. Evaluation then determines whether the goals and outcomes have been achieved. When desired outcomes are not achieved, the activity director must try to discover the reasons for the lack of success.

The process of program evaluation involves continuous and systematic collection of relevant data on outcomes. To collect outcome data, two main records should be kept. First, an accurate attendance record should be maintained for each activity. A computer spreadsheet can greatly facilitate this type of recordkeeping. The data should reflect each resident's participation by the specific program he or she attends and by how many times the resident attended each program. These attendance data would yield two critical pieces of information: which programs are the most popular and the level of participation for each resident.

The second type of record involves qualitative information on the goals and progress of the program in relation to the goals planned for each resident in the care plan. This information can also facilitate documentation in each resident's medical record. When these two types of data are analyzed for each resident, it will be clear how well the activity programming is addressing each resident's individual needs and what changes may be necessary when certain needs are not met.

Volunteer Support

The activity director is generally responsible for developing and coordinating the facility's volunteer program. With proper training and supervision, volunteers from the local community can provide valuable assistance in a number of nontechnical areas because staff resources are often limited. Because most volunteers have regular and frequent contact with the facility, they also establish an important link between the facility and the local community.

Volunteer roles are not just confined to helping with activity programs. Depending on personal interests, volunteers may pass meal trays or pour beverages during lunch or dinner, sweep up the dining room after dinner, maintain wheelchairs in working order, and do other such tasks. Volunteers may also assist with shopping and other chores for the residents or provide transportation for outings. Some key factors in recruiting and retaining volunteers are as follows:

- Recruitment efforts must be ongoing. Numerous community organizations can be tapped into.
- People most likely to volunteer are retirees, homemakers without small children to take care of, and young adults in school. Volunteering can be an important avenue for young people to find paid employment later. As mentioned earlier, some family members are also potential recruits for volunteering.
- Making personal contacts is more effective than advertising. Methods such as contacting potential volunteers directly, visiting local schools and discussing after-school opportunities, using current volunteers to recruit others, offering incentives, or sponsoring a volunteer recruitment day in collaboration with other service agencies are some methods that can work. The facility's own employees can also refer friends and relatives.
- Volunteers' availability, skills, and interests should be matched with the needs of the residents. The facility may state what its most critical needs are, but the desired areas of service should be chosen by the volunteers.
- Volunteers must be carefully selected using a formal process that should include filling out an application, screening, interviewing, and reference checks. Orientation and training must follow.
- Maintain a log book for recording the time each volunteer spends in the facility.
- Praise and recognition are paramount. Apart from providing the opportunity for personal gratification that the volunteer derives from helping others, recognizing the volunteer's work is the only way that the facility compensates volunteers for their efforts. The facility should plan an annual dinner and award ceremony exclusively for volunteers. Letting volunteers have meals at the facility at subsidized prices or for free, depending on the tasks they perform while they are in the facility, is also a good policy.

Terminology for Review

activity

continuous activity programming

multisensory stimulation

passivity

program evaluation

programming

reality orientation

reminiscence

secondary disability

sensory stimulation

Snouezelen

validation therapy

For Further Thought

As a nursing home administrator, how would you determine whether or not you have an effectively run activity program in your facility?

CASE

iPods for Alzheimer's

Contributed by Anne P. Stich, MMS, MPS, PA, Health Science College of Arts and Sciences, Bellevue University, Texas.

Nell, the activity director for a Continuing Care Retirement Community (CCRC) complex, has learned about the benefits of music therapy. She is convinced that the residents of the 30-bed Alzheimer's unit, named Rosewood Court—a specialized unit in the complex's skilled nursing facility—can really benefit from music therapy. However, she faces the dilemma of how to deliver music that would appeal to the residents, which range in age from 52 to 91.

At the next interdisciplinary meeting of the Alzheimer's unit, Nell made an appeal backed by current research on music therapy. During the ensuing discussion, most of the participants quickly dismissed the idea of providing a variety of piped-in music for the entire unit because it would create negative distractions for both residents and staff. The discussion focused mainly on the individual desires and interests of the residents. Most members of the team would like Nell to explore the feasibility of putting individualized music on iPods for each resident. Because the technology is rapidly changing, many people have upgraded their older iPods; Nell may be able to find used iPods for each resident.

Assuming that used iPods could be procured, selecting, obtaining, and downloading numerous musical genres that would appeal to individual tastes would remain a daunting challenge. Nell was given the responsibility to find the answers. She quickly arranged a brainstorming session with her six activity assistants who had responsibilities for the various units of the CCRC. Nell summarized the ideas generated by her activity team:

- Purchase of iPods will be very expensive. They should find ways to obtain donated iPods.
- They should identify how many residents would be able to use individualized music.
- They should ask family members about the residents' individual tastes in music.
- The staff will not have the time to search for music, procure it, and download it to iPods. The facility should find ways to obtain music. Family members and volunteers could be solicited to assist with finding sources for obtaining at least some of the music.
- The CCRC has a formal Adopt a Grandparent program in which the second and third graders from the local Lawndale Elementary School participate. Ms. Johnson, the principal, should be contacted for leads to try and enroll students from the Lawndale Middle School to help download music and teach the staff on how to access music from the iPods.

Associates in the Activity Department assisted Nell in developing a brief survey for families:

A. Did your relative enjoy music prior to his/her admission to Rosewood Court? What kind of music? Please check all that apply:

Jazz	Hip-Hop	Rock and Roll	Big Band
Acoustic	Seasonal	Celtic	Folk
Romantic	Classical	Ballet	Opera
Gospel	Barbershop	Blues	British invasion
Calypso	Chamber	Country	Punk
Dance	Disco	Instrumental	Honky-tonk
Merengue	Musicals	Piano	Polka

- B. Are there specific songs or music that your relative associates with good times in the past?
- C. Do you have any of this music on vinyl records, tapes, CDs, or other media?
- D. Would you be able to lend your media so we can download the music to iPods?

With Ms. Johnson's help, the 24 students of the seventh-grade social studies class at Lawndale Middle School made it a cultural project. With the enthusiastic support of Mr. Reibold, the social studies teacher, the students helped with finding music on the Internet and downloading it. The CCRC paid the nominal cost for the downloads. A local recording studio donated the time to convert some of the music from other media to a downloadable format for the iPods.

Nell and Mr. Reibold arranged a field trip for the students to meet the facility's residents. Each student presented the individualized iPod to each of the residents in the presence of family members, staff, volunteers, and a few guests from the local community. The students also gave a demonstration on how to use the iPods. Some of the residents tried their "new" iPods. Muffled laughter was heard and smiles were seen forming. Nell and her activity staff were delighted. The celebration ended with cake and punch.

Questions

1. Suggest some ways how Nell could obtain used iPods for the residents.
2. Is there any other alternative to the use of iPods?
3. How does Nell's use of music measure up to the six basic considerations for program development?
4. Nell is using which of the intervention approaches described in this chapter? Does it lend to person-centered care?
5. Despite the initial enthusiasm expressed at the completion of the project, what future problems do you foresee with the use of iPods?

For Further Learning

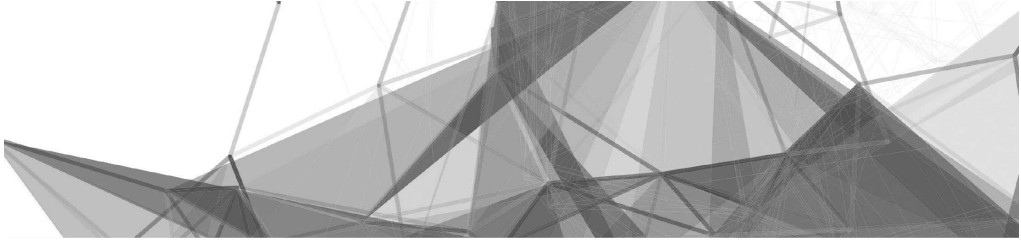
The National Association of Activity Professionals is the only national group that represents activity professionals in geriatric settings exclusively. <http://www.naap.info>

The National Certification Council for Activity Professionals is one of the certifying bodies recognized by federal law and is the only national organization that exclusively certifies activity professionals who work with the elderly. <http://www.nccap.org>

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CHAPTER 12

Dietary Services

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WHAT YOU WILL LEARN

- Food has universal appeal, but in nursing facilities, it must also address a variety of nutritional issues.
- The food service director oversees the entire dietary operation and is responsible for staffing, purchasing, inventory management, and cost control. Traditional facilities have cooks, helpers, and dietary aides to staff the kitchen. A registered dietitian functions as a consultant.
- Menu planning requires consideration of meal plans, menu choice, and menu cycle.
- Menus must be nutritionally balanced, include dishes that are palatable, and be within budgetary cost allowances. Standardized recipes and portions are designed to yield consistent quality and cost.
- Selection of vendors should be based on reliability, quality, and cost. Ordering schedules vary by the type of food product. Even independent facilities can take advantage of combined buying power by joining a group purchasing organization.
- Blind receiving is a more reliable method than invoice receiving for order delivery.
- Adequate inventory control is based on perpetual and physical inventory systems. The physical inventory is also used for food costing.
- Food production requires planning and contingency arrangements. Each of the main production methods has its advantages and disadvantages.
- Therapeutic diets can be simple or complex. Supplements are used when special nutritional issues exist. Between-meal snacks can be beneficial for some residents.
- Food acceptability and intake issues should be addressed. Various types of interventions can improve food intake for residents with dementia.
- Various clinical conditions may necessitate the use of intensive nutrition techniques.
- Centralized food service is more traditional than decentralized service. Each has its advantages and disadvantages that must be evaluated before making a switch from one type of service to another. Maintaining foods at their right serving temperatures is a main challenge in food service.
- Food poisoning is almost entirely preventable by practicing good sanitation and good food handling techniques.

Introduction

Food has universal appeal as a necessity for physical sustenance, as a means of sensory gratification, and as an agent for creating social interaction. These three major aspects of food provide the basic principles that guide food preparation and service in nursing facilities. For residents who have special dietary needs, food intake must also serve a therapeutic purpose.

In many nursing facilities, the dietary department is also responsible for preparing meals for the staff, visitors, and volunteers. In most cases, preparing food separately for residents, staff members, and guests is impractical. Hence, the basic menu should be designed to meet the needs of all these groups. Generally, the dietary department is also responsible for making refreshments or special preparations for certain activities, such as parties and functions. Some large facilities may also have contracts to prepare meals for the local Meals on Wheels program. Although most facilities operate their own kitchens, some facilities contract food preparation to outside vendors. In newer facilities in particular, smaller household-style kitchens and dining services are catching on as part of the culture change movement.

Dietary services (food and nutrition services) must also address the needs of those who have loss of appetite, difficulty eating independently, problems with chewing, swallowing difficulties, and inadequate nutrition. Other dietetic needs are related to diseases such as diabetes, heart conditions, or liver disease. Residents with dementia also require appropriate interventions. The main federal regulations¹ for dietary services in certified facilities are summarized in **Exhibit 12-1**.

Exhibit 12-1 F-Tags for Main Dietary Services (Summarized)

F- Regulatory Requirements Tag

- F800 The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.
- F801 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population. A qualified dietitian or other clinically qualified nutrition professional must be employed either full-time, part-time, or on a consultant basis.
- F802 The facility must employ sufficient staff with the appropriate competencies and skills sets to safely carry out all the functions of the food and nutrition service.
- F803 Menus must be developed and followed to meet resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.
- F804 Food preparation methods should conserve nutritive value, flavor, and appearance. Food and drink should be palatable, attractive, and served at a safe and appetizing temperature.
- F805 Food must be prepared to meet each resident's needs and according to his or her assessment and care plan. For example, food should be cut, chopped, ground, or puréed for residents who have difficulty chewing or swallowing their food.
- F806 Residents' allergies, intolerances, and preferences must be accommodated. The facility must provide appealing options of similar nutritive value to residents who choose not to eat what is initially served or who request a different meal choice.
- F807 Drinks, including water and other alternative sources of fluids, must be provided to maintain sufficient hydration.
- F808 Therapeutic diets must be prescribed or overseen by the attending physician
- F809 The facility must provide at least three meals daily. No more than 14 hours must elapse between a substantial evening meal and breakfast the following day, except that up to 16 hours may elapse if a nourishing snack is served at bedtime.
- F810 The facility must provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat or drink independently.
- F692 Residents must maintain, to the extent possible, acceptable parameters of nutritional and hydration status. A therapeutic diet must be provided that takes into account the resident's clinical condition.

Note: This exhibit is illustrative only. The reader must consult the cited source for a full description of the regulations.

Excerpted and summarized from Centers for Medicare and Medicaid Services. (2017). *State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities* (Rev. 173, 11-22-17). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf.

¹ Federal regulations for nursing homes are identified by F-Tags (e.g., F800).

Dietary Department

Supervision

After nursing services, dietary is the second largest department in a nursing facility. The department is managed by a full-time food service director (or dietary manager) who reports to the administrator. State and federal regulations specify the qualifications required for the position of dietary manager. The two most common choices for filling the dietary manager's position are a Registered Dietetic Technician (DTR) (or Registered Nutrition and Dietetics Technician [NDTR]) who holds an associate's degree in general dietetics, or a Certified Dietary Manager (CDM) who has completed the requirements for certification by the Association of Nutrition and Foodservice Professionals (ANFP). A person also qualifies if he or she has an associate's or higher degree in food service management or in hospitality, if the course of study includes food service or restaurant management, from an accredited institution of higher learning (F801).

The dietary manager has both management and clinical responsibilities. This individual is responsible for staffing functions that include hiring, training, and scheduling; purchasing food and supplies; inventory management; managing the food preparation and food service within the departmental budget; and sanitary practices. Clinical responsibilities of this position include nutritional screening, assessment, care planning, diet planning, and documenting progress notes in consultation from a clinical dietitian.

Large facilities require one or more assistant food service managers. Dietary managers and assistants should supervise the preparation and service of all meals and share clinical responsibilities. Supervision should also be provided on weekends and holidays, particularly when special meals are planned and when the facility is likely to have more than the usual number of visitors, some of whom may have a meal with the residents they may be visiting.

Food Service Assistants

The dietary department has three main categories of food service workers who perform a number of functions in the main kitchen. Food service workers include cooks, cooks' helpers, and dietary aides. Cooks and their helpers are responsible for food preparation. Cooks prepare the main dishes (also known as entrées) and are responsible for portion control. Cooks' helpers may assist with the preparation of main dishes, but their main job is to prepare side dishes, such as potatoes, pasta, vegetables, and salads. Dietary aides are responsible for portioning out food at the tray line, clean-up, and dishwashing. Cross-training these employees is often necessary to allow cooks' helpers and dietary aides to perform more skilled functions when they must fill in for cooks and helpers because of sickness and when cooks and helpers need time off.

During meal service, certified nursing assistants (CNAs), preferably with additional help from volunteers, serve meals and drinks to the residents. CNAs are also responsible for collecting trays and dishes after each meal and for bringing them to the dishwashing area.

Dietary aides operate the dishwasher and clean cooking utensils. Some large facilities have a position of night cleaner who comes in after the kitchen has been closed to thoroughly clean floors, equipment, and other cooking, service, and storage areas.

Dietary Consultation

Therapeutic functions, which include menu planning based on nutritional guidelines, are under the direction of a registered dietitian (RD) (For the same certification, some dietitians choose the designation, Registered Dietician Nutritionist [RDN])—(Commission on Dietetic Registration, [2020](#)). Only some very large facilities may be able to afford a full-time RD. When a nursing home does not have an RD on its staff, regulations require the services of a dietary consultant who works under contract. Multifacility chains are likely to have one or more clinical RDs in a corporate-level position to provide consultation to the facilities operated by the chain.

Federal regulations (F801) specify the following qualifications for a dietitian: (1) a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) in nutrition or dietetics, (2) completion of at least 900 hours of supervised dietetics practice under the supervision of an RD or RDN, (3) RD or RDN certification by the Commission on Dietetic Registration, and (4) licensed by the state in which the services are performed.

The consultant RD must have active involvement in planning menus, developing recipes, ensuring the nutritional adequacy of food served, and assessing nutrition-related resident problems, such as weight loss or self-eating issues. The consultant dietitian must also review dietary assessment and care plans, determine equipment needs, review dietary policies and procedures, and make recommendations for sanitary and safe food preparation and storage practices.

In addition to getting written reports, the administrator should have periodic face-to-face meetings with the dietitian to remain involved with any issues or concerns. The consultant dietitian should also meet with charge nurses to address specific resident problems and consult regularly with the director of nursing. Diet and nutritional issues should also be discussed with the resident's attending physician.

Nutritional Screening

Nutritional status of each resident is a critical aspect of holistic care. Determining a resident's nutritional needs begins with [nutritional screening](#)—identifying residents who may be at risk for nutritional problems. Examples of at-risk residents include those who sustain weight loss, those on therapeutic diets, and those who either cannot take food by mouth or have difficulty eating. Nutritional screening relies on the physician's diet orders and on a comprehensive screening by the dietitian.

Menu Planning

The menu is central to food service operations because it determines how the resources of the department will be used. Hence, menu planning is a major function carried out with the assistance of the clinical dietitian.

In multifacility chains, menu planning is generally centralized at the corporate office. Standardized menus and recipes are developed for use by affiliated facilities. In this situation, corporations must allow their individual facilities some flexibility for variation to accommodate local tastes. Too rigid a system is likely to result in client dissatisfaction. In nonchain, independent facilities, the consultant dietitian helps the dietary manager develop appropriate menus for the facility.

Three considerations are fundamental to menu planning: meal plan, menu choice, and menu cycle.

Meal Plan

Meal plan refers to the number of meals to be served per day. The daily nutritional intake should be distributed in a balanced fashion over the number of meals served (Mahaffey et al., 1981).

Conventional Three-Meal Plan

Nursing facilities typically follow a three-meal plan consisting of breakfast, lunch, and dinner (also known as supper). Federal regulations specify the maximum time lapse between dinner served at night and breakfast the following morning (see [Exhibit 12-1](#)). Typically, under the three-meal plan, breakfast is served between 7:30 and 8:30 am, lunch at 11:00 am to 12:30 pm, and dinner at 5:30 to 6:30 pm.

Modified Five-Meal Plan

A modified meal plan with five daily meals has received enthusiastic acceptance from both residents and caregivers. The extended meal service hours give residents greater access to meals with less disruption of their preferred daily routines. In contrast, under the conventional meal plan, residents need to be up, toileted, and dressed for the scheduled breakfast service. The mornings become the busiest and the most rushed time for the nursing staff, and many residents resent having to get up early in the morning and to be hurried through daily hygiene chores.

Under the modified five-meal plan, a continental breakfast consisting of items such as rolls, muffins, yogurt, custard, juice, and coffee is served at 7:30 am. Residents can sleep in if they do not wish to be up that early. By the time a more substantial brunch is served, from around 10:30 to 11:30 am, almost all residents are up and around. The other three meals include a lunchtime snack consisting of beverages and high-calorie items served from 1:30 to 2:00 pm, a regular dinner at around 6:00 pm, and a late evening snack before bedtime.

Choice of multiple small meals during the day can lead to greater client satisfaction as well as greater nutritional intake. In a study evaluating family members' preferences to improve nursing home residents' oral food and fluid intake, three nutritional interventions were rated as the most desirable: improving food quality, providing feeding assistance, and making multiple small meals and snacks available throughout the day (Simmons et al., 2003).

Menu Choice

The most common type of menu in nursing homes is a **nonselective menu** that does not regularly offer a choice of entrées to all residents. One main dish is specified for each of the three meals. The main dish on the menu is served unless it conflicts with the resident's preferences as noted in the resident's records. Regulations require that an alternate food item of equal nutritional value be made available to accommodate individual preferences (F806). The facility must also make every reasonable effort to address the residents' religious, cultural, and ethnic food preferences (F803).

Upscale facilities with a high proportion of private-pay residents typically offer a **selective menu** that offers a choice between two entrées from which each resident can make a selection. A full selective menu also generally offers two choices of vegetables and desserts. Offering a selective menu can lower plate waste (food left unconsumed), increase personal satisfaction, and still be accommodated within the food budget. To accomplish this goal, Puckett and Miller (1988) proposed pairing an expensive entrée with an inexpensive one to offset costs. However, a selective menu is likely to require some additional staff time and is more expensive to produce than a nonselective menu.

Another alternative to a selective menu is a buffet offering a variety of food choices. A buffet can also be used as an alternative to a five-meal plan, straddling the hours of the brunch and light lunch services and offering greater mealtime flexibility to residents.

Menu Cycle

The length of time for rotating the same menu is referred to as the **menu cycle**. A set of menus is developed to cover a predefined period, generally 3 or 4 weeks, during which the main items on the menus are not

repeated. At the end of this period, the same daily menus are repeated in the same order. Different cycle menus can be created to go with changing seasons. For example, hot soups are more popular in winter, whereas cold cuts and salads go well in summer. Cycle menus do not have to be rigid. There should be flexibility to include festive menus for holidays and other social occasions. Special ethnic themes, such as Chinese, Italian, or Hawaiian, can also be incorporated to break the monotony of regular meal service, especially when special menus are coordinated with social activities promoting some ethnic theme. An outdoor barbecue in summer or a picnic in early fall also add variety to the menu and provide a nonroutine social setting.

Menu Development

Appropriate main and side dishes are selected for each meal based on several factors that include food preferences, nutritional adequacy, appearance and palatability, food cost, and standardized recipes and portions. Items selected for the menu should appeal to as many residents as possible, but demand is growing to accommodate individual culture-based diet preferences, such as vegetarian, and kosher diets.

Food acceptability by the residents can be evaluated by documenting plate waste. Widespread plate waste among residents often indicates poor choice of foods for the resident population or preparation methods that most people do not like. In such cases, menus must be revised.

Nutritional Adequacy

Menus must meet the nutritional needs of residents in accordance with established national guidelines (F803). Unless a resident has special nutritional requirements, a balanced combination of foods can meet the nutritional needs of most people. The U.S. Department of Agriculture (USDA) and the U.S. Department of Health and Human Services (DHHS) jointly publish dietary guidelines to promote nutritional adequacy, including for those at higher risk of chronic disease. The following key recommendations are made in the 2015–2020 *Dietary Guidelines for Americans* for a reference diet consisting of 2,000 calories per day (USDA/DHHS, [2015](#)):

- Consume 2 cups of fruit and 2½ cups of vegetables per day.
- Choose a variety of fruits and vegetables each day. In particular, select from all five vegetable subgroups (dark green; red and orange; legumes, i.e., dried beans and peas; starchy vegetables; and other vegetables) several times a week.
- Consume 6 ounces of grains, at least half of which should be whole grain products per day.
- Consume 3 cups per day of fat-free or low-fat milk or equivalent milk products such as yogurt and cheese.
- Choose 5½ ounces of protein from lean meats and poultry, eggs, fish/seafood, nuts and seeds, and soy products.
- Limit oil intake to 27 grams (a little less than 1 ounce or 5 teaspoons). Saturated fats (coconut and palm oil, butter, and animal fats) should be limited to less than 10% of calories per day.
- Added sugars should provide no more than 10% of total calories. Sodium should be limited to less than 2,300 milligrams per day.
- For vegetarians, legumes, nuts, and soy products must be included in meals as appropriate meat substitutes for an adequate intake of proteins. Vegans (vegetarians who avoid eggs and dairy products) should consume calcium-fortified beverages and foods that substitute for milk products.
- Older adults should also consume extra vitamin D from vitamin D–fortified foods or supplements. Assuming minimum sun exposure, adults older than 70 years should take 800 IU of Vitamin D per day.
- Dietary potassium can lower blood pressure and blunt the effects of salt on blood pressure in some individuals. Other possible benefits of potassium include a reduced risk of developing kidney stones and decreased bone loss.
- Dietary fiber is important for laxation (bowel movement); the recommended amounts are 22 grams per day for women and 28 grams for men. Beans, peas, vegetables, fruits, and whole grains furnish fiber in the diet.

Dietary Reference Intakes

Before the menus are finalized, their nutritional content must be evaluated to comply with the [Dietary Reference Intakes](#) (DRIs) issued by the Food and Nutrition Board of the Institute of Medicine. The DRIs are a common set of reference values for the United States and Canada and are based on scientifically grounded relationships between nutrient intakes and indicators of adequacy. It is important to note that DRI recommendations are for healthy people; they do not necessarily furnish adequate nutrient intakes for individuals who are already malnourished or for certain disease states that may require increased nutrient intake. Age-related declines in nutrient absorption and kidney function may also occur (National Academy of Sciences, [2006](#)). Hence, evaluation of diets and menus by qualified dietitians is critical for making needed adjustments.

Appearance and Palatability

Research over the years has shown that variety of food in terms of color, shape, and flavor significantly affects appetite. Pleasing food appearance stimulates blood flow in the frontal lobe region of the brain, especially the left orbitofrontal cortex, which is related to appetite (Koyama et al., [2016](#)). Hence, the menu should include dishes that can be attractively served to a relatively large number of people. Federal regulation (F804) requires that cooking methods should conserve the nutritive value, flavor, and appearance of food.

Food Cost

One of the most challenging aspects of menu planning is to keep the cost of food to a minimum without compromising quality. The dietary department is generally allowed a per-patient-day (PPD) [or per resident day —PRD] cost for the raw food budget to allow for census fluctuations. The daily raw food budget will be a dollar amount calculated as follows:

$$\text{Daily raw food budget} = \text{PRD cost} \times \text{Census (number of residents)}$$

To stay within the budgeted allowance, the daily food cost allowance should first be allocated to each meal. Then the cost of each item on the menu should be calculated, allowing for any inflationary projections in the cost of food. Lunch is generally the most expensive of the three meals, followed by dinner and then breakfast. The cost of bedtime snacks must also come out of the food budget.

Standardized Recipes and Portions

A standard recipe is a blueprint for food preparation and is essential for controlling food cost. Recipes are designed and tested so that a consistent product with known quality, quantity, and taste will be produced. Each recipe must provide details on the specific raw ingredients and their quantity, method of preparing the raw ingredients, utensils and equipment needed, method and temperature for cooking, amount of time needed for preparation and cooking, total yield, number of portions, size of each portion, temperature for serving, and any other pertinent information. Portion size is one of the easiest ways to save on cost without sacrificing quality (FoodService Director, [2015](#)). Recipes based on 100 portions can be easily adapted to serve any number of people.

Other Factors

Preparation methods, time required for food preparation, skills of the kitchen staff, storage space, serving temperatures, and type of kitchen equipment are things to consider when planning a menu. In other words, facility resources and capabilities must be taken into account.

In addition to the menus included in the regular menu cycle, the facility's dietary policies and procedures should specify menus for emergency situations, such as when the facility has a prolonged power failure or when the dietary department may have to be operated on a skeletal crew because of emergencies such as snowstorms, floods, or other unforeseen events that prevent most of the scheduled staff from getting to work. Under these conditions, preparing the regular menu would be impractical. Emergency menus require the use of canned, preserved, packaged, and precooked food items. The facility must also make prior arrangements for procuring bottled water for emergencies.

Purchasing Food and Supplies

Vendor Arrangements

The facility should make arrangements with reputable food vendors to procure dry goods, frozen foods, fresh produce, and dairy products. Regulation F812 requires that food for resident consumption must be obtained from sources approved or considered satisfactory by federal, state, or local authorities. Several vendors should be asked for competitive bids based on written specifications. Reliability, regular delivery schedule, consistent quality, and price are important considerations when selecting vendors. Depending on the location of their facilities, multifacility chains often have a great deal of purchasing power to select the vendors that their affiliated facilities are required to use. Independent facilities and small chains can explore the possibilities of participating in cooperative or group-purchasing arrangements, such as [group purchasing organizations \(GPOs\)](#) that can give even small facilities extraordinary buying power. A GPO is a company that pools together the combined buying power of its members to negotiate substantial discounts from vendors.

Food vendors have different grades of products to meet the needs of a variety of customers. For instance, quality can vary according to brand, grade, size, thickness, weight, or count. Because of these variations, a facility ought to have written specifications for the food it buys as part of its contracts with vendors or GPOs. Specifications also enable rational price comparisons with different vendors.

Food Ordering

Menus and recipes provide the basis for food purchasing. However, careful planning is necessary to ensure that the needed food items will be available in time for food production. Size of the order is governed by the resident census, anticipated number of guest meals, and meals for volunteers and staff. In essence, the number of portions to be served must be carefully forecasted, and the time lapse between food delivery and preparation must be taken into account. The frequency of delivery depends on the vendor's delivery schedule, the type of food item delivered, and the facility's storage capacity. Puckett and Miller (1988) suggested the following steps for economical food delivery:

- Frozen food: weekly or semimonthly
- Chilled meat, fish, and poultry: twice a week
- Fresh produce: once or twice a week
- Canned goods and staples: weekly, semimonthly, or monthly
- Fresh dairy items, breads, and baked goods: daily or every other day
- Butter, eggs, and cheese: weekly

Dietary Supplies

Supplies used in the dietary department can be classified into three main categories: supplies used in the kitchen for food production, such as aluminum foils, plastic wraps, and storage containers; supplies used for serving meals; and chemicals and supplies for dishwashing and cleaning. Supplies used for food service can be categorized as reusable or disposable. Such supplies include trays, dinnerware, tableware, hollowware, glassware, and disposable paper, plastic, and Styrofoam products.

Reusable supplies come in a variety of materials, such as rubber, plastic, fiberglass, and other materials, such as vitrified china, which is designed for both durability and attractiveness. Stainless steel cutlery resists tarnish, is durable, and is easy to clean. Some disposables, such as paper napkins, may be used on a regular basis, but they are mostly kept on hand for emergency use. An adequate amount of disposable plates, cups, and cutlery should be kept in stock to be used when a power outage occurs or when the dishwashing equipment is out of order. Regular use of disposables in the long run is quite expensive, yet it comes across as "cheap" to residents and visitors and diminishes the aesthetic appeal of the dining experience. Tablecloths, cloth napkins, and table centerpieces used at least for the main meal add to the quality of the dining experience.

Receiving, Storage, and Inventory

Receiving

Control procedures are necessary to ensure that the food and supplies delivered by vendors match the quality and quantity of items ordered. The job of receiving should be assigned only to authorized personnel, and receiving responsibilities and procedures should be clearly described. Two receiving methods are commonly used: invoice receiving and blind receiving (Puckett & Miller, 1988).

Invoice Receiving

Invoice receiving is a method in which the items delivered are checked against the original order. The focus is on finding any discrepancies between what was ordered and what is received. Shortages, substitutions, deviations from quality specifications, and any rejections should be carefully noted by the receiver.

Blind Receiving

Blind receiving is a method in which the original order shows the specific items but not the quantities; the quantities received are recorded by the person checking the order. This method is more reliable than invoice receiving because the receiver may fail to do accurate comparisons when using the invoice receiving method. In either case, the facility should use its own ordering record rather than the supplier's delivery invoice to ensure that all items received are exactly as they were ordered.

Storage

Food handling begins with receiving and storage. Many commodities, such as meats, fresh produce, and dairy products, are prone to contamination by pathogenic microorganisms if proper handling and storage procedures are not followed. Also, ground beef and poultry are particularly susceptible to contamination, hence, irradiated products are recommended (Nelson et al., 2008).

The facility should have adequate, secure, and sanitary space for storage of various food items at their proper temperatures. Three types of food storage space are necessary: dry storage, refrigeration, and freeze storage.

The dry storeroom must be clean, cool, and dry. It should also have adequate ventilation and lighting. The recommended temperature range for dry food storage is between 50°F and 70°F (10°C to 21°C) (Puckett & Miller, 1988). All food must be on shelves or kept above the floor on dollies or pallets, which should be 6 to 12 inches above the floor, depending on state regulations. Off-the-floor storage enables the entire floor area to be kept clean. Chemicals and cleaning supplies should be stored in a separate room or closet.

Refrigerator temperatures should be maintained at 40° F (4°C) or lower (USDA, 2013). To prevent cross-contamination, raw meat should be separated from other foods and should be stored on the bottom shelves so meat juices do not drip on other foods.

Frozen foods should be kept at 0°F (–18°C) or below (USDA, 2013). Refrigerators and freezers should be equipped with functioning thermometers. A temperature log should be maintained to record regular temperature readings for refrigerators and freezers. Any malfunctions should be reported to the maintenance department for prompt repairs.

Inventory Control

Determining how large a food inventory should be on hand at any given time depends on two main factors: immediate needs and contingency needs. A sufficient stock of food must be on hand at all times to prepare meals for the next 4 to 7 days, depending on the ordering cycle.

In accordance with the policy on emergency menus, adequate nonperishable food items must be held in stock to last for 3 to 4 days. State regulations may also specify how many days' worth of food inventory and nonperishable emergency food supplies must be maintained.

Two methods of keeping track of inventory are used conjointly for adequate control: the perpetual inventory system and the physical inventory system.

Perpetual Inventory System

A perpetual inventory system is used to maintain a continuous record of the quantity on hand for each item. Modern scanning and inventory software technology has greatly facilitated maintaining a continuous record of inventory. In small operations, cards can be used that need to be updated each time items are added or taken out. This can be time consuming for large operations. Perpetual inventory is kept up to date as follows:

$$\text{Amount on hand} = \text{Amount on hand shown on the previous line} + \text{Purchases} - \text{Amount withdrawn}$$

This system provides a running balance of quantities remaining on shelves at any given time.

Physical Inventory System

In the physical inventory system, each item in storage is actually counted, generally once a month. Physical inventory gives an accurate count of what is on hand. The quantities on hand should tally with the amounts on hand shown in perpetual inventory. Discrepancies may suggest either pilferage or errors in recording data (Sullivan & Atlas, 1998).

Rotating the inventory is important to prevent spoilage. The first in, first out system, abbreviated as FIFO, requires that all products be dated when received. Secondly, newly received products should be stored at the back of the shelves; products already on the shelf should be moved to the front. When products are needed for food preparation, they should be picked from the front. This system ensures that older products are used first.

Food Costing

Facilities should at least take a monthly physical inventory to accurately determine the food cost. Although an inventory can be taken on any date during a month and the food cost calculated using resident data since the previous inventory, it is easier to track the food cost by taking inventory on the last day of each month.

a. Cost of physical inventory at the end of the previous month

+

b. Cost of all food invoices (food purchased) during the current month

-

c. Cost of physical inventory at the end of the month

=

d. Gross food cost for the month [(a) + (b) - (c)]

-

e. Cost of meals served to nonresidents:

$$\frac{(d)}{\text{Total number of meals served}} \times \text{Number of nonresident meals served}$$

=

f. Net food cost for the month [(d) - (e)]

g. Food cost per resident day (PRD):

$$\frac{(f)}{\text{Total of resident days for the month}}$$

Note: Resident days = Cumulative census for the month

A high food cost does not necessarily indicate that the food being served is of high quality. The dietary manager must always be conscious of food waste and the potential for pilferage. Periodic monitoring of receiving procedures and regular checks of receiving and storage areas can reveal problems that may otherwise go unnoticed. Food in poor condition may have to be discarded, but the department must have a strict policy that no food is to be discarded without specific approval from the dietary manager. Ordering foods not called for by the menus, ordering in excessive quantities, and overproduction are other factors that often lead to waste and higher food cost than what is necessary. Theft and pilferage may be occurring that may go unobserved. The dietary manager should do occasional spot checks to reconcile invoiced and received items.

The administrator should be aware that even though the dietary manager and his or her assistants have the responsibility for controlling dietary products, the supervisors may themselves be involved in theft. This consideration does not automatically imply guilt, but it should increase awareness of the possibility of theft by supervisors. Precosting menus establishes the expected food cost. When the actual food cost substantially exceeds or routinely exceeds the expected cost, the administrator should first look into the methods being used for inventorying food and calculating the food cost before investigating probable breaches of security.

Food Production

Production Planning

Food production requires planning ahead. For instance, frozen meats must be thawed in the refrigerator 3 to 4 days in advance so that they are available for cooking on the day they are on the menu. Some food items require full or partial cooking on the day before the menu is to be served. On rare occasions, deviations from the planned menu may become necessary. In such instances, menu substitutions should match the nutritive value of the food item replaced, and all substitutions should be properly documented.

Production Methods

Three basic types of food preparation methods are commonly used in health care institutions (Puckett & Miller, 1988). Each method has its advantages and disadvantages, which should be carefully evaluated during menu planning.

Cook-and-Serve Method

The cook-and-serve method is the traditional approach to food production, in which most menu items are prepared primarily from raw ingredients on the day they are to be served. After cooking, the food is kept hot or cold until serving time. Cook-and-serve requires a relatively large inventory and more labor than the other two methods. Greater control over quality is one of the main advantages. Food cooked from scratch has “home-cooked” appeal. Use of seasonal fresh produce makes food even more appealing. Home-style cooking can be marketed to prospective clients as an added value. Some facilities prepare fresh bakery items, such as breads and pies, on a daily basis. The pleasant aroma of freshly baked goods permeating throughout the facility appeals to most people, and it adds to the homelike atmosphere.

Cook-Chill or Cook-Freeze Method

Chilling or freezing after cooking requires two stages of heating: initial cooking and reheating before serving. The main advantage of these methods is the extended shelf life of the prepared food. For example, foods prepared using cook-chill *sous vide* (under vacuum) technology can be kept refrigerated for as long as 42 days before serving (Hyytiä-Trees et al., 2000).

In the cook-chill method, the food is first completely cooked. It is then rapidly chilled to between 33°F (1°C) and 38°F (3°C), using an ice bath or blast chiller. Typically, complete chilling is accomplished in 90 minutes to 2 hours. The food is then stored in a chilled storage cabinet until it is ready to be served, when it is reheated to a temperature of 165°F (74°C).

The cook-chill and cook-freeze methods are similar in all respects except that the latter involves freezing the food to 0°F (–8°C) or below. Cook-freeze requires a fast-freezing unit and special packaging, both of which increase the cost. One major advantage of cook-freeze items is that they can be kept on hand for contingency use or be used during a subsequent menu cycle. Frozen cooked foods must be thawed in the refrigerator or in the microwave, never at room temperature because it promotes the growth of illness-causing bacteria.

Incorporating these methods is also helpful when selective menus are offered. Menus can be planned in such a way that low labor productivity (slack time) on certain days can be used to prepare additional items to be served on a later day. Another major advantage is that chilled or frozen foods are less perishable and retain nutrients longer than foods cooked and held at serving temperatures for relatively long periods in the cook-and-serve systems. The freezing process does not destroy nutrients. One major drawback is that some foods lose their flavor or texture after freezing. Such foods include certain vegetables and foods with eggs or milk. Limited refrigeration and freezer space presents additional obstacles.

Assemble-and-Serve Method

This method is also called the “convenience system” because only minimal food preparation is necessary. The foods are commercially prepared and packaged. Depending on how they will be used on the menu, a variety of prepared products can be purchased in fresh, frozen, canned, or dehydrated forms. Menu variety is often greater in assemble-and-serve systems than in most cook-and-serve systems. But inconsistent quality and greater upfront expense are the main drawbacks. Despite its advantages, the higher cost of assemble-and-serve products cannot be justified unless it reduces labor costs.

Therapeutic Diets, Supplements, and Nourishments

A regular well-balanced diet is the most appropriate diet for most elderly residents. Certain medical conditions, however, necessitate therapeutic diets or supplementation. Such needs should be evaluated jointly by the dietitian, nurses, and the resident's attending physician. A [therapeutic diet](#) is prescribed for treatment for a disease or clinical condition, to eliminate or decrease specific nutrients in the diet (e.g., sodium), to increase specific nutrients in the diet (e.g., potassium), or to facilitate chewing and eating (e.g., a texture modified diet). Nursing facilities are required, under F692, to provide therapeutic diets when there is a nutritional indication.

Sometimes, serving therapeutic diets becomes a balancing act. On the one hand is the need to incorporate restrictions from a purely dietary standpoint. On the other hand is the compromised palatability of a diet that can become a little too restrictive, which may in turn contribute to poor nutritional intake. For some residents, imposing severe restrictions may lead to stress, anger, anxiety, or depression (Robinson & Leif, [2001](#)). Relaxing the restrictions in some therapeutic diets—referred to as a [liberalized diet](#)—may help prevent malnutrition. The American Dietetic Association (ADA) recommends that the quality of life and nutritional status of older residents in **nursing facilities** may be enhanced by a **liberalized diet** (Dorner et al., [2002](#)).

Simple Therapeutic Diets

Some residents can benefit from minor modifications of the regular food on the menu. For instance, a texture-modified diet is produced by simply grounding or chopping the food so it requires minimum chewing. The regular food can also be pulverized to a puréed consistency using a food processor. Puréed foods are often prescribed for residents with dysphagia or those with dental problems.

Restricted diets are also relatively simple modifications of regular menu items, and these diets generally require restricting or eliminating certain condiments. For example, in a bland diet, irritants such as caffeine and spices are left out. A low cholesterol diet requires restricting foods rich in saturated fats.

Complex Therapeutic Diets

More complex diets than those just described call for substituting certain items on the regular menu and may need rebalancing of nutritional values. Examples include low-fiber and high-fiber diets in which appropriate foods must be added or eliminated from the diet. A diabetic diet requires a careful balance of carbohydrates, proteins, and fats, and sugar substitutes are used in place of natural sugars. High-carbohydrate and high-protein diets also must be carefully balanced. Clear-liquid and full-liquid diets are based on a judicious selection of appropriate liquids such as clear broths and gelatin-based products.

Nutritional Supplements

Commercially prepared oral formulas, called [nutritional supplements](#), are used for residents who may not be eating enough to get balanced nutrition. However, it could be beneficial to minimize restrictions, such as therapeutic or mechanically altered diets, and provide preferred foods before using supplementation. A secondary benefit of reevaluating the need for supplements is cost. Appropriate supplements are prescribed for residents with actual or potential weight loss, wounds, and nonhealing pressure ulcers (McDaniel, [2018](#)). The food-first philosophy promotes the belief that nutrients are most potent when they come from food. When they must be used, supplements come in a variety of flavors, and they furnish protein, fat, carbohydrates, vitamins, and minerals (Mayerson & Thompson, [2020](#)).

Nourishments

[Nourishments](#) consist of light foods or snacks that are served in between the main meals. Some residents may want to eat at nontraditional times or outside of scheduled meal service times, consistent with their plan of care. During the day, however, most residents do not require additional snacks if they have adequate food intake. Snacks may actually diminish a person's appetite for consuming the regular meals. However, residents must be offered a snack at bedtime, if they desire it (F809).

Assistance with Eating Issues

Food intake problems may be related to a decline in self-feeding skills or improper positioning while eating. Such problems should be evaluated by an occupational therapist (OT), who may recommend proper positioning or adaptive tableware to improve a resident's self-feeding skills. Problems related to swallowing (dysphagia) should be addressed by a speech/language pathologist.

To the extent possible, residents must be encouraged to eat without assistance. Therefore, the facility must provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat or drink independently. For example, poor grasp can be improved by enlarging silverware handles with foam padding. Plate guards and specialized cups can aid residents with impaired coordination or tremor. Staff assistance may be necessary to ensure proper use of the assistive devices (F810).

Eating Issues—Residents with Dementia

Because of cognitive, physical, and psychological problems, individuals with dementia often need extra care. These residents may have difficulty initiating the feeding tasks, problems with chewing or swallowing, or other mealtime issues such as wandering, pacing, refusal, or apathy (Chang & Roberts, 2008). Hence, effective intervention techniques become necessary, realizing that there will be individual differences and not all interventions will work for everyone. Interventions, such as staff training, assistance with feeding, and modification of the environment and routines, have been found to be effective. For example, switching between high-contrast red and high-contrast blue tableware increased food intake in one study (Dunne et al., 2004). Playing relaxing music at mealtime may decrease agitation and other behaviors (Hicks-Moore, 2005). Use of reminiscence conversation and verbal prompts encouraging the resident to eat may also be helpful (Cleary et al., 2012). Sharing mealtimes between residents and caregivers has also been shown to produce positive results, such as weight gain (Charras & Frémontier, 2010); meal sharing is a common culture change practice in Green Houses. Those with dementia tend to gravitate toward their original cultural values and patterns. Hence, people with dementia might not like the taste of modern cooking; they may prefer more traditional recipes (Calverley, 2007). For the same reason, residents with dementia benefit more from family-style meals that characterize their culture of origin than from congregate meals (Charras & Frémontier, 2010).

Intensive Nutrition

Intensive nutrition support may be necessary for residents who are unable to maintain adequate food intake with either a regular or a therapeutic diet. Intensive nutrition may be prescribed for conditions such as protein or energy malnutrition, liver or kidney failure, coma, or dysphagia because of stroke, brain tumor, or head injury. Although this type of care is a nursing responsibility and not something overseen by the dietary staff, intensive nutrition is discussed here because it is an integral part of meeting residents' total nutritional needs.

Enteral Feeding

Enteral feeding is a method of delivering liquid food directly into the stomach through tubes. There are two common types of tube feeding: a nasogastric tube (NG-tube) passes through the nasal openings, down the esophagus, and into the stomach; a gastrostomy tube (G-tube) passes through a surgical opening in the abdomen. Enteral feeding is a safe method of providing nutrients to residents who have a normally functioning gastrointestinal system but who cannot eat normally. Depending on the resident's medical needs, tube feeding may be necessary for only a short time or permanently.

Enteral feeding may be used as the sole source of nutrition or as a supplement to inadequate oral intake. Commercially prepared liquid formulas are used according to the resident's nutritional needs. The formula is either delivered through a small bedside pump or allowed to drip naturally into the tube. In other instances, puréed or liquefied foods may be used, requiring special preparation by the dietary department.

Parenteral Nutrition

Parenteral nutrition is a method of delivering balanced nutrition directly into the bloodstream. A special liquid formulation, called total parenteral nutrition (TPN), is infused into the bloodstream by inserting a catheter in a central or peripheral vein (Robinson & Leif, 2001). The process must be carefully monitored by licensed nurses. Parenteral nutrition may be necessary in cases of severe malnutrition or when the resident's gastrointestinal tract is not functioning properly.

The cost of commercially prepared nutritional formulas is not regarded as a food expense. This cost is best classified as a separate line item on the budget under the nursing department. To correctly calculate the regular food cost, the number of resident days incurred by residents receiving TPN should be subtracted from the total number of resident days.

Subcutaneous Infusion

Subcutaneous (applied under the skin) infusion may be particularly suited for residents with mild to moderate dehydration or malnutrition when oral or enteral intake is insufficient. The technique uses small-gauge needles that are typically inserted into the thigh, abdomen, back, or arm to infuse fluids into the subcutaneous space for hydration or nutrition. Compared to the parenteral route, this technique provides ease of application, low cost, and the lack of potential serious complications, particularly infections (Caccialanza et al., 2018).

Food Service

Centralized Meal Service

Tray service from a centralized kitchen has been the most common method of serving food to residents in nursing facilities. At meal time, the food service station is staffed by several kitchen workers in order to minimize the serving time. All foods are maintained at appropriate temperatures and plated for service to the residents. Any cold food is put on the plate first, and then it is moved to the hot section where hot food is dished out from a steam table. Infrared lamps are also used to keep certain foods hot.

Standardized recipes establish the size of portion to be served for each food item. Measuring scoops, ladles, serving spoons, food-weighing scales, and other serving equipment are essential for portion control. Some food items are prepared in predetermined portions, which makes service both quicker and easier.

Holding wells in the steam table are replenished as needed. The recommended holding and serving temperatures are $\leq 40^{\circ}\text{F}$ (5°C) for cold foods and $\geq 140^{\circ}\text{F}$ (60°C) for hot items. Clean thermometers must be used to periodically monitor food temperatures during meal service. The holding equipment is not meant for reheating food, only to maintain food at the right serving temperature.

It is increasingly being recognized that what is on the menu is just as important as how it is served. Consequently, many nursing facilities are adopting a more personalized waited table service (Schenkel, 2006). Food can be brought to the table on a tray or trolley, but plated food is set in front of the resident. Beverages are poured at tableside.

Decentralized Meal Service

In facilities that have smaller dining rooms or household kitchens, a decentralized meal service is appropriate. Food produced in the main kitchen is transported in bulk to various smaller dining locations where the food is portioned and served. For example, the household architectural design with decentralized dining rooms requires this type of food service. The food is kept hot on steam tables from where it is dished out on plates and served family style, eliminating tray service (Noell, 1995). Research shows that when meals are served family-style, they result in a significantly higher level of satisfaction for the residents. Decentralized meal service results in improved food quality and temperature because of reduced food handling and the creation of a more home-like environment (Wright et al., 2011). These factors can result in higher nutritional intake, which translates into weight stability and cost savings on supplements (Howell, 2013). However, before implementing a decentralized service, managers should take employee concerns into consideration because they may experience frustration from the increased demands on their time, as one Canadian study pointed out (Shatenstein et al., 2001). Switching to decentralized service would likely require additional costs, hence, a cost-benefit analysis should be done before making a decision. **Table 12-1** provides an example of cost-benefit analysis.

TABLE 12-1 Cost-Benefit Analysis for Decentralized Food Service

Estimated costs	Annual cost
<u>Additional labor cost</u> 6 hours per day to serve lunch and dinner at an average hourly rate of \$15 (include wages and benefits)	\$32,850
<u>Cost of additional equipment</u> \$12,000 to be spread over 5 years	\$2,400
<u>Cost of structural modifications</u> \$80,000 to be spread over 5 years	\$16,000
Potential benefits	
<u>Savings on nutritional supplements</u> \$700 per month	Annual savings \$8,400
<u>Census increase</u> 1 resident @ \$130 daily rate (Medicaid insurance)	Annual revenue \$47,450
Benefits (\$55,850) less costs (\$51,250)	Cost-benefit \$4,600

Note: The above assumptions show benefits exceeding costs by \$4,600, hence, it will be a good decision to implement decentralized dining. In a further analysis, what if the probability of increasing the census is only 50%? That will reduce the potential revenue to \$23,725 ($\$47,450 \times .5$). Under that scenario, the annual costs will exceed benefits by \$19,125. In that case, switching to decentralized dining may not be the right decision. Instead, the administrator may want to consider other less expensive alternatives to enhance the dining experience in centralized dining.

Accuracy

Individual trays are assembled using individualized diet cards, or diet tickets that may be generated by computerized systems. The diet cards are updated to reflect any changes in diet, food preferences, and any contraindications. To minimize diet errors, a trained individual must work at the end of the tray line as a checker. The checker is responsible for ensuring that the food items on each resident's tray match the diet card/ticket.

Food Transportation Systems

Food must often be transported from the kitchen to auxiliary dining rooms located away from the main kitchen. Depending on the type of food service, food is either dished out in the main kitchen where the diet cards/tickets are maintained, or it is transported in bulk to family-style kitchens/dining rooms. The challenge is to maintain foods at their right serving temperatures. To facilitate this goal, a variety of food transportation systems are available.

In centralized food service, heated pellets have been in use for a long time. A pellet is a metal plate that requires heating in a pellet dispenser before the food plate is placed on the heated pellet. The pellet system requires removing the hot pellet before serving the resident to prevent burns. To overcome these drawbacks, insulated trays with hot and cold compartments are in use. With either the pellet system or the insulated tray system, basic transportation carts are used. These carts do not have heating or refrigeration capabilities.

Carts with temperature controls are equipped with heating and refrigeration mechanisms. Specially designed split trays can slide into a cart that has hot and cold sections. In this system, part of the tray is held in a heated compartment and the rest in a refrigerated compartment. A major drawback of all food transportation carts is the difficulty of maneuvering them because of their heavy weight (Greathouse & Gregoire, 1997). Accident prevention through proper training becomes essential.

Another type of transportation system uses rethermalization carts. The trays have special cutout areas for entrée, soup, and vegetable dishes so that, when the trays are loaded onto the rethermalization carts, the dishes make contact with the conduction heat element in the cart (Greathouse & Gregoire, 1997).

When properly used, all of these systems can work quite satisfactorily. But each system has its own advantages and disadvantages, which must be carefully evaluated by the administrator and the dietary manager when deciding on which system to use.

Mealtime Observation

Jackson (2003) pointed out that dietitians and food service managers who routinely circulate in dining rooms during mealtime can gather a wealth of information by simply observing and talking to residents. Such observation can reveal, among other things, which menu items are well accepted, whether the food presentation is attractive, whether personal food preferences are respected, whether diet orders are being followed, and whether portion control standards are adhered to. Similarly, the nursing staff should ensure that residents are properly positioned while eating. Inappropriately positioned residents can aspirate, experience difficulty eating, or get tired and frustrated (Jackson, 2003).

Food Safety and Sanitation

Promoting food safety and preventing food-borne illnesses are of critical importance in nursing facilities. Compared with the general population, residents in nursing homes are more susceptible to illness and may exhibit more severe adverse outcomes when they are ill. An outbreak of disease can place severe burdens on the nursing home staff and result in much adverse publicity in the community. Yet, food poisoning is almost entirely preventable by practicing good sanitation and good food handling techniques.

All staff members involved with the handling, cooking, and service of food must receive training in food sanitation and safety. Hygienic practices, such as hand washing, cleaning and sanitizing equipment and food preparation surfaces, and washing fresh produce and meats before use must be enforced by management. All staff members must wear appropriate head covering and gloves when indicated. The dietary department must also have written policies on food safety, and the staff must be trained on the proper storage and use of cleaning chemicals.

Food-borne illnesses can result when food is contaminated by bacteria, viruses, parasites, or chemicals. Bacterial infection is the most common cause of food-borne illness because bacteria can easily grow and produce toxins in foods. Almost half of all bacterial outbreaks (incidents involving two or more single cases) are the result of cross-contamination (Cody, 1997). Common examples of cross-contamination sources include using the same knife or cutting surface to prepare raw and cooked foods, using a contaminated sink for thawing frozen meats, and unsanitary food handling. Flies, cockroaches, and rodents can transmit pathogens (disease-causing organisms) to food. Therefore, pest control by a reputable firm is an essential part of food sanitation.

The most common illness-causing bacteria include *Salmonella*, *Clostridium botulinum*, and *Escherichia coli*. They can be destroyed by heat. Hence, internal temperatures in meats should be monitored using a probe thermometer during cooking. Beef, pork, veal, and lamb should be cooked to an internal temperature of 145°F (63°C), ground meats to 160°F (71°C), and poultry to 165°F (74°C) (USDA, 2013). *Staphylococcus aureus* is another organism that can be destroyed by heating, but the toxins that it produces in food are relatively heat stable. Therefore, practice of food hygiene by all associates is essential.

Maintaining proper food holding temperatures is critical because bacteria thrive best at temperatures between 40°F (5°C) and 140°F (60°C) (USDA, 2013), the range regarded as the [temperature danger zone](#). In the temperature danger zone, bacteria can double in number in as little as 20 minutes. In general, food should not be held at room temperature for longer than two hours; if it is, it must be discarded.

Another frequent cause of temperature-related food-borne disease is improper cooling when cooked food requires storage. Leftover foods must be quickly cooled and refrigerated within 2 hours. Refrigerators should be maintained at a temperature no higher than 40°F (5°C). Before serving, leftovers should be reheated to an internal temperature of 165°F (74°C) (USDA, 2013).

Proper dishwashing procedures for cleaning and sanitizing tableware and kitchenware are also critical. A three-compartment sink for washing, rinsing, and sanitizing is recommended for handwashing utensils and equipment. Sanitizing can be achieved by immersion in hot water at 171°F (77°C) for 30 seconds or by using a chemical solution in accordance with the manufacturer's recommendations. The temperatures for mechanical dishwashing vary according to heat sanitization or chemical sanitization as shown in [Table 12-2](#). Dishes and utensils should be left on racks to air dry. Wiping with cloths can result in cross-contamination.

TABLE 12-2 Mechanical Dishwashing Temperatures

High temperature dishwasher
(heat sanitization)

Wash	150°–165°F (65.5°–74°C)
Final rinse	180°F (82°C)

Low temperature dishwasher
(chemical sanitization)

Wash	120°F (49°C)
Final rinse	50 parts per million chlorine on dish surface

Centers for Medicare and Medicaid Services. (2017). State operations manual. Appendix PP – guidance to surveyors for long term care facilities. P. 565.

Terminology for Review

blind receiving

Dietary Reference Intake

enteral feeding

group purchasing organization

invoice receiving

liberalized diet

meal plan

menu cycle

nonselective menu

nourishment

nutritional screening

nutritional supplements parenteral nutrition

perpetual inventory system

physical inventory system

selective menu

temperature danger zone

therapeutic diet

For Further Thought

What can the administrator of a nursing facility do to minimize pilferage of assets such as supplies and food?

CASE 1

Unhappy with Mechanical Soft Diet

Contributed by Julie McCullough, PhD, RD; Katie Ehlman, PhD, CHES, HFA; Elizabeth Ramos, MS, RD, CD; and Mary Kay Arvin, OTD, OTR, CHT, College of Nursing and Health Professions, University of Southern Indiana.

After a 5-day hospitalization subsequent to a heart attack, 82-year-old Mr. Lee has been admitted to a nursing home. The admitting physician prescribed a low-fat, low-sodium diet. On assessment at the nursing facility, Mr. Lee was found to have trouble chewing food due to poor dentition (missing teeth and partial dentures that do not fit well). The nurse called the physician and had the diet order changed to a mechanical soft² low-fat, low-sodium diet. Also, because of some issues with choking, the speech therapist conducted a swallowing study, which revealed nothing wrong. The therapist, however, thought that the mechanical soft diet would minimize the risk for choking.

Today, the consulting dietitian is visiting Mr. Lee at lunch time in the dining room. The dietitian notices that the resident tires easily when eating. Mr. Lee expresses dissatisfaction with the mechanical soft diet. He refers to it as “dog food” but adds that in his culture food is never wasted. So, he feels obligated to eat it all even though he does not like it. He would like to have the regular food he could order when he was in the hospital.

²Mechanical soft diets are designed for people with chewing problems due to missing teeth, oral issues such as surgery, or fatigue when chewing food.

Questions

1. How should the dietitian address Mr. Lee's dissatisfaction with the food?
2. Would it be appropriate to liberalize Mr. Lee's diet?
3. What should the facility do if Mr. Lee simply returns his food to the kitchen?

CASE 2

Complaints About Dietary Services

Contributed by Cindy K. Manjounes, MHA, EdD, Lindenwood University.

Complaints from residents have started to surface regarding availability and selection of items on the menu. Residents on restricted diets as well as vegetarians have limited choices. The facility offers a nonselective menu, but to the extent possible, accommodations are made. Recently, meal hours have been reduced because of staff shortages in the dietary department. The administrator was invited to this month's resident council meeting in which some residents became emotional, and the council's president stated, “We used to look forward to meal times, but things have gone downhill. The hours have been cut, and we are rushed through the meals. Some of us are thinking about moving to another facility even though we like the nurses here. They are really caring. We have heard that the home has a new food service manager. This person needs to straighten things out before we all leave.” Attendance in the dining room has dropped because residents have started to request in-room meal delivery so they can take the time to eat their meals. Some CNAs have been grumbling about the extra work they have to do to deliver meals and pick up afterward.

Questions

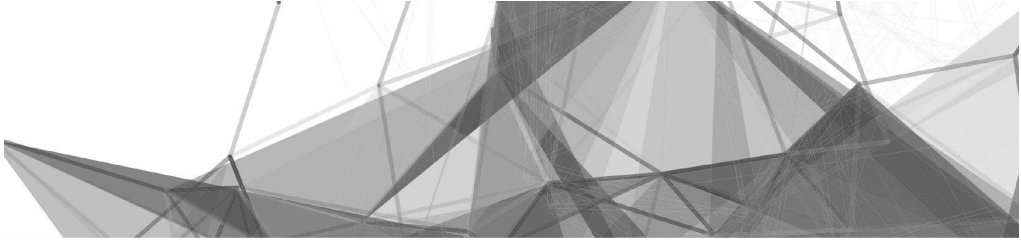
1. Identify the main issues that need to be addressed. What may have caused these problems?
2. Prioritize the issues based on their potential impact on the residents, staff, and the facility.
3. How should the administrator go about addressing the issues?

For Further Learning

Basics for handling food safely. U.S. Department of Agriculture.
[https://www.fsis.usda.gov/wps/wcm/connect/18cece94-747b-44ca-874f-32d69fff1f7d/Basics for Safe Food Handling.pdf?MOD=AJPERES](https://www.fsis.usda.gov/wps/wcm/connect/18cece94-747b-44ca-874f-32d69fff1f7d/Basics_for_Safe_Food_Handling.pdf?MOD=AJPERES)

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CHAPTER 13

Plant and Environmental Services

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WHAT YOU WILL LEARN

- Plant and environmental services include maintenance, housekeeping, laundry, security, waste management, and environmental safety.
- Maintenance operations must plan for urgent service calls, routine repairs, preventive maintenance, and different types of contract work.
- Housekeeping practices require daily routine cleaning, weekly heavy-duty attention, and periodic reconditioning. Certain sanitizing and infection control practices specifically apply to housekeeping.
- Laundry operations require microbicidal washing, standard precautions, and prevention of cross-contamination. To ensure an adequate linen supply, the administrator should institute a multi-par system and inventory control.
- A security audit should be part of the physical security operation. The administrator should be able to do simple cost-benefit analyses to make decisions about investing in surveillance equipment.
- All associates must be trained in fire protection steps represented by the acronym RACE. The facility must have designated areas of refuge during a fire or disaster emergency. Plans must include partial and total evacuation.
- Waste disposal practices must include removal of general waste and hazardous waste.
- Various environmental safety procedures and monitoring of hot water are necessary to prevent accidents.

Introduction

Plant and environmental services are organized to accomplish three main objectives: (1) to perform regular building maintenance and upkeep tasks that ensure a clean, comfortable, and safe environment; (2) to undertake timely maintenance and repairs of all equipment so that all services can be provided efficiently and with the least interruption possible; and (3) to protect the residents, associates, and visitors against various types of hazards. Plant and environmental services should help optimize clinical care as well as the residents' quality of life.

In general, the facility must provide a safe, clean, comfortable, and homelike environment (F584¹). To accomplish this, housekeeping and maintenance services are necessary to maintain a sanitary, orderly, and comfortable interior. Each resident must have clean bed and bath linens that are in good condition (F584). The ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia, or hyperthermia, or is comfortable for the residents (F584). A temperature range of 71° to 81°F is recommended (F584). Apart from maintaining air quality, cleanliness, waste removal, and environmental safety, security operations and fire and disaster planning and training are also part of environmental services. In addition, environmental services should support the aesthetic appeal of the facility's exterior.

In their annual facility assessments, Medicare- and Medicaid-certified facilities are required to incorporate risk assessment (F838). The physical environment, equipment, services (including contracts with external agencies), and other physical plant considerations necessary to care for the resident population must be identified. An all-hazards approach must be used to evaluate the facility's ability to maintain continuity of operations and its ability to secure required supplies and resources during an emergency or natural disaster. According to the Centers for Medicare and Medicaid Services (CMS), an all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters (CMS, 2017).

¹ Federal regulations for nursing homes are identified by F-Tags.

Organization of Environmental Services

The organization of the various environmental functions varies according to the size of the facility and the skill levels of the supervisory personnel responsible for environmental services. Some large nursing homes have a position of *facilities manager* responsible for all plant and environmental services. Other facilities have working supervisors responsible for the various services.

Maintenance Department

In most facilities, maintenance is a separate department, even though it may be staffed by just one or two people. An average-size facility of 100 beds needs one full-time person responsible for all maintenance and repairs. A half-time person may be added for each additional 50 to 60 beds. Staffing for maintenance will vary according to how much of the routine work, such as grounds keeping, is contracted out. For the winter season, snow removal is generally contracted out, especially if the facility has large parking areas and walkways. Many facilities add temporary staff during summer to do their own grounds keeping, whereas others outsource this service. Large facilities may find it cost effective to have a painter on staff. As a rule of thumb, every resident room and private bathroom should be completely repainted once every 2 to 3 years. Some areas of the building may require more frequent painting than others. Touch-up painting to keep walls free of scuff marks is an ongoing function.

In a typical nursing home, the maintenance department is headed by a maintenance mechanic (usually called “maintenance man”), although the position is formally referred to as *maintenance supervisor*. This individual must be multi-talented to handle simple plumbing, heating, ventilation, air conditioning, and electrical problems. Apart from handling routine repair jobs, the maintenance supervisor is responsible for an ongoing preventive maintenance (PM) program. Other than minor troubleshooting and repairs, mechanical system breakdowns are restored by calling outside service contractors. By working alongside these external tradesmen, over time the maintenance supervisor can develop substantial technical skills in handling more than just basic problems.

Housekeeping and Laundry Departments

Housekeeping and laundry are considered two separate departments. Depending on the size of the facility, the two departments may be headed by one supervisor or two separate supervisors, who are often working supervisors. For example, the supervisor may take on routine cleaning assignments for certain sections of the building or may perform specific tasks such as floor polishing. A position strictly confined to supervisory duties may be necessary only when the number of beds exceeds 150, provided that the facility operates its own in-house laundry.

The facility should determine the number of housekeepers needed according to the square footage, the layout of the facility, and the number of resident rooms. Adequate weekend coverage is also essential, and a skeleton crew should cover the evenings to finish cleanup chores after dinner and attend to any other sanitation needs in the facility. Most facilities also require janitorial/custodial staff for routine floor and carpet maintenance and for handling other heavy work such as window washing and moving furniture.

The laundry requires personnel in two categories: sorting and washing soiled laundry, and drying and folding clean laundry. Separating these two functions is essential to prevent cross-contamination.

Security and Safety Functions

In many locations, security has become a growing concern for facilities. Except for some very large retirement living and nursing care complexes, a typical nursing facility does not have a security department. In fact, most facilities do not employ any security personnel. In the absence of a designated person being in charge of security, the responsibility for security falls on the administrator's shoulders.

Safety specifically means fire and disaster preparation and accident prevention. Some aspects of safety and physical security (discussed later) can be delegated to the maintenance supervisor. Accident prevention, on the other hand, requires leadership from the administrator but is the responsibility of everyone working in the facility.

Maintenance Operation

Federal guidelines (F908) require the facility to maintain all mechanical, electrical, and resident care equipment in a safe operating condition. Regular inspection must be conducted of all bed frames, mattresses, and bed rails to identify any risks of entrapment (F909). Although not specifically mentioned in the regulations, other features of building and equipment maintenance are covered in this section. The main operations in the maintenance department can be classified into four areas: urgent service calls, routine repairs, preventive maintenance, and contract work.

Urgent Service Calls

Because emergencies arise without warning, an unexpected breakdown of critical mechanical systems, components, or equipment can severely disrupt vital services, compromise resident safety, or result in loss of property. For example, a breakdown of the heating system in the middle of winter will severely disrupt resident care and threaten the safety of residents. Failure of the food storage freezer can result in the loss of hundreds or even thousands of dollars' worth of food. Such breakdowns or a failure of the facility's emergency systems, such as fire alarms, fire suppression system, or emergency power generator, must be attended to immediately.

Along with the administrator, the director of nursing (DON), and the maintenance supervisor are on call 24/7. If by chance the maintenance supervisor is not available during an emergency, the administrator should be notified so that an outside firm can be called to deal with the situation. Similar authority should be given to the DON and also to the dietary manager for occasional unforeseen breakdowns of dietary equipment.

Routine Repairs

Routine repair work is organized by instituting a system in which all routine requests for repairs are submitted on a work order. Each department and each nursing station keeps a box where their work orders are placed. Many facilities have a computerized work order system. The work orders are prioritized to plan the day's work. Other routine tasks such as lawn care should be included in a weekly schedule. Local trips to purchase needed supplies and parts should also be planned to minimize the number of trips away from the facility. With proper planning, no more than one to two trips per week should be necessary.

A work order system generally works well for reporting problems that hinder staff members' ability to do their jobs or addressing complaints from residents and family members. However, this system misses many other problems that go unreported. To address unreported concerns, the facility needs a preventive maintenance program.

Preventive Maintenance

Preventive maintenance (PM) is the term used for routine inspections and performance of certain tasks that are planned in advance and are carried out to prevent unexpected equipment failures (Niebel, 1985). Over the long run, a good PM program is cost effective because it prevents costly breakdowns, delays the need to replace equipment that may otherwise wear out prematurely, and minimizes disruption of vital services. Maintenance of air handling equipment becomes even more important during disease outbreaks. For example, during the SARS-CoV-2 pandemic, the Centers for Disease Control and Prevention (CDC) recommended optimization of air handling equipment and, if necessary, use of portable HEPA (high-efficiency particulate air) filtration units to augment air quality (CDC, 2020).

To carry out an effective PM program, it is helpful to maintain certain types of documentation (Bobenhausen, 2016):

- A master equipment list, with model and serial numbers, required spare parts, and parts suppliers
- Dates of installation and repair history of each equipment
- Operating manuals for each piece of equipment
- Blueprints of mechanical, electrical, and plumbing systems

In addition to the above documentation, PM requires a master schedule according to which PM activities would be carried out. Written or electronic logs must be maintained showing completion of each PM activity. The administrator should go over these logs and spot check selected areas along with the maintenance supervisor.

All equipment must be checked for smooth operation in accordance with the master schedule. Equipment coils and motors require periodic cleaning. Manufacturers' recommendations may also require periodic lubrication, filter changes in HVAC (heating, ventilation, and air conditioning) equipment, or inspection and replacement of components that show signs of wear and tear. If the maintenance supervisor does not possess the necessary training and skills to perform this maintenance, the administrator may outsource preventive

maintenance work to a private independent firm. However, outsourcing would be quite expensive. So, at the very least, the facility must have a basic PM program that includes three main functions: routine checks, revolving inspections, and ongoing upkeep.

Routine Checks

Routine checks and tests are necessary to ensure that all emergency systems are operating. A written or electronic log of these tests must be maintained. Emergency systems include the fire alarms, smoke detectors, automatic sprinkler system, kitchen range hood fire suppression system, portable fire extinguishers, and emergency power systems. *Life Safety Code*® requirements for testing and servicing of these systems are provided in **Table 13-1**. The law requires a qualified person to do the testing and servicing, which may require contracting with a certified company.

TABLE 13-1 Minimum Testing and Servicing Requirements for Emergency Systems

Fire alarms	Monthly testing; annual servicing
Smoke detectors	A sensitivity test must be performed 1 year after installation, and every alternate year thereafter
Automatic sprinkler system	Dry system: weekly inspection Wet system: monthly inspection Annual servicing Internal inspection every 5 years
Kitchen range hood	Automatic extinguishing system must be inspected monthly and serviced every 6 months
Portable fire extinguishers	Monthly inspection; yearly maintenance
Emergency power system	Weekly inspection of the generator Monthly test under load for 30 minutes

Note: An inspection generally means a visual examination to look for issues, such as corrosion or damage. Testing.

Revolving Inspections

A plan must be instituted by the facility to ensure that every day, in accordance with a rotating schedule, a different specified section of the building interior and exterior is closely inspected. The goal should be to conduct a revolving inspection so that all resident rooms, bathrooms, utility rooms, kitchen, laundry, mechanical rooms, and all other areas receive a close inspection once every 4 to 6 weeks. Such inspections often reveal irregularities that may not get reported through the routine work order system. Examples include leaky faucets; leaks at the bottom of toilet bowls; windows that do not properly close or lock; doors that do not completely shut; missing ceiling tiles; ventilation or exhaust problems in bathrooms, kitchen, laundry, or utility areas; moisture buildup; scuffed walls in need of painting or repair to the wall covering; and curtains and window coverings in disrepair.

During the detailed inspections, the maintenance supervisor should look for safety problems such as missing fire extinguishers, operation of exit doors, torn or buckled carpeting, nonfunctional resident call systems, missing floor tiles, and burned-out light bulbs. Sanitation problems may be noticed near the garbage dumpster, which can attract vermin and other scavengers. Broken screens or missing exterior screen doors may allow flies and other insects to enter food preparation areas. Signs of pest activity, such as droppings, may be noticed in the kitchen, food storage areas, or resident rooms. Outside the building, lights may be missing, the parking lot may be in need of cleaning, cracks in pavement may require sealing, or shrubs may require trimming.

Ongoing Upkeep

Ongoing maintenance of a facility's internal and external appearance is also an important part of PM. Damage to walls caused by wheelchairs and other equipment is a common occurrence. When undertaken on a daily basis, touch-up painting only requires a fraction of the time it would take to paint large sections of the building that have been left unattended. Wall coverings should be cleaned and repaired periodically and replaced when they are worn or faded. The parking lot also needs daily attention to pick up loose trash and cigarette butts. Effectively managed facilities maintain attractive lawns, have some basic landscaping, and plant seasonal flowers to present an inviting appearance.

Contract Work

The need for contracting is unavoidable, but the maintenance supervisor should oversee the work of outside contractors to ensure that the agreed-upon work is completed satisfactorily. Professional completion of work includes any cleanup and removal of debris after a job is finished.

Some contracts for services that are performed on a regular basis, called **routine contracts**, are generally executed annually. Routine contracts cover pest control, waste removal, snow removal, lawn care, annual inspection of emergency equipment, inspection and maintenance of elevators, and expert preventive maintenance. Routine contracting is undertaken by the administrator, in consultation with the maintenance supervisor. As a matter of policy, no contract should exceed 1 year. This limit allows the administrator to review each year, the quality of services performed, and to compare prices.

Nonroutine contracts include open-call contracts and job-unit contracts. [Open-call contracts](#) are established with preferred contractors to provide services on an as-needed basis. Contracts for heating and cooling, plumbing, and electrical work are the most common types of open-call contracts. This type of contracting eliminates the time and administrative effort required in setting up a separate contract each time the need for services arises (Heintzelman, [1987](#)). By making a commitment to use the same contractor on an open-call basis, the facility can receive priority service and often negotiate discounted fees.

A second type of nonroutine arrangement is a [job-unit contract](#), which is established each time a need arises for infrequent major jobs (Heintzelman, [1987](#)). The contract automatically terminates when the specified work has been completed and paid for. Job-unit contracting is appropriate for jobs that are occasionally needed, are planned ahead of time, and generally involve substantial capital outlays. Examples include renovation projects, roof repair or replacement, installation of major equipment, and major landscaping.

Housekeeping Operations

The housekeeping department is responsible for maintaining a sanitary, pleasant, and safe environment in the facility. The department must have policies and procedures for cleaning, sanitizing, infection control, and safety. Unlike hotels and motels, the housekeeping staff in nursing facilities must not handle either clean or soiled linens. The tasks of bed making, replacing clean linens in resident rooms, and removing soiled linens are assigned to nursing assistants.

Cleaning, Reconditioning, and Floor Care

Housekeeping jobs can be classified as daily cleaning, weekly cleaning, reconditioning, and floor care. *Daily cleaning* consists of routine procedures for cleaning, sweeping, mopping, and vacuuming all resident care and public areas in the facility. *Weekly cleaning* tasks include dusting furniture and fixtures, cleaning baseboards, paying attention to floor edges and corners, polishing bathroom fixtures, cleaning draperies and cubicle curtains, and other heavy-duty tasks. The housekeeping supervisor should develop a rotating schedule so that all areas of the building receive weekly heavy-duty cleaning. To accomplish this goal, certain sections of the building are included in the daily cleaning schedules to receive the weekly heavy-duty attention. On weekends, many facilities have reduced staffing to perform the daily tasks; in that case, weekly tasks are covered using a five-day rotating schedule.

Reconditioning involves thorough cleaning of certain areas, particularly resident rooms. Reconditioning is always performed after a resident has been discharged and involves tasks such as cleaning and sanitizing the bed and mattress. All resident rooms should receive periodic reconditioning. *Floor care* is generally assigned to the janitorial/custodial staff, who are responsible for stripping, waxing, and polishing floors and for shampooing carpets.

Sanitizing

The term **sanitizing** describes a process that results in a reduction of microbes to relatively safe levels (Belkin, 2003). Sanitizing requires the appropriate use of disinfectants approved by the U.S. Environmental Protection Agency (EPA), which oversees the registration of antimicrobial products. A list of registered antimicrobials is available at the EPA's website (see **For Further Learning**). The listed categories include sterilants, tuberculocides, anti-HIV products, anti-HBV (hepatitis B virus) products, anti-HCV (hepatitis C virus) products, and products that are effective against methicillin-resistant *Staphylococcus aureus* (MRSA). The EPA has also registered products that are effective against SARS-CoV-2. High-touch areas, such as door knobs, telephones, and counter tops require daily sanitizing.

The housekeeping supervisor should periodically determine whether the housekeeping procedures are effective on a microbiological level. Such an evaluation is done by taking periodic cultures from various surfaces for bacterial colony counts.

Infection Control Practices

The housekeeping staff plays a vital role in controlling infections in the facility by following sanitary practices that can prevent the spread of microorganisms. Disease-causing pathogens can spread through dust particles, air particles, and surface contact. Proper cleaning and sanitizing of floors and other surfaces is a means of infection control. But housekeeping practices employed while performing daily tasks are equally important. For instance, a housekeeper who gives a quick shake to a dust rag after having used it to dust furniture is spreading germs through the air. Hence, plain dry sweeping and dusting have no place in health care housekeeping practices; chemically treated disposable dry mops and dust cloths should be used. Vacuum cleaners used for carpeted areas should have microbial filters to avoid disseminating microorganisms into the air. Wet-mopping should employ a double-bucket technique, with one bucket for cleaning with a disinfectant solution and the other for rinsing the mop (Vesley & Greene, 1973). Frequently changing the mop water is also necessary for minimizing the spread of microorganisms along the floors. Handwashing is critical when contact is made with clean surfaces after touching soiled objects or surfaces.

Laundry Operations

The laundry department is responsible for the washing, distribution, and storage of linens, residents' personal clothing, and other such items. An alternative to operating an on-site laundry is to have a contract with a commercial laundry service. For small facilities in particular, it may not be cost effective to operate an on-site laundry.

The basic laundry tasks include sorting, washing, drying, folding, storing, and delivering. Soiled linens are brought to the laundry by nursing assistants in closed bags, or bags of soiled laundry are conveyed down a laundry chute in multistory buildings. Clean linen is delivered to the resident care areas by the laundry staff. Clean linens must be transported through the facility using covered carts to prevent cross-contamination. Nursing home laundries generally do not do ironing and mending. Widespread use of no-iron linens has eliminated the need for ironing.

Microbicidal Washing

The microbicidal (killing of microbes) action of the normal laundering process is affected by several physical and chemical factors. Soaps or detergents loosen soil and also have some microbicidal properties. Hot water provides an effective means of destroying microorganisms. A temperature of at least 160°F (71°C) for a minimum of 25 minutes is commonly recommended for hot-water washing of laundry (CDC, 2019). Chlorine bleach in the wash provides an extra margin of safety. The final action performed during the washing process is to add a mild acid to neutralize any alkalinity in the water supply, soap, or detergent. Detergents that can reduce microbial contamination at lower water temperatures are also available. Instead of the microbicidal action of hot water, low-temperature laundry cycles rely heavily on the presence of bleach to reduce levels of microbial contamination.

Standard Precautions

The handling, transportation, processing, and storage of linens are covered under federal regulations (F880, pp. 655–657. State operations manual: Appendix PP—Guidance to surveyors for long term care facilities, revised 11/22/17). All soiled laundry in nursing facilities must be assumed to be contaminated. Hence, standard precautions must be followed when handling all soiled laundry. Sorting of laundry is generally done before washing, which protects both the machinery and fabrics from hard objects (e.g., needles, syringes, and patients' property) and reduces the potential for recontamination of clean linens. Sorting laundry before washing also allows for customization of laundry formulas (CDC, 2019). Laundry workers should use personal protective equipment (PPE)—gloves, gowns, masks, and eye protection—when sorting and washing linens. Laundry should be handled as little as possible and with minimal agitation. To avoid punctures from improperly discarded syringes, personnel should hold laundry bags and linens away from the body and avoid squeezing them. Using normal washing cycles in accordance with the laundry detergent manufacturer's recommendations should be quite sufficient for thorough washing. However, resident linens (bed sheets, towels, washcloths, etc.) should be washed separately from kitchen laundry and residents' personal clothing.

A separate room, equipped with negative-pressure ventilation, is best for the sorting process. The negative pressure allows air to move from a clean to a soiled area, and not vice versa, and is designed to prevent movement of airborne particles from the soiled area to the clean linen processing area (Vesley, 1973). Laundry chutes should also be maintained under negative air pressure to prevent the spread of microorganisms from floor to floor (CDC, 2019).

Linen Inventory

A system of linen inventory is essential for control purposes. This system requires a secured linen storage room to which only authorized personnel have access. The main institutional linens include bed sheets, towels, and washcloths. After washing, drying, and folding, linens are temporarily stored. Residents' personal clothes are delivered to their individual rooms.

The nursing facility must maintain a multi-par system in inventory to provide enough quantities of linens so that after washing all linens get a chance to "rest" for at least 24 hours before being put into service again. This time allows the fibers to relax, evens out wrinkles, and prevents linens from becoming stiff (Brooks, 2014). Although for hotels a three-par system is considered adequate, nursing facilities should maintain a five-par system—for every piece of linen in use, four others are being processed or are in storage (Inventory = number of items used daily × 5). It allows for frequent changes of linens for incontinent residents and to meet all resident care needs over the weekend when the laundry operation is generally closed.

A certain amount of linen loss is to be expected. Such losses can result from wear and tear as well as pilferage. An inventory control system is used to find out the extent of loss and to determine the quantities of linen that should be purchased to replenish the stock to maintain the multi-par levels. A running linen inventory record includes the following entries:

Initial inventory (quantity on hand when the last physical inventory was taken)

+ Purchases

– Discards (frayed or heavily stained linens taken out of circulation)

= Closing inventory

The facility should take a physical inventory of linens once every 3 or 4 months to compare the actual linen count to the closing inventory. The difference shows how much linen is being lost that must be replenished to maintain the par levels.

Security Operations

Physical Security

Physical security encompasses three main areas: (1) protecting people against bodily harm by intruders from the outside, (2) protecting residents from wandering out and getting injured, and (3) protecting the property of both residents and the facility against theft. Physical security requires integrating a variety of protective measures, including control of the facility's parameter, intrusion alarms, lock-up procedures, and electronic surveillance. Installing and maintaining security systems and hiring security personnel can be quite expensive. However, some minimal equipment installed in strategic locations is generally necessary. Undertaking risk assessment and cost-benefit evaluation are essential before a large investment is committed for security. Potential costs to the facility include restitution to the party harmed, legal action against the facility, and loss to the facility's image if a resident or associate is harmed and the injury is attributed to lack of security.

A cost-benefit analysis requires making certain educated assumptions. An estimated value of losses and the probabilities of incurring such losses are compared to investment in equipment that would prevent the losses from occurring. **Table 13-2** provides a simple example in which the benefit exceeds the cost by \$11,750. Hence, the facility should strongly consider investing in the surveillance equipment.

TABLE 13-2 Cost-Benefit Analysis for Installing Security Surveillance Equipment

Benefit (losses prevented)	Probability of Loss (%) (a)	Estimated Loss (\$) (b)	Potential Loss (\$) a × b
Petty thefts	70%	2,500	1,750
Legal costs and awards	20%	800,000	160,000
Opportunity of loss prevention			\$161,750
Cost (investment in surveillance equipment)			\$150,000
Excess of benefit over cost			\$11,750

The administrator should work with the local law enforcement authorities to evaluate security needs. Following their recommendations, the administrator can then work with two or three reputable security firms to obtain bids for appropriate security technology. At a minimum, the facility must ensure that all parking areas and the building's exterior are adequately lit. The administrator should also arrange with local law enforcement to have the facility on routine police patrol. A high-visibility patrol is one of the best deterrents against crime (Sells, 2000).

All facilities must have policies specifying who is responsible for locking up designated entrances after specified hours in the evening and for locking up the remaining entrances for the night. Self-locking timer devices can be installed to minimize human error. Security policies may also specify that no employee can go outside the building unaccompanied after certain hours.

Many facilities provide employee lockers for safeguarding personal effects such as purses. Most facilities also have resident policies that discourage keeping valuables, such as expensive jewelry, or more than minimal amounts of cash on one's person or in the room.

A variety of monitoring systems are available to prevent unnoticed wandering by residents who may be particularly vulnerable because of dementia or confusion. In many locations, local or state codes allow installation of a delayed opening system on fire exit doors. With these devices the doors will not open for a set time, usually 15 seconds, when someone tries to open a fire exit door. During the delay period an alarm sounds to alert the staff on duty (Sells, 2000). This short delay, along with the sound of the alarm, may be sufficient to dissuade a resident who may be attempting to exit unnoticed.

Security Audit

Periodically, the administrator should undertake a [security audit](#). In this audit, all physical security measures and potential lapses should be closely examined. A comprehensive audit must be undertaken any time a significant security incident occurs or a problem that could have resulted in an incident is reported. A security audit would be undertaken in addition to a thorough investigation and documentation of any actual incidents. The purpose of an audit is to prevent recurrence of an incident or prevent the occurrence of a nonrelated incident. All security audits and corrective actions resulting from such audits should be documented.

Procedural Security

Procedural security involves control systems to prevent internal theft and pilferage of supplies and materials. Four different systems are needed to protect the facility's assets:

- A system for ordering, receiving, storing, and controlling the inventory for all supplies and materials.
- A tagging and inventory system for all movable capital assets.
- Entry systems that restrict access to various storage and office areas.
- Security of electronic data.

Supplies and Materials

The facility must have a central system for ordering, receiving, storing, and controlling the inventory for all supplies and materials. Other than food, supplies and materials that may be vulnerable to theft include linens, cleaning chemicals, maintenance tools and equipment, and medical supplies. Large facilities may have a central storeroom with a stock clerk responsible for all items other than food. In most facilities, however, each department head has the responsibility for ordering and maintaining supplies used by the department. In this case, each department manager must exercise adequate controls over the supplies and materials by using inventory systems to minimize theft.

Movable Capital Assets

A tagging and inventory system is used to identify and control all movable capital assets, such as television sets, cameras, computers, office equipment, and medical equipment. Permanent, nondetachable metal tags with the facility's name and a tag number should be affixed to all movable assets. A record, which can be easily computerized, should identify each item, its tag number, location, date of acquisition, and cost. This record should also bear the date of retirement after an item has been retired from service. An annual or biannual inventory should verify that each item still in service is actually present in the facility.

Access Control

Access to various parts of the building is controlled by establishing a centralized system to regulate distribution of keys to authorized personnel only. However, security lapses occur when keys are not properly managed. Old fashioned lock-and-key systems can become quite cumbersome because they require a hierarchical system of grand master keys, master keys, submaster keys, and individual keys. Records must be kept to account for every key issued, keys must be retrieved and accounted for as personnel leave their positions, and when keys are lost the locks must be rekeyed. Modern keyless access technology includes push-button digital locking systems and card entry systems. Push-button entry requires a code which can be reset. Periodic code changes can ensure misuse. Card entry systems offer entry control and audit trail features, but may be expensive to install. Key cards can be issued or revoked as necessary. Wire free virtual technology may be another option for access control.

Security of Electronic Data

Security breaches of electronic data have been on the rise. The matter takes on added seriousness when resident information is compromised. First, all computers and networks must be adequately secured. Second, password protection is not enough; data must be encrypted using encryption technology. Scam artists can also try to steal residents' billing information for financial gain. They may call a facility posing as physicians, pharmacists, or insurance representatives. Such calls must be authenticated.

Fire and Disaster Planning

All facilities must have written fire safety, disaster, and evacuation plans. These plans must outline duties and responsibilities of various staff positions and the steps to be taken during emergencies such as a tornado, hurricane, earthquake, flood, or blizzard. These plans are best developed and rehearsed in conjunction with the local fire department and other civil defense agencies. The plans must address the individual characteristics of the particular facility and take into account the availability of local resources and the response time of emergency services to deal with events in which the safety of residents is paramount. Copies of the emergency plan must be available to all supervisory personnel, and all associates must be periodically trained and kept informed with respect to their duties under the plan.

Fire Safety Plan and Steps

The *Life Safety Code*® requires a written fire safety plan to include the following: use of alarms, transmission of alarms to fire department, emergency phone call to fire department, response to alarms, isolation of fire, evacuation of immediate area, evacuation of smoke compartment, preparation of floors and building for evacuation, and extinguishment of fire.

All associates must receive training in the sequential fire-protection steps represented by the acronym RACE (Kavaler & Spiegel, 1997):

R—Rescue and remove anyone in immediate danger.

A—Activate the nearest fire alarm.

C—Confine and contain the fire and smoke by closing all doors and windows.

E—Extinguish the fire with portable extinguishers, wet sheets, and blankets.

The most critical step in fire protection is to activate the fire alarm. This step is vital because the fire department must be notified immediately when fire is suspected. The *Life Safety Code*® requires that the fire alarm system be connected to an outside agency, such as a fire security company, that will transmit the alarm to the nearest fire department. A phone call should also be made to the fire department to confirm that there is a fire. When the alarm box is activated, a fire alarm also goes off within the facility, and all fire doors close automatically.

The facility's fire safety protocols should also include a preestablished code phrase, such as "Doctor Red" or "Code 99." The code is used to alert all associates in case of an actual fire and during fire drills conducted at night. The code phrase is generally announced over the intercom system.

The real danger from a fire is usually not the flames, but smoke that can travel quickly to areas far from the fire. Smoke inhalation is the major cause of death during a fire. Hence, closing doors and windows and using wet towels to cover any open spaces between the doors and the floor must be given top priority after residents in immediate danger have been evacuated and the fire alarm has been activated. The associates should start closing doors and windows throughout the facility as soon as the alarm is sounded. In all emergency situations, the staff must remain calm and reassure residents and visitors that appropriate procedures are being followed.

Fire safety procedures should clearly designate the person who takes charge when a fire or suspected fire is discovered. Provided that the fire department has already been notified, an associate should be posted at the front entrance of the facility to direct the fire department personnel to the location of the fire in the building, while the person in charge of fire safety directs associates to secure all residents and follow the RACE steps.

On the other hand, when no smoke or fire is detected, notice of a false alarm should be relayed to the fire department by telephone to confirm that there is no fire, because an alarm would have been previously relayed if a fire alarm had been activated. In most instances, however, the fire brigade is already on its way by the time the person in charge of fire safety has confirmed the "all clear." In this case, the individual should meet the fire brigade at the front entrance and explain the situation. Some fire personnel may still want to go through the building and ensure complete safety before leaving the premises.

Emergency Evacuation

Evacuation is the removal of residents and vital equipment from an unsafe area to a safe area during a fire or other emergency situation (Tweedy, 1997). It does not necessarily refer to evacuation of the building.

Evacuation plans should cover both partial and total evacuation of residents. When a fire alarm is activated, automatic closure of fire doors segregates the point of origin of the fire from other areas on the same floor. Because fire doors provide a barrier against smoke and flames, a safety zone is created beyond the fire doors away from the point of origin of the fire (**Figure 13-1**). Such a space becomes an area of refuge, which the *Life Safety Code*® defines as either (1) "a story in a building where the building is protected throughout by an approved, supervised automatic sprinkler system and has not less than two accessible rooms or spaces separated from each other by smoke-resisting partitions," or (2) "a space located in a path of travel leading to a public way that is protected from the effects of fire, either by means of separation from other spaces in the same building or by virtue of location, thereby permitting a delay in egress travel from any level." In simple

terms, an [area of refuge](#) is a zone of safety within a building that is protected from the effects of fire and smoke and provides direct access to an exit.

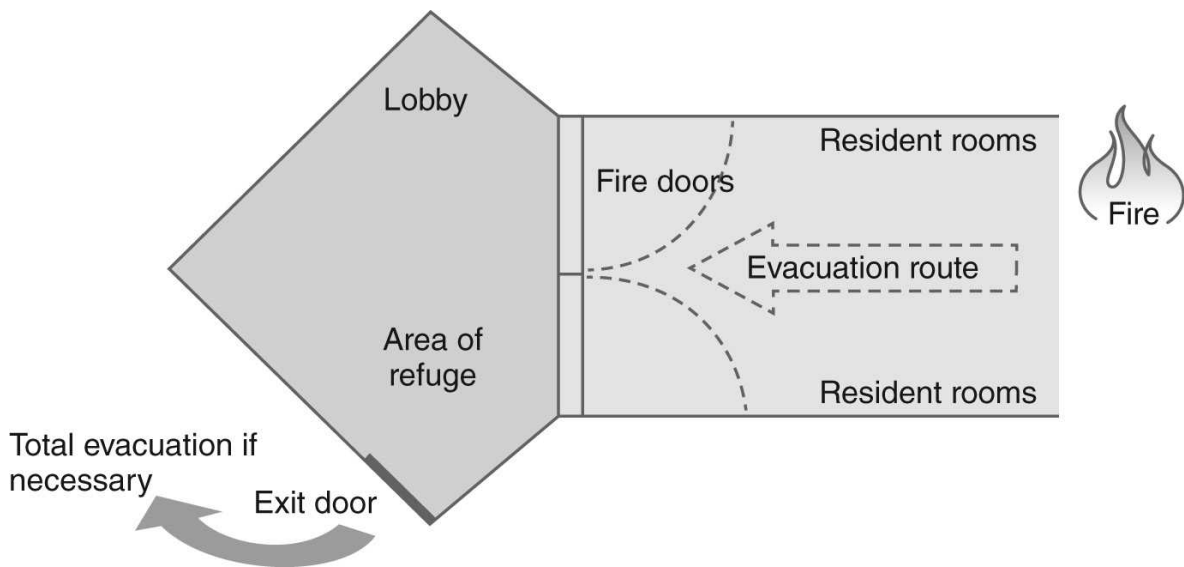


FIGURE 13-1 Partial evacuation to an area of refuge or total evacuation during a fire emergency.

A partial evacuation consists of moving residents from the area of fire to a neighboring area of refuge. Total evacuation consists of removing residents and vital equipment from an entire wing or floor or evacuating the entire building. Bed-bound residents should be evacuated on stretchers because rolling beds into the hallways can quickly clog vital evacuation routes. Nonambulatory residents who are not bed bound can be rolled out in wheelchairs. Ambulatory residents should be led as a group, holding each other's hands. An associate should lead such a human chain, with another associate following the chain. After residents have been moved to an area of refuge, they must remain under staff supervision.

For the purpose of total evacuation, the facility must make prior arrangements for temporary shelter of residents in a local school, hospital, or Red Cross center. Evacuation plans should include transfer of residents; protecting and transferring medical records; continuing critical medical care services; and maintaining vital functions such as providing food, water, and clean linens.

Simulation Drills

The *Life Safety Code*® requires that the facility conduct an unannounced fire drill on each shift once a quarter. Because of staff turnover, however, more frequent fire drills are recommended. The facility's associates are not expected to function as firefighters, but they must know how to operate a portable fire extinguisher. The staff members' main role is to contain any immediate danger and minimize the spread of fire till the fire brigade gets to the scene, at which point the firefighters will take over. A disaster simulation drill is necessary once a year to rehearse the response of the associates and the response of the local civil defense teams. All fire drills and disaster simulation drills must be documented, and training should follow to address areas of weak response. Simulation drills are also used to educate associates about the importance of remaining calm and thinking clearly during unexpected emergencies.

Waste Management

General Waste

As much as 90% or more of the waste produced by nursing care facilities is regarded as “nonrisk” general waste, which is comparable to domestic garbage and can be safely disposed of by contracting with a reputable waste removal company. A dumpster of sufficient size is essential so that trash does not overflow at any time. The dumpster must be a covered container, and it must remain covered after each use. All garbage and waste must be appropriately bagged; no loose trash should be thrown into the container. The ground around the dumpster should be kept clean at all times. This function is generally the responsibility of the maintenance department.

Hazardous Waste

The facility must have policies and procedures in effect for the safe handling, removal, and disposal of all wastes regarded as hazardous. The most common types of hazardous waste can be classified as infectious wastes, pathological wastes, and sharps. [Infectious waste](#) can pose health risks from communicable infectious agents. Such waste can come from residents who have been isolated for infections, dressings from infected wounds, human excreta, or laboratory cultures. [Pathological waste](#) is human waste that may contain human tissue, blood, or body fluids. It includes stoma bags, incontinence pads, and protective gloves and masks used by associates. [Sharps](#) can be any objects that can cut or puncture, such as needles, blades, broken glass, and nails.

Hazardous waste must not be deposited in the regular dumpster used for general waste. Safe handling requires precautions to avoid injury from sharps and to prevent cross-contamination from infectious and pathological waste. Special puncture-proof containers are used for all sharps. Infectious and pathological waste are bagged in clearly marked or color-coded heavy-duty plastic bags that are also leak proof. The plastic bags are placed in rigid leak-proof containers, never on the floor. Unlike most hospitals, nursing facilities generally do not have on-site disposal or incineration facilities. Contracts must therefore be established with qualified waste carriers for the regular removal and disposal of all hazardous wastes. Any storage of waste before collection for off-site disposal should be in a secure location designated for that purpose (Prüss et al., [1999](#)).

Environmental Safety

The facility's environmental policies and procedures must incorporate safety. Personnel working in a facility's environmental services departments should also monitor the environment for safety. For instance, monitoring hot water in residents rooms and bathrooms is a critical aspect of safety that prevents scalding. As a general rule, hot water temperature in these areas should not exceed 110°F (43°C). Hot water supply to resident areas and public areas is equipped with thermostatically controlled mixing valves to keep the water temperature from rising above the specified limits. The maintenance supervisor must pay particular attention to this area and record daily temperature readings. On the other hand, adequate supply of water that is hot enough for washing and sanitizing in the kitchen and laundry is equally important. Because the hot water temperatures required for resident care areas and for sanitizing functions differ substantially, a common practice is to have separate hot water systems and booster heaters that are locally mounted on sanitizing equipment to achieve the desired temperatures.

Maintenance and housekeeping personnel must pay close attention to their equipment. If equipment is left unattended, it presents a hazard. Floor cleaning and polishing chemicals should be nonskid. Safety signs must be used while mopping floors. Mopping the hallways lengthwise, doing one half of the hallway at a time, leaves the other half for safe passage.

Furniture and equipment must be kept away from traffic paths and exits. Various electrical gadgets are operated with long cords, which should be kept along the baseboards and not across the hallway. Heavy housekeeping trucks, food transportation carts, and linen carts can cause serious injury. They often block the operator's view and require caution, especially when turning blind corners. Strategically placed mirrors can help associates using these carts to see people around the corner and use caution to prevent injuries.

Terminology for Review

area of refuge

evacuation

infectious waste

job-unit contract

microbicial

negative-pressure ventilation

open-call contract

pathological waste

preventive maintenance

reconditioning

routine contract

sanitizing

security audit

sharp

For Further Thought

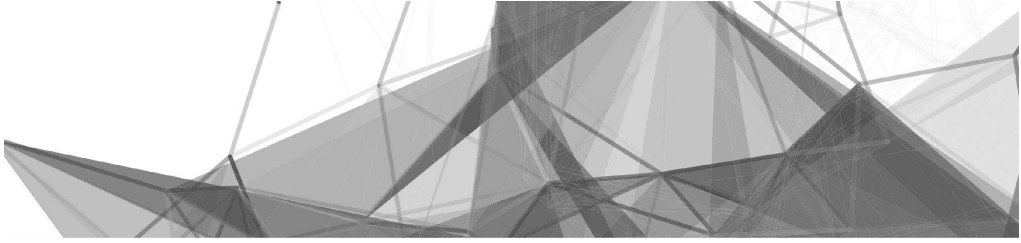
1. What would be some of the important clauses to include in (a) routine contracts, (b) open-call contracts, and (c) job-unit contracts?
2. What may be some of the reasons for not allowing the housekeeping staff in nursing facilities to handle either clean or soiled linens, unlike hotel and motel operations?
3. Discuss how certain environmental standards in the facility can be effectively used to convey value to potential clients.

For Further Learning

U.S. Environmental Protection Agency: Provides information on registered antimicrobial products. <https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>

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CHAPTER 14

Administrative and Information Systems

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WHAT YOU WILL LEARN

- Facilities must be staffed to perform basic bookkeeping and reception functions.
- Payroll and compensation practices are governed by the federal Fair Labor Standards Act. The act specifies exempt and nonexempt worker categories, minimum wage, and overtime pay. Other compensation matters are governed by the facility's own policies.
- The facility is responsible for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA) withholdings and court-ordered wage garnishments.
- The facility's bookkeeping staff also generally handles accounts payable, petty cash, billings and collection of accounts receivables, cash receipts and bank deposits, and the resident trust fund.
- Complete medical records on each resident must be maintained in accordance with current laws and accepted professional standards.
- Medical records enable caregivers to coordinate services, and the records provide evidence of actual care rendered. Medical records are summoned in malpractice cases.
- Information systems have numerous applications for managing the facility as well as delivery of clinical care.
- A growing emphasis on coordinated care and delivery of long-term care in home- and community-based settings will make it necessary to have integrated networks across various health care providers.
- Security of information requires increasing vigilance. Information system development requires careful study and planning.

Introduction

Administrative and information systems support the management and clinical functions in the facility. In a hospital, these support functions are generally segregated into several departments. In nursing facilities, however, the functions are generally consolidated in a business office, except for medical records, which are typically under the supervision of the director of nursing. Information systems link various administrative and clinical functions.

The Business Office

The business office generally combines reception, secretarial, clerical, and bookkeeping functions. Most facilities have a front desk staffed by a receptionist and an adjoining office occupied by bookkeeping and other clerical staff. The receptionist also performs some secretarial and clerical duties.

The number of bookkeepers needed by the facility depends on two factors: the size of the facility and the business and accounting functions performed at the facility. Multifacility chain operations centralize most accounting and finance functions at their corporate offices, but the corporate office relies on the facility's business office for vital inputs needed to prepare financial and management reports. Stand-alone facilities generally contract with an accounting firm to carry out most accounting and finance functions, but the bookkeeping staff at the facility performs basic routine functions and prepares inputs for accountants.

The business office is supervised by a business office manager, who is a department head reporting to the administrator. This individual also handles the facility's bookkeeping. Even though the business office is open 5 days a week during regular business hours, facilities with 100 to 120 beds or more should have a receptionist for evenings and weekends. In smaller operations, telephone answering duties are taken over by a designated nursing station when the business office is closed.

Regulations do not mandate specific qualifications for the employees who staff the business office. Bookkeepers must be skilled in basic accounting functions. However, bookkeepers also have regular interactions with residents and families, so they must have good communication skills. The bookkeepers also generally relieve the receptionist for lunch and break time, sickness, and vacations. Cross-training may also enable a facility to use other personnel, such as the medical records clerk, to cover the reception desk for brief durations.

The Front Desk

To most first-time visitors, the front desk provides a window into the facility. With their first contact, many people form lasting opinions about the rest of the operation and its services. A smile, a warm greeting, an offer of assistance, and an eagerness to meet people's needs create a positive impression. Hence, the front desk should be staffed with personnel who can display a pleasant demeanor and also have the mental capacity to carry out clerical and secretarial duties in an atmosphere in which frequent interruptions and distractions are common.

Knowledge of the facility, the location of resident rooms, the key functions of the different departments, the names of residents, and knowledge of some of the residents' routines and habits can all play an essential role in directing visitors appropriately. Effectively managed facilities maintain a notification system for the receptionist to know when certain key personnel are out of the facility or in meetings. A small board with the names of all key personnel can be easily updated to avoid embarrassing moments when a visitor may be kept waiting for someone who is eventually found to be unavailable. Having this type of a system also enables the receptionist to know who is available to attend to a walk-in or telephone inquiry from a prospective client at any given time.

Accounting and Bookkeeping Functions

The main accounting and bookkeeping functions include payroll, accounts payable, the petty cash fund, billing for resident services, accounts receivable, the resident trust fund, and bank deposits. Trained bookkeepers may also be able to perform more advanced accounting functions, such as posting to the general ledger, doing payroll accounting and processing payroll checks for employees, processing payable checks for vendors, and completing quarterly tax forms. In this case, preparation of financial statements (income statement, balance sheet, cash flow statement, and certain managerial reports) and annual financial auditing will be contracted to an independent accounting firm. For nursing homes affiliated with a hospital or multifacility corporation, these functions are generally centralized at the corporate office, and the costs are passed on to the facility in the form of management fees. Generally, centralized accounting functions are more cost effective than outsourcing them to an accounting firm.

Payroll and Compensation

Payroll accounting comprises three main activities: determining gross wages, deducting payroll withholdings, and calculating payroll-based contributions made by the employer on behalf of the employee. The actual pay employees receive is gross wages minus the withholdings.

Employees are paid on the basis of their rates of pay and the hours they work. Both require appropriate controls to prevent any irregularities.

This section provides a general overview of the main requirements of the Fair Labor Standards Act (FLSA) that govern payroll practices in businesses. The Wage and Hour Division of the U.S. Department of Labor is responsible for administering and enforcing federal labor laws.

Exempt and Nonexempt Employees

Under FLSA, all employees must be classified as either exempt or nonexempt. **Nonexempt employees** are paid an hourly rate, which must equal or exceed the minimum wage established under law. Nonexempt employees are also entitled to overtime pay (discussed later). Most employees in a nursing facility are nonexempt. These employees are issued time cards for each pay period and are required to punch a time clock that records the times when an employee came in to work (clocked in) and when the employee left work (clocked out).

Exempt employees are generally salaried and are exempt from the overtime provisions of the law. However, the mere fact that someone is salaried or holds a certain job title does not necessarily make that person exempt. Two main criteria that determine exempt status are the employee's compensation and specific job duties (Department of Labor, [2019](#)). Both criteria must be met.

Criterion 1: Compensation

To qualify for exemption, employees must be paid no less than \$684 per week (effective January 2020) on a salary basis. As a general rule, the full salary must be paid regardless of the number of days or hours worked during a given week.

Criterion 2: Job Duties

The emphasis is on the primary duties that constitute the nature of an exempt employee's job even though a person may perform some nonexempt duties. FLSA regulations define three main "white-collar" categories. These categories, however, cannot be used arbitrarily with the intent of classifying certain employees as exempt:

- **Executive:** The duties are primarily managerial in nature; the person supervises and directs the work of two or more full-time employees; and the person makes substantive recommendations on personnel decisions such as hiring, firing, or advancement of other employees. Under these guidelines, the facility's administrator, assistant administrator, director of nursing, food service director, and perhaps a facilities manager who is in charge of all plant and environmental services would be exempt, provided they also meet the compensation test. Other department head positions in nursing homes are unlikely to be classified as exempt.
- **Administrative:** The employee's primary duty must be the performance of office or nonmanual work directly related to the management or general business operations of the employer or the employer's customers. In addition, the employee's primary duties must include the exercise of discretion and independent judgment with respect to matters of significance. Only the facility's administrator and possibly the assistant administrator in large facilities would fall in this category.
- **Professional:** The employee's primary duty must be the performance of work requiring advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment. The advanced knowledge must be in a field of science or learning that is customarily acquired by a prolonged course of specialized intellectual instruction. Only physicians and nurse practitioners are likely to qualify as exempt under this category.

FLSA classifies certain other categories of employees as exempt, for example, certain skilled workers in the computer field and outside sales employees. These categories generally do not apply to long-term care facilities.

Minimum Wage

In 2020, the federal minimum wage was \$7.25 per hour,¹ which has not changed since July 2009. However, approximately half the states have higher minimum wage rates. In those states, a nonexempt employee must be paid the higher of the state or federal minimum wage. A youth minimum wage of \$4.25 per hour may be paid to those under the age of 20 but only during the first 90 consecutive calendar days after initial employment.

Overtime Compensation

A workweek of 7 consecutive days can begin on any day of the week. Federal law mandates that nonexempt workers be paid overtime for any hours worked in excess of 40 hours in a workweek. Although the 40-hour week is generally the standard for determining overtime, FLSA permits employers to enter into an agreement or understanding with a certain category of employees, such as nurses, whereby a work period of 14 consecutive days (instead of 7) may be established. Commonly known as the 8-80 rule, this alternative requires paying overtime for any hours in excess of 8 hours in any one day or for any hours in excess of 80 hours during the 14-day work period (Department of Labor, [2009](#)).

Overtime must be paid at the rate of time-and-a-half the regular rate of pay. Even when overtime is not authorized, if an employee has incurred it, it must be paid. As a general rule, nonexempt employees cannot be given compensatory time off in lieu of overtime.

The law does not require employers to pay more than an employee's established rate of pay for working the evening shift, night shift, or weekends. However, to ensure adequate staffing, many facilities have established extra pay as an incentive for late shifts, weekends, and holidays.

Compensable and Noncompensable Time

Not all time spent at the facility is considered work time. Hence, it is important to distinguish between what is compensable and what is not. Determining where to begin and where to end the compensable time for a worker's shift can be difficult. Hence, facility policy should clearly specify paid and unpaid time.

Meals and Breaks

Short rest breaks must be counted as work time. Some states require that employees be given a 10-minute break for every 4 hours of work. In other states, it is up to the employer to have a policy on short breaks; most employers do give short breaks of 10 or 15 minutes. When the length of rest breaks is specified by facility's policy, any unauthorized extensions of break time need not be compensated. Meal periods (typically 30 minutes or longer) need not be compensated as work time. To avoid paying employees for meal time, the employees must be fully relieved of all duties and be free to leave their work stations, or the facility, during their meal breaks. It is particularly important to monitor meal breaks in facilities experiencing staff shortages and in facilities where well-meaning employees may have a tendency to "grab a quick bite" at the work station itself in order to minimize interruptions in resident care. If this is the case, the law would likely require that the employee be compensated for meal time. Similarly, meal breaks may be compensable if the employer requires that employees be available to respond to resident care needs when called. An example would be requiring employees not to leave the facility or wear pagers while on meal breaks. In *Hoffman v. St. Joseph's Hospital*, the court held that respiratory therapists should be compensated for their 30-minute meal break because hospital policy required the employees to wear pagers during their meal breaks and they were subject to discipline if they failed to respond to pages.

De Minimis Time

Facility policy should specify the amount of time allowed as incidental time for preparatory and concluding activities. For instance, at the change of a shift, workers may have to wash their hands, change into or out of uniform, etc. Also, many workers need to clock in or clock out at the same time, but generally some waiting time is involved because they cannot all use the time clock simultaneously. This waiting time could be considered incidental time that is not compensable under law, as long as it is specified in the facility's payroll policies. Courts have used what is referred to as [de minimis doctrine](#)—de minimis means "of minor importance." Under this doctrine, 5 to 7 minutes, as a rule of thumb, spent at the time clock will not be compensable.

Integral and Indispensable Tasks

There is a fine line between *de minimis* and other tasks that courts have defined as "integral and indispensable" to an employee's principal activities. For example, if the employer requires maintenance personnel to wash all equipment, such as a lawnmower, after each use, this is likely an integral and indispensable part of the employee's principal activity and must be compensated. Two tests need to be applied: (1) the task is necessary to the principal work performed and (2) the task is done for the benefit of the employer.

Other Compensable Time

As a rule of thumb, time spent on anything that the employer requires must be compensated. For example, compensable work includes orientation, training, and in-service education that an employee is required to attend.

Limits to FLSA's Jurisdiction

FLSA does not regulate a number of employment practices. These compensation matters are governed mainly by the facility's own policies and practices. For example, the FLSA law does not regulate the following:

1. Vacation, holiday, severance, or sick pay
2. Premium pay for weekend or holiday work
3. Pay raises or fringe benefits
4. A discharge notice, reason for discharge, or immediate payment of final wages to terminated employees

Payroll Withholdings

Employers are legally required to withhold taxes from their employees' pay and to deposit the withheld amounts with the appropriate tax agencies. Taxes normally withheld from employee paychecks include federal, state, and local income taxes. Under the Federal Insurance Contributions Act (FICA), employers must also withhold half of the Social Security and Medicare taxes from the employees' paychecks. Employers who fail to withhold and deposit taxes in a timely manner are subject to criminal and civil sanctions (Internal Revenue Service [IRS], 2020).

The employer may also be required to withhold union dues for employees who belong to a trade union. Wage garnishment is another type of compulsory withholding. A [wage garnishment](#) is any legal or equitable procedure through which some portion of an employee's earnings must be withheld by an employer to pay a debt incurred by the employee. Most garnishments are made by court order with which employers must comply. Other types of legal or equitable procedures include levies by the IRS or a state tax-collection agency for unpaid taxes and federal agency administrative garnishments for nontax debts owed to the federal government.

There may be other withholdings that are voluntary, and these usually require the employee's written consent. Voluntary withholdings include the employee's portion of health/dental insurance and life insurance premiums; employee's contribution into a retirement plan; and premiums for other types of insurance, such as accident and disability.

Employer-Paid Tax Contributions

Employers must pay half of the FICA taxes on behalf of their employees. Also, under federal law, employers must pay unemployment taxes under the Federal Unemployment Tax Act (FUTA). In most states, the employer must also pay a state unemployment tax. These taxes are based on taxable wages paid to employees.

To pay for employees' work-related injuries, workers' compensation laws vary from state to state. Depending on the state, employers either pay into a state-run insurance program or purchase workers' compensation insurance from a commercial insurance company.

¹ At the time of this writing, Congress was considering raising the federal minimum wage to \$15 an hour. If passed, it would place a serious cost burden on many nursing facilities that rely primarily on Medicaid reimbursement.

Other Bookkeeping Tasks

Most of the bookkeeping tasks are carried out according to general business practices. Management of the resident trust fund, particularly for Medicare and Medicaid beneficiaries, must comply with federal and state regulations.

Accounts Payable

Accounts payable is the accounting term for money owed to vendors from whom goods, supplies, and services have been purchased on credit. With the exception of minor and nonroutine purchases, most goods and services are purchased on a noncash basis. Utility bills for telephone, gas, electricity, water, TV, Internet, and the like also need to be paid on a timely basis.

Payments are made on the basis of invoices received from the vendors, after they have been reviewed and authorized by the appropriate department heads. Payments are recorded in the general ledger, which is maintained on a computer-based accounting system.

Petty Cash Fund

To pay for certain cash purchases and other small incidental expenses, a facility must maintain a petty cash fund. Petty cash is maintained in a locked box or drawer.

The facility should establish a policy on the imprest amount and on the maximum amount per disbursement that the business office can incur without requiring authorization from the administrator. The **imprest amount** is a fixed amount, such as \$500, that is maintained by periodically replenishing the cash that has been disbursed.

Each disbursement from the petty cash fund requires completion of a voucher to which any supporting documentation, such as a sales receipt from a store, is attached. The voucher is signed by the person receiving the money. The cash and the amounts shown on the vouchers must always add up to the imprest amount. When the amount of cash drops below a predetermined level, the vouchers are removed and totaled. Cash equaling this total is replenished, and the petty cash fund once again equals the imprest amount. Inconsequential shortages may occur because of errors, but substantial or frequent shortages could indicate mishandling of funds.

Billing, Accounts Receivable, and Collection

The nursing facility provides services to the residents but does not get paid for those services immediately. The facility, however, has the legal right to receive money at a future date. The amounts that remain to be collected by the facility for services already rendered are called **accounts receivable**.

In the billing system, each resident is classified according to his or her pay type. Each month, the facility must bill the respective payers such as Medicare, Medicaid, and private insurance companies—called third parties—or individual private parties responsible for paying. Medicaid and Medicare bills, called **claims**, are submitted electronically to the fiscal intermediaries contracted by Medicaid and Medicare to pay claims from providers. Medicaid and Medicare pay all-inclusive *per diem rates* (daily rates) to the facility. Only copayments and specifically requested services, such as guest meals, can be billed to the resident. Private-pay rates generally cover room, board, nursing care, and other routine services, such as social services and activities. Charges for ancillaries, such as therapies, nursing supplies, and medications, must be collected from the residents or their representative parties.

The basis for daily charges is the midnight census report, which is prepared each night by the charge nurse on duty and verified by the director of nursing. The **midnight census report** verifies the presence of each resident in the facility during the night. On a daily basis, the bookkeeper should match residents in the billing system against the midnight census report.

On a daily basis, the various resident charges as well as all payments received are posted to each resident's ledger account. These ledger accounts are used to prepare a monthly accounts receivable **aging report**, which is a managerial report, not a financial statement. Also known as an *aging schedule*, this report provides a detailed analysis of unpaid balances on each resident's account. It is called an aging report because it also shows how old each account balance is. Unpaid balances are shown under columns for 0–30 days, which is considered “current,” 31–90 days past due, 91–120 days past due, and over 120 days past due. The older an unpaid account gets, the less likely it is to be collected. Facilities often jeopardize their own financial standing by neglecting to collect accounts receivable.

Third-party claims are often rejected because of billing errors. The only way such accounts can be collected is by rectifying the errors and resubmitting corrected claims. To collect past-due balances owed by private individuals, the facility must have collection policies and procedures. When monies are legitimately due for services delivered, the facility should have no hesitation in making all efforts to collect past-due balances.

Cash Receipts and Deposits

Control of cash receipts is a critical function. All cash and checks must be recorded on a cash receipt voucher that shows the exact amount received. These monies must be deposited into the facility's bank account daily, without mingling them with the facility's petty cash fund or the resident trust fund. The bank deposit slip should be reconciled against the cash receipt vouchers, which are then used for posting credits to the respective residents' ledger accounts. The ledger account for each resident shows the debits or amounts initially owed, credits or amounts paid, and the accounts receivable due.

Resident Trust Fund

Nursing home regulations allow residents to retain the right to manage their own financial affairs. However, many residents ask the facility to manage their personal funds. When asked to do so, the nursing home is obligated to establish a resident trust fund.

Medicare and Medicaid certification regulations mandate that nursing homes deposit into an interest-bearing account all individual resident funds exceeding \$100 (\$50 for Medicaid beneficiaries) [F567²]. Lesser amounts may be held in a noninterest-bearing account or petty cash fund that is separate from the facility's petty cash. The residents' account with a bank must also be separate from the facility's own account. Federal regulation F570 requires the facility to purchase a surety bond or otherwise assure the security of all personal funds of residents deposited with the facility.

The facility can make a charge against a resident's personal funds only for deductibles and copayments and for any items or services that are not covered under Medicare or Medicaid. The noncovered items must be specifically requested by the resident (F571). Appropriate safeguards and procedures to account for the use of resident funds must be instituted. Residents must be provided individual quarterly statements (F568). Misappropriation of resident funds is a serious crime and is a punishable offense in all U.S. states (Nathan, 2020).

² Federal regulations for nursing homes are identified by F-Tags.

Medical Records

Staffing

Depending on the size of the facility, medical record services are staffed by a full- or part-time individual. Credentials of registered health information administrator (RHIA) or technician (RHIT), conferred by the American Health Information Management Association (AHIMA), is a necessary qualification for hospital medical records personnel. Certification is based on academic qualifications and an examination. Only large nursing homes may be able to employ someone credentialed as RHIA or RHIT. Most facilities designate a clerical person with some relevant experience or training to handle medical records and contract with a duly certified medical records consultant, who provides routine oversight.

The medical records clerk is responsible for ensuring that the records are maintained in an organized manner in accordance with current laws and accepted professional standards. Quality is ensured by auditing records according to an audit schedule. Open records are maintained at the nursing station responsible for the care of the residents.

Medical Record Content and Purpose

A resident's medical record contains all significant information on the care of the resident from admission to final discharge. Thus, it becomes a permanent and comprehensive historical record of the resident's medical condition, the course of treatment and specific services delivered during the resident's stay in the facility, and the clinical outcomes.

The medical record includes a resident's identifying information as well as clinical information. Clinical information includes records of medical and social history, physical examinations, principal diagnoses, results of the initial assessment and any subsequent reassessments, informed consent and advance directives, plan of care, treatments prescribed, diet plan, therapeutic procedures carried out, and medications administered. Also included in the clinical information are records of laboratory test results, clinical observations, response to treatment, any change in condition and action taken, any incidents or accidents, any treatment errors and action taken, any adverse reaction to medications, any use of restraints and psychotropic drugs, and discharge summary. All physicians' orders must be signed and dated by the attending physician.

The format of medical records should enable a diverse group of caregivers in coordinating services provided to a resident. To promote interdisciplinary collaboration, each discipline should be able to see the documentation furnished by others.

Medical records provide documentary evidence of actual care rendered. Regulators and third-party payers rely on the medical records as a basis for determining compliance with requirements. The documentation also forms the basis for payment for services delivered and for evaluating whether the services provided were clinically necessary. Medical records also provide vital information for improving quality and for research.

Medical records are summoned in malpractice cases. As part of a facility's defense during litigation proceedings, timely, complete, and accurate medical records are essential to demonstrate that all reasonable and necessary care was provided. It is important for nursing home administrators to become familiar with the system of medical records used in their facilities. Administrators should review these records as part of their investigation when allegations of lapses in care are made by family members, regulators, or others. Common abbreviations used in patient documentation are listed in **Appendix 14–1**.

The facility retains ownership of the medical record, but the information contained in it belongs to the resident. Privacy of all information contained in the medical records is a legal requirement under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Information Systems

Information systems (IS) are computer-based applications used for transforming raw data into information that can be used in a variety of ways to improve operational efficiencies and the quality of services. Data themselves do not constitute information. Discrete data become information only when the data have been accurately recorded, organized, processed, interpreted, and used. Large quantities of data can be processed by computer software programs to produce summaries and reports that can help employees do their jobs more effectively and to help managers make decisions for improving the operations. Most nursing homes use IS for Minimum Data Set (MDS) reporting; for managing admissions, transfers, and discharges; for updating medical records; and for budgeting and financial controls. Electronic health records (EHRs) are now widely used to support the delivery of health care services in various types of health care organizations. EHRs replace the traditional paper medical records.

On the administrative side, IS applications can be expanded into staff scheduling, menu planning and food ordering, inventory management, activity planning, and preventive maintenance scheduling. IS can also be used to manage the facility's marketing program and to keep track of inquiries, follow-up, and admissions generated from inquiries.

Meaningful information can facilitate instituting managerial controls, making timely decisions, making quality improvements, and delivering improved resident care. For example, summaries of accounts payable help management identify unauthorized payments to vendors. Other reports help management to study labor-hour use and overtime in order to control labor costs, to monitor aging of accounts receivables to identify and collect past due accounts, and to control costs using budget variances. Analysis of data on resident falls, use of restraints, and use of psychotropic medications can help improve resident care.

Integrated Networks

Integrated IS networks are designed to integrate multiple functions and provide multiple users access to the same information. Several examples can be given to illustrate how integrated IS can support more efficient management planning and decision-making:

- *Staffing:* Absenteeism and turnover patterns can be incorporated into staff scheduling to minimize understaffing. Staff turnover patterns can be projected to determine future hiring and training needs. Clinical information can be incorporated to determine the appropriate staffing levels and skill mix needed in accordance with the overall resident acuity levels indicated by the facility's case mix.
- *Capital budgeting:* Preventive maintenance and repair history can be used for forecasting future capital needs for equipment replacement. Such information can help the administrator decide at what point it makes better financial sense to replace equipment than to repair it.
- *Quality improvement:* Data pertaining to a variety of clinical outcomes—such as infections, falls, and medication errors—can be analyzed to better understand their causes and to propose actions for minimizing negative outcomes. Standardized clinical practice guidelines can be integrated with assessment and care plans to improve care delivery. **Clinical practice guidelines** are protocols based on research and expert opinion for resident care delivery in specifically identified areas needing clinical intervention, such as falls reduction, pain management, prevention of pressure ulcers, and incontinence care. Use of these guidelines is an important step toward ensuring high-quality nursing home care.
- *Operational budgeting:* Historical data on census patterns, associated revenues, and costs can be automatically retrieved to project future budget needs.
- *Marketing:* Data on inquiries, follow-up, and admissions can be analyzed to determine the type of residents the facility is admitting in terms of pay types and acuity levels. The system can also help identify the major sources of referral and determine why certain residents may have selected other facilities.

In the future, integrated networks across various health care providers will be necessary. For example, the Affordable Care Act places increased emphasis on care coordination and use of home- and community-based services, such as the Community First Choice. Coordination of long-term care services along the continuum of care—which would include home care, custodial care, skilled nursing care, and mental health services—would require integrated systems.

Security Issues

Integrated information networks are fast becoming indispensable, but safeguarding sensitive information presents challenges. Administrators must grapple with the critical question of who should have access to what information on the network. For instance, the facility's financial information should not be accessible to anyone who uses a computer terminal in the facility. The system must also have adequate safeguards to prevent tampering with existing data. Some high-profile cases of break-ins by external hackers into computer systems of major U.S. corporations and the government further highlight the need for adequate security measures. Other security issues pertain to the physical security of the equipment. For instance, having backup records in case a system is destroyed in a disaster or is vandalized is essential.

System Development

Most nursing facilities must rely solely on outside vendors to meet their IS needs. Numerous vendors specialize in hardware, software, and set-up of [local area networks \(LANs\)](#) within the facility. A LAN links a group of computers to a central server so that LAN users can access the same information. Because a turnkey system can be quite expensive, a decision to upgrade existing systems should not be undertaken without careful study and planning. The administrator must first define the objectives of the system in terms of what the system should be able to accomplish. These objectives must specify the level of integration a proposed IS must achieve. Current capabilities should then be evaluated in conjunction with these desired objectives. In some cases, certain upgrades may enable the facility to reach its objectives. In other instances, replacing the existing system may be the best alternative.

Several reputable vendors should be invited to evaluate the current systems and desired objectives and to submit detailed written proposals along with costs. The facility may not be able to purchase a fully integrated system immediately. In that situation, feasibility of future upgrades should be discussed. In any case, making a firm commitment is not advisable without a test run to ensure that the system would indeed accomplish what the facility desires. Finding out what kind of ongoing support and training the vendor provides and how often the vendor upgrades products to meet changing needs and improve informational efficiency are also critical. Another important consideration is the system's compatibility with Medicare and Medicaid billing and with clinical data requirements. For instance, the system should enable electronic billings as well as electronic transmission of resident assessment information. Finally, the system must comply with all applicable laws and regulations.

Terminology for Review

accounts payable

accounts receivable

aging report

claim

clinical practice guideline

de minimis doctrine

exempt employee

imprest amount

information system

local area network

midnight census report

nonexempt employee

wage garnishment

For Further Thought

1. Why is it important that the petty cash and resident trust fund be reconciled each month and that the reconciliation be done by someone other than the person responsible for maintaining the funds?
2. Develop some policies pertaining to meal breaks and incidental preparatory and concluding activities to provide clear guidance on compensable and noncompensable time.

For Further Learning

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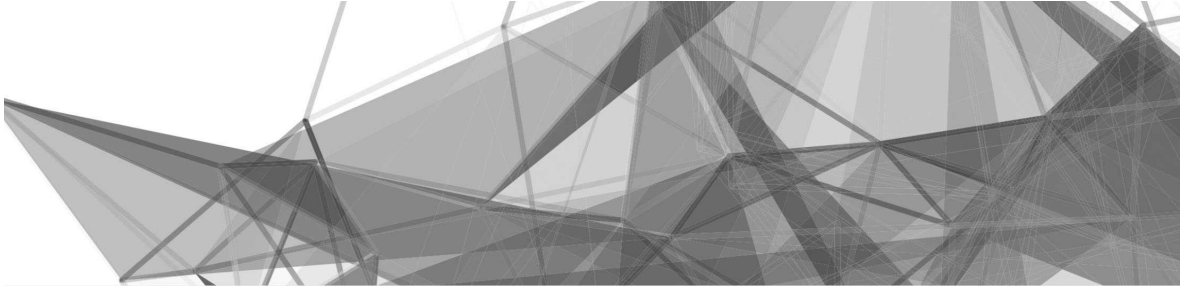
Appendix 14–1

Common Abbreviations Used in Patient Documentation

act	before meals
ad lib.	as desired
AMA	against medical advice
A&O	alert and oriented
aq	water
ASS:	assessment
ATC	around the clock
B	both
B&B	bowel and bladder
b.i.d.	twice daily
bin	twice a night
b.i.w.	twice a week
BKA	below knee amputation
BM	bowel movement
BP	blood pressure
BR	bed rest
B.R.	bathroom
b.t.	bedtime
BTW M	between meals
BUE	both upper extremities
CBR	complete bed rest
CHO	carbohydrate
chr	chronic
c/o	complains of
COPD	chronic obstructive pulmonary disease
ct.	count
CV	cardiovascular
CVA	cardiovascular accident
CXR	chest x-ray
d/c	discharged
d.c.	discontinued
decub	decubitus
def	deformity
D.F.A.	difficulty falling asleep
Diab	diabetic
DOB	date of birth
Dx	diagnosis
ELOS	estimated length of stay
end	endurance
ESRD	end-stage renal disease
et	and
ETOH	alcohol

EXP	expired
FAM	family
F.B.	foreign body
FBS	fasting blood sugar
Fe	iron
flds	fluids
Fx	fracture
gt.	drop
gtt.	drops
HBP	high blood pressure
HL	hearing loss
H&P	history and physical
hr	hour
h.s.	at bedtime
Hx	history
I&O	intake and output
IV	intravenous
K	potassium
LBP	lower back pain
lf	left
lg	large
MB	mix well
MI	myocardial infarction
M/S	mental status
NA	not applicable
N/A	no authorization
Na	sodium
NGT	nasogastric tube
NKA	no known allergies
noct	at night
NPO	nothing by mouth
NSC	no significant change
OBS	organic brain syndrome
o.d.	once a day
om	every morning
on	every night
OOB	out of bed
os	mouth
P	after
pc	after meals
PN	pneumonia
po	by mouth
p.p.	after meals
p.r.n.	whenever necessary
pt	patient
PTA	prior to admission

pvt.	private
q	every or each
qam	every morning
qd	every day
qh	every hour
qhs	every bedtime
ql	as much as desired
qn	every night
qod	every other day
q/s	every shift
qw	once a week
ROM	range of motion
Rx	prescription, treatment
SHx	social history
si/sx	signs/symptoms
S/O	standing order
SOS	only if necessary
ss	one-half
Stat	at once
T	temperature
TB	tuberculosis
TF	tube feeding
Tid	three times daily
Tin	three times a night
Tiw	three times a week
T/O	telephone order
T&P	turn and position
TPN	total parenteral nutrition
TPR	temperature, pulse, and respiration
ung	ointment
URI	upper respiratory infection
UTI	urinary tract infection
VS	vital signs
w/	with
W/C	wheelchair
w/o	without
X3	oriented to time, person, and place



PART IV

Essentials of Effective Management

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[Chapter 15 Effective Governance, Leadership, and Management](#)

[Chapter 16 Effective Human Resource Management](#)

[Chapter 17 Effective Marketing Management](#)

[Chapter 18 Effective Financial Management](#)

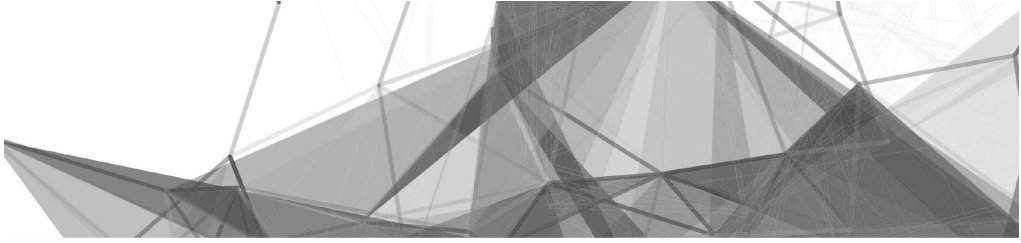
[Chapter 19 Effective Quality and Productivity Management](#)

This section covers the main areas of management in which administrators must become proficient. The five chapters apply business management principles to long-term care organizations.

Effectively managing a nursing facility is a complex undertaking because it involves a wide spectrum of responsibilities that require careful balancing in accordance with the varied organizational needs while at the same time complying with federal and state regulations. Leadership and management skills must be constantly developed and refined in conjunction with frequent self-evaluation.

With few exceptions, most facilities do not have separate positions for human resource manager, financial officer, marketing director, and quality control manager. Thus, a typical nursing home administrator wears several different hats.

- [Chapter 15](#) discusses governance, compliance and ethics, and the application of leadership and management skills to operate a successful organization. The chapter concludes with an explanation of the various tools necessary for effective management.
- [Chapter 16](#) emphasizes that human resource management in long-term care facilities requires special skills in creative recruitment, determination of staffing levels and skill mix, management of absenteeism and turnover, and empowerment of frontline associates such as certified nursing assistants. The chapter includes issues pertaining to unionization, and it concludes with an overview of workers' rights and antidiscrimination laws.
- [Chapter 17](#) explains that value creation is at the heart of marketing. It also demonstrates that marketing is more than just externally focused activities; a client-focused attitude must permeate the entire organization. Typical marketing topics such as segmentation, market targeting, positioning, differentiation, personal selling, and public relations are applied to long-term care marketing.
- [Chapter 18](#) presents an understanding of financial statements. Using a number of exhibits, the chapter also discusses several financial management tools such as variance analysis, inventory management, midnight census report, and aging schedule. The chapter concludes with the techniques of budgeting revenues, expenses, and margins.
- [Chapter 19](#) clarifies some common misconceptions related to quality and productivity. It explains the QAPI program that certified facilities must implement. The principles of continuous quality improvement can enable a facility to successfully carry out the QAPI program. The Donabedian model of quality and Deming's principles are described.



CHAPTER 15

Effective Governance, Leadership, and Management

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WHAT YOU WILL LEARN

- The governing board mainly provides oversight and direction. The administrator manages the facility's day-to-day operations.
- A compliance and ethics program begins with the development of policies, standards, and procedures; it requires training, lines of communication, internal review, and enforcement. Compliance and ethics are an integral component of good management.
- The effective administrator manages the facility by maintaining a balance among the business aspect, managing work and workers, and the facility's obligations to the community and society.
- Leadership is people focused. It can be understood through differences between the Theory X and Theory Y approaches, the balance between task orientation and relationship orientation, and use of different styles to fit a given situation.
- Management is about getting things accomplished on a daily basis. The nursing home administrator functions in a variety of management roles, identified by Henry Mintzberg.
- Almost all managers are involved in performing the classical functions of planning, organizing, leading, and controlling.
- The purpose of a vision is to clarify what an organization should become. The mission guides its main objectives and defines what stakeholders can expect. Values provide an ethical framework of conduct for the administrator and associates.
- Goals, rules, policies, and procedures help routine decision making. Rational decisions involve a process, but intuition also plays a role.
- Meetings should be planned in accordance with their main purpose, such as information sharing or problem solving. A different approach is needed when meeting with external stakeholders.
- Depending on its nature and extent, conflict can be either healthy or dysfunctional. Various conflict management techniques can be employed, depending on the situation.
- The boss–subordinate relationship is based on mutual dependence.
- A risk management program should focus on risk identification and reporting, risk analysis, and risk prevention.

Introduction

Solid governance is the foundation to ensure that a nursing facility is managed with integrity. Even the Affordable Care Act puts new demands in this area on facilities that are certified to serve Medicare and Medicaid beneficiaries. Managing a nursing facility has been complex and will become more so in a health care environment marked by ongoing change. Hence, well-prepared leaders are needed as never before. This chapter furnishes essential knowledge and practical tools that will prove to be of benefit regardless of whether this is a person's first exposure to management or whether the individual has had prior courses in this area.

Governance

Governance refers to stewardship of an organization's resources. An organization's material, financial, and human resources must be used to produce outcomes that benefit the organization's stakeholders. A nursing home's main stakeholders are its clients; the community at large; employees; regulators; other health care providers, such as hospitals; and third-party payers.

Nursing homes are required by law to have a **governing body**—referred to as the board of directors, board of trustees, or simply “board”—to oversee the organization and provide broad direction. The board bears ultimate authority and accountability for the organization's affairs.

The Board's Composition

Selection of board members should be guided by the ownership structure and by the organization's mission. For example, the board of a publicly owned facility will include people who can best represent the organization's charity mission. The board may include one or two city or county administrative and health officials, a representative of the local social services department, one or two community physicians who mainly serve Medicare and Medicaid clients, a public health nurse, and an official from the local hospital.

In privately owned corporations—both for-profit and nonprofit—the board generally includes some corporate officers, such as the corporation's president or chief executive officer (CEO), the vice president of operations, the vice president of human resources, and the chief financial officer (CFO). The board should also include representatives from the community and some local business leaders. Regardless of the type of ownership, the nursing home administrator (NHA) should also be a member of the board.

Board members should be selected from among respected leaders in the community on the basis of their qualifications and character. The skills and social standing of potential board members should be carefully reviewed to help select people who can provide technical expertise in health care, finance, law, or public relations to the extent possible; represent the community and clients; and bring their own individual perspectives to the operation of the facility.

The Board's Functions

In the public sector, the board will focus particularly on the facility's charity mission while also ensuring that the facility remains financially viable. In the nonprofit sector, the special focus should be on meeting the health care needs of the community, which should include a charity function to justify the corporation's tax-exempt status. In the for-profit sector, maximizing profits and creating value for the owners or shareholders are the main goals. Long-term care facilities operated by various religious organizations, which are private, nonprofit entities, may adhere to certain religious tenets, spiritual values, and moral commitments upheld by the sponsoring organizations.

The NHA reports to the board and looks to it for general direction. In effectively managed organizations, a close relationship based on trust, mutual commitment, communication, and professionalism exists between the board and the administrator. The main responsibilities of the board are summarized as follows:

- Appoint a qualified administrator to manage the facility. Clarify performance expectations.
- Periodically review the administrator's performance, determine compensation, and make decisions about the administrator's continuing employment.
- Establish or review the mission and vision for the facility and assist the administrator in establishing a strategic plan that is periodically updated. Establish or approve major goals and objectives for the organization.
- Establish broad policies that provide adequate guidelines to the administrator in making decisions pertaining to finance, budgets, quality of resident care, building and equipment, staffing, employee relations, and legal and ethical conduct.
- Approve financial goals reflected in annual budgets.
- Provide needed support to the administrator by procuring technical expertise when necessary and by committing adequate resources so that the facility can be effectively managed and an acceptable level of resident care can be delivered.
- Oversee the facility's operations and outputs. Because of its legal accountability, the board must ensure the facility's compliance with quality standards, financial goals, and legal and ethical expectations.

Although the board has the primary responsibility for the functions just outlined, the NHA should be actively involved in developing policies, mission and vision, and strategic direction for the facility. As a general rule, the board exercises due vigilance, but without undue interference with the NHA's job. How much autonomy the NHA is given to make independent decisions, however, depends on his or her level of skills and experience. The NHA must keep the board updated and informed on substantive operational matters, such as quality issues, deficiencies cited on survey inspections, any legal issues, any negative publicity, budgetary compliance, need for resources, and staffing-related issues.

Role of the NHA

The NHA acts as the agent of the board and is responsible for the day-to-day management of the nursing facility. In managing the facility, the NHA must provide leadership and direction to the department managers. The NHA also has the primary operational responsibility for human resource management, marketing and public relations, budgetary compliance and financial management, and quality and productivity management.

Corporate Compliance and Ethics

Accountability to the various stakeholders is the essence of [corporate compliance](#). Fundamentally, compliance efforts are designed to establish within the organization a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to laws, regulations, as well as the organization's ethical and business policies (Merritt, [2015](#)).

Compliance with the various laws and regulations is a very basic expectation. The Affordable Care Act adds two main requirements for certified nursing facilities (Farhat, [2013](#)): (1) They must institute effective compliance and ethics programs, and (2) in case of a facility closure, they must provide a written notice at least 60 days prior to closure. Nursing home regulations require that the compliance and ethics program must be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care. Governance efforts, however, must go beyond the legal and regulatory realm to incorporate standards of ethics and to "do what is right." The organization's officers must govern with integrity. They must be vigilant, and they must voluntarily take corrective steps before issues turn into major legal and ethical dilemmas.

An effective corporate compliance and ethics program has six main requisites:

1. Compliance begins with standards and procedures to be followed by the employees. Employees must understand what the standards are and what procedures to follow when violations of the standards are observed. For example, a hotline or toll-free phone number can be instituted to facilitate confidential reporting of violations. Training on the organization's compliance and ethics program must be conducted at least annually.
2. A high-level corporate officer—such as the vice president of human resources or the vice president of operations who has direct access to the CEO—must function in the capacity of compliance officer to administer and oversee the program.
3. Effective lines of communication must be established and assured. Managers must be open and honest in conveying the company's expectations to the associates. Associates must feel comfortable in both questioning and informing management on issues that may be of concern.
4. An internal review and audit protocol must be implemented to verify that standards and procedures are being followed. The compliance and ethics program must be reviewed at least annually.
5. Protocols must be established to promptly investigate all allegations of violations. If a violation is found, disciplinary action must be taken. Depending on the perceived severity of the alleged violation, consultation with legal counsel may be necessary. Legal counsel can help ensure that contemplated disciplinary action will not violate any federal or state laws or a union contract.
6. After a violation is confirmed, steps must be taken to prevent further violations.

The Effective Administrator

Effective NHAs come in all shapes and sizes; the only thing they may have in common is the ability to get things done (Drucker, [1985](#)). The NHA should function as the general manager of a nursing facility. As discussed later, the NHA must have both leadership and management skills. According to Drucker ([1974](#)), the well-known management guru, an effective manager must find the right balance among three domains:

- Managing the business aspect
- Managing work and workers
- Managing the organization in community and society

A balance among the three is necessary because “a decision or action that satisfies a need in one of these functions by weakening performance in another weakens the whole enterprise” (Drucker, [1974](#), p. 398). Thus, effective management becomes a skillful juggling act; it requires expertise in various management disciplines.

Managing the Business Aspect

Here, the term *business* is used in the sense of economic performance (Drucker, [1974](#)), which applies to all ownership types. The essence of business management lies in using resources in a manner that adds value, that is, creating a far greater good than the worth of the resources employed. The added value that society expects from a nursing facility is affordable resident care that meets established standards of quality. In other words, the nursing facility must satisfy the residents, their families, and the payers. Because the payers include those who pay the facility directly on a private-pay basis as well as government payers—mainly Medicare and Medicaid—who pay indirectly out of taxes levied on citizens, society as a whole has expectations that nursing facilities achieve the twin goals of affordability and quality. Affordability is achieved through cost containment measures without compromising the quality of care and through avoidance of waste in the delivery of services. Delivering high quality of care that meets regulatory standards can avoid fines and other costly actions against the facility. Avoidance of fraud through compliance and ethics measures can prevent heavy fines and loss of reputation in the community.

Managing Work and Workers

One of the essential functions of management is to make work productive (Drucker, [1974](#)). Productivity incorporates quality as a major output that results from the use of resources over which management has control. [Productivity](#) maximizes quality for each unit of resources used in delivering health care. In simple words, the facility must improve quality while reducing costs.

To make work productive, managers must first understand what work needs to be done and how to organize it. (The entire Part III of this book is devoted to understanding and organizing various tasks necessary for effective delivery of services.) Direct hands-on resident care, as well as support services, must be delivered effectively toward achieving and maintaining quality standards.

A second and often a more difficult task in achieving productivity is building a cooperative spirit among the workers through leadership and motivation. The challenge for the effective NHA lies in creating a workplace environment in which each person contributes his or her best efforts toward organizational goals. The effective NHA understands that if work and workers are mismanaged, organizational performance will suffer no matter how good the NHA may be in managing the business side of the operation (Drucker, [1974](#)).

First, the organization must offer rewards—wages, benefits, and opportunities for individual development and growth—that are at least commensurate with what the associates bring to the organization. The organization can do several additional things to create work environments in which exemplary associates would flourish, find satisfaction, and boost their self-esteem (Kelley, [1998](#)):

- Remove roadblocks to productivity by shielding associates from excessive bureaucratic demands that may interfere with getting real work done. Workers must fill out papers and reports and attend meetings, but such demands can be overdone.
- Associates should be kept free from constant interruptions from administration. Facility administrators can “keep their fingers on the pulse” but also promote self-management because most workers want to manage themselves.
- Participative management is fine, but most workers want to be involved only in decisions that affect them. Above all, exemplary workers are not interested in knowing the trivia about their boss’s jobs or their personal lives.

- Although associates want to manage themselves, the NHA must make sure that the various departments' efforts come together. An important aspect of administrative responsibility is to fill any chasms between departments and to promote interdependencies that will enhance the value of the services delivered.
- People are interested in knowing what outcomes their efforts have produced. Similarly, the value added by the synergistic use of interdependencies should be disclosed to associates to promote ongoing cooperation between departments.

Managing the Facility in Community and Society

In Drucker's words, "None of our institutions exists by itself and is an end in itself. Every one is an organ of society and exists for the sake of society Institutions must be part of the community Mismanaging social impacts eventually will destroy society's support for the enterprise and with it the enterprise as well" (Drucker, 1974, pp. 41–43). From this perspective, the effective administrator must frequently evaluate whether the facility is making positive strides in connecting with the community and whether it is adequately discharging its responsibility toward society. The latter requires a constant striving to seek excellence in caregiving and upholding the highest standards of ethics.

Understanding Leadership

Leadership can be defined as influencing people to act for certain goals that represent the wants, needs, aspirations, and expectations of both leaders and followers (Burns, 1998). Although leadership can have many different meanings, Northouse (2001, p. 3) concluded that four main components are central:

- Leadership is a process that requires continuity. It is also interactive and involves give and take between the leader and followers.
- Leaders use their influence to direct people toward a common purpose.
- Leadership occurs within a group or “people” context. Leadership finds its meaning in relation to other people. Hence, a genuine care and concern for those being led makes leadership effective.
- Leadership involves goal attainment. Leaders direct their energies toward individuals who are trying to achieve something together.

The following words on leadership have been ascribed to the Chinese philosopher Lao Tse, who lived in the fifth century B.C.:

A leader is best when people barely know that he exists,
Not so good when people obey and acclaim him,
Worst when they despise him.
Fail to honor people, they fail to honor you.
But, of a good leader, who talks little,
When his work is done, his aim fulfilled,
They will say, “We did it ourselves.”

The entire process of leadership is people focused. Hence, the signs of outstanding leadership appear primarily among the followers. Are the followers reaching their potential? Are they learning? Are they devoted to serving? Do they achieve the desired results (DePree, 1998, p. 130)?

Leadership Attitudes and Styles

Much has been written about leadership styles that explain how leaders think and act when managing workers. Leaders’ behaviors emanate from their general attitudes and assumptions about workers. Leaders’ personal styles are also oriented in varying degrees toward relationships and tasks. Finally, leadership is situational.

Two-Model Theory

To explain management behavior, Douglas McGregor (1906–1964) proposed two models known as Theory X and Theory Y, which present two contrasting assumptions leaders make about workers. According to Theory X, leaders assume the following about workers:

- They are lazy.
- They dislike work and responsibility.
- They will avoid work if not closely supervised.
- They are indifferent to organizational needs and goals.

Traditional leadership was based on Theory X and focused on monitoring and controlling people in the organization in an effort to make them obey managers’ orders or face negative consequences. Theory X assumptions lead to task-oriented behaviors on the part of leaders, as opposed to relationship-oriented behaviors; such leaders will have a tendency to adopt a directive style (**Figure 15–1**). Directive leadership can be characterized as take-charge, one-directional, and single-handed decision making by the leader. Directive leadership involves giving orders, establishing goals and methods of evaluation, setting time lines, defining roles, and establishing methods and processes for achieving the organization’s goals (Northouse, 2001, p. 57).

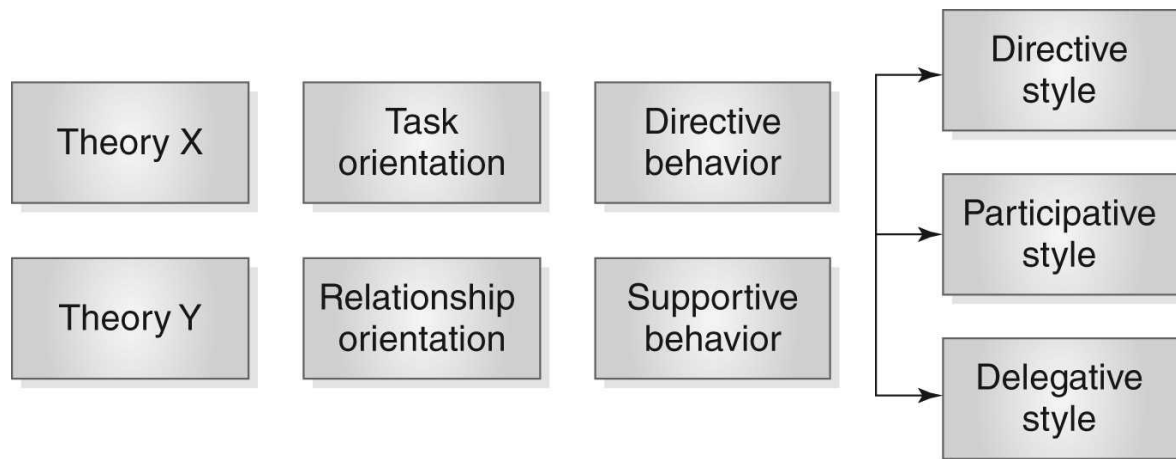


FIGURE 15-1 Relationship among leadership attitudes, behaviors, and styles

In what McGregor called Theory Y, leaders have the opposite attitudes toward workers:

- They want to take responsibility.
- They like challenging work.
- They desire opportunities for personal development.
- They want to help achieve organizational goals.

Leaders who espouse a Theory Y perspective are likely to adopt relationship-oriented behaviors and will be inclined to use a participative or a delegative style of leadership (Figure 15–1). This relationship orientation results in supportive behaviors in which open communications, listening, praising, asking for input, and giving feedback are important (Northouse, 2001, p. 58). The main characteristic of the participative style is involving other people in decision making and giving their ideas due consideration. The leader may present ideas and invite feedback from workers or solicit new ideas from them. In the delegative style, leaders share decision-making responsibilities with their associates (Brody, 2000).

Two-Dimensional Model

In the mid-twentieth century, several independent research studies resulted in two-dimensional models of leadership comprising *task orientation* (also called production orientation, or initiating structure) on one end of a continuum and *relationship orientation* (also called person orientation, or consideration) at the other end. The main contribution of the two-dimensional theory has been in highlighting that leadership is not necessarily a dichotomous phenomenon, as suggested by Theory X and Theory Y. A leader could be oriented toward both tasks and people, albeit in various degrees, depending on the leader's predominant attitude whether it is embedded in Theory X or Theory Y. Accordingly, Blake and Mouton (1964) proposed a managerial grid in which each leader could be rated on both task orientation and person orientation and be classified into one of five leadership styles (Figure 15–2):

1. *Impoverished management.* Characterized by low task orientation and low person orientation, these leaders remain hands off and aloof. An NHA who spends little time at the facility and does only what is necessary to keep his or her job falls in this category. Long-term success of such administrators is highly questionable.
2. *Task management.* These leaders are highly task oriented. They are mainly concerned with getting work done and have minimal concern for people. A highly directive style is effective for short-term situations that require critical action or for turning around a failing operation, sometimes referred to as crisis management (Kapucu & Ustun, 2018).
3. *Country-club management.* These leaders rate very high on person orientation. They are concerned mainly with creating a pleasant and harmonious working environment and have little concern for accomplishing tasks. In rare situations, a facility may have highly skilled and self-directed department managers where such a style may be effective. A change in style would be necessary when the situation demands.
4. *Team management.* These leaders rate high on both person orientation and task orientation. They value their workers and solicit their participation in setting goals, making decisions, and accomplishing tasks.

They try to achieve a healthy balance between directing the work of their subordinates and empowering them to make decisions.

5. *Middle-of-the-road management.* These leaders seek the middle ground and keep a moderate amount of balance between relationships and tasks. These leaders are generally able to maintain the status quo.

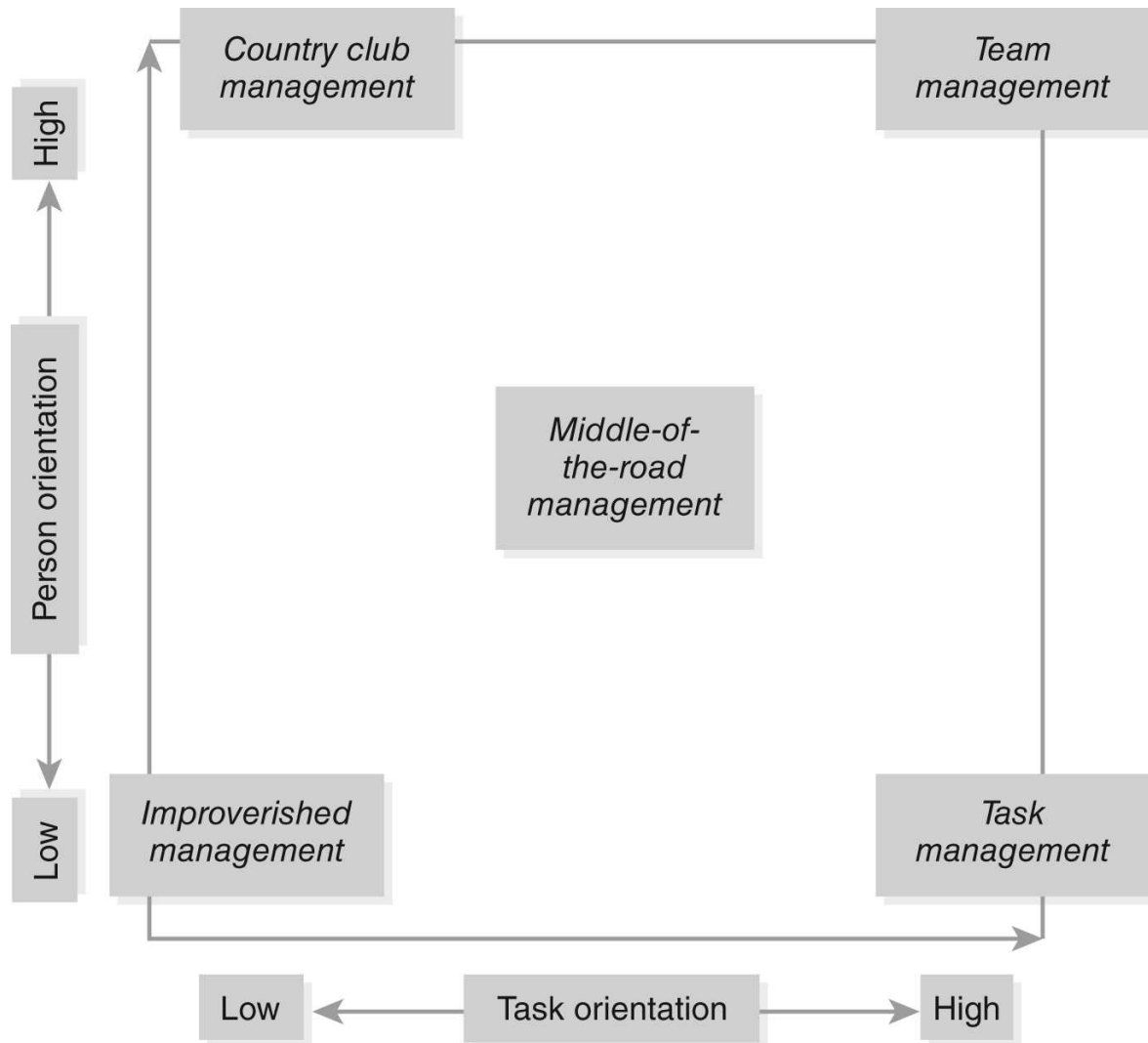


FIGURE 15-2 Blake and Mouton's managerial grid and leadership styles

Situational Leadership

Contemporary management theories recognize that leadership styles must fit the situation. Different situations demand different styles and, therefore, effective leaders change their styles according to the situation. Conceptually, this situational approach is similar to Blake and Mouton's managerial grid model. Instead of using task orientation and person orientation, the two dimensions in the situational model are directive and supportive behaviors. The [situational model](#), however, goes beyond Blake and Mouton's by suggesting that a leader should apply an appropriate measure of both directive and supportive behaviors as dictated by the competence and commitment of each worker or group ([Figure 15-3](#)):

- *Directing style*, characterized by high directive–low supportive behavior, is appropriate when the development and commitment levels of a subordinate or group are low. The leader focuses on giving specific instructions and engages in close supervision.
- *Coaching style*, characterized by high directive–high supportive behavior, is useful when the development and commitment levels of a subordinate or group are moderate to low. The style requires focusing on goals while soliciting input from the subordinate and giving encouragement.
- *Supporting style*, characterized by low directive–high supportive behavior, is useful when the development level of a subordinate or group is moderate to high. In this approach, the leader uses supportive behaviors

that bring out the employee's skills. The subordinate is given flexibility in routine decisions, and the leader is available for consultation as needed. Listening, praising, asking for input, and giving feedback are commonly employed.

- *Delegating style* is characterized by low directive–low supportive behavior. The delegating leader lessens his or her involvement in planning, control, and goal clarification. Once agreement is reached on what must be done, the subordinate or group takes responsibility for getting the job done (Northouse, 2001, pp. 57, 58).

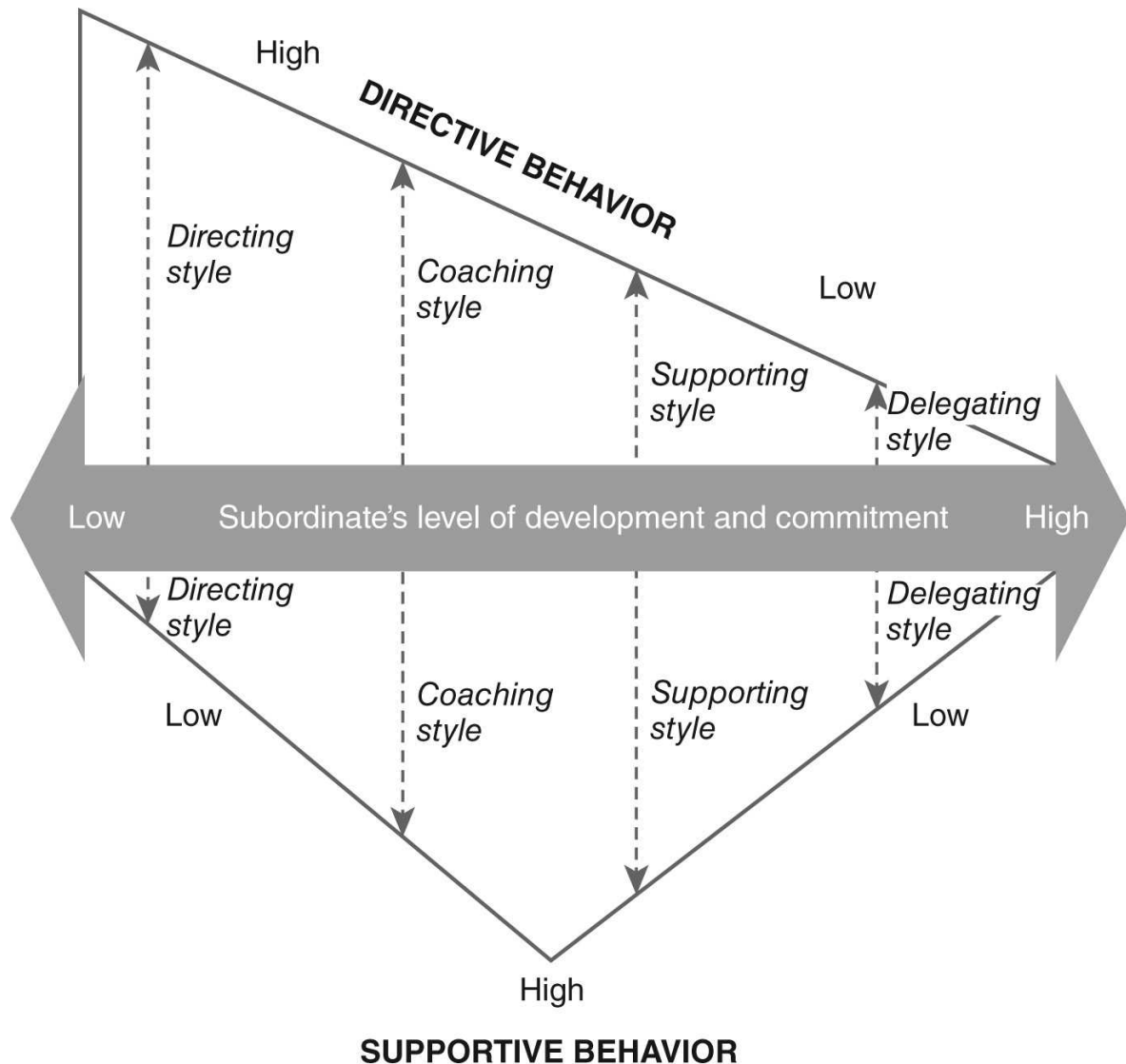


FIGURE 15-3 Situational leadership model

Implications of Leadership Theories

The discussion of leadership in this chapter concentrates on the most basic and simple concepts in the classical understanding of leadership. Many newer theories have been proposed that have only created a jumble of ideas. Consequently, research has not delivered any meaningful conclusions about what works best. However, the fact remains that leaders can exercise a range of behaviors depending on the situational context (Anderson & Sun, 2017).

In a study specific to nursing home leaders, the researchers found five specific behaviors that were most characteristic of highly rated leadership (Backman et al., 2017):

1. Experimentation with new ideas that allowed staff to take some risks has been instrumental in delivering person-centered care in nursing homes.

2. Empowering subordinates to take initiatives—another prerequisite that promotes the delivery of person-centered care—requires the leader to trust the staff to take initiatives.
3. Coaching and giving direct feedback promote learning—understanding of organizational values and goals and sharing of knowledge and skills.
4. Handling conflicts in a constructive manner is another leadership characteristic that promotes efficiency and improves resident outcomes.
5. Effective leaders keep close control over what goes on in the nursing facility. Effective leaders monitor operations and performance.

The listed results show that task orientation and relationship orientation are closely related for achieving organizational results. Staff generally do not differentiate between the two styles. However, several studies show that the effect of task-oriented leadership style on achieving positive organizational results is stronger than relationship orientation, although a balance between the two is essential (Havig et al., 2011).

Management Roles and Tasks

There is no universally accepted definition of management. In a very simplistic sense, management is what managers do to maintain an organization and to get things accomplished on a daily basis. Management is the “glue” that holds an organization together; it is the “oil” that keeps the organization functioning as smoothly as possible to fulfill the main purpose for which the organization exists. Management requires the efficient use of resources to accomplish organizational objectives. Hence, management is essential work without which an organization will slowly disintegrate into chaos. Effective management is mainly about managing stability; it is about finding what works and doing it well. Consistently pursuing this objective institutionalizes excellence and places the organization in an enviable position to respond to well-studied change whenever change is necessary to enhance value for the stakeholders.

Describing what managers do can be complex. However, management theorists have tried to simplify the understanding of management by describing management roles and tasks.

Management Roles

During the course of a day, the NHA will function in a variety of roles. For example, the NHA's day may begin by walking over to the dining area for a cup of coffee. On her way back to the office, the maintenance man stops and informs her that he would have to leave at noon to take his sick child to the doctor. The NHA may respond, “Certainly . . . and, oh, by the way, Sam, make sure Mr. Hollinger's wheelchair gets fixed before you leave. I don't want to hear from his daughter again.” Next, she stops to chat with the director of nursing (DON) about the salary she would be willing to offer to hire the night charge nurse they had both interviewed 2 days earlier. As soon as she sits down in her office and takes a sip of coffee, the social worker comes in and asks whether the facility will cover the cost of a lost hearing aid for a resident because Medicaid will not pay for it. Then, the receptionist comes in and hands her two messages about phone calls that came in earlier, one from the vice president of operations at the corporate office and the other from a resident's family member. The NHA spends the next 20 minutes returning the two phone calls. The vice president of operations wanted to know why the accounts receivable had escalated during the previous month. A resident's daughter wanted to report that the nurse was very rude to her the previous evening when she asked the nurse about why the leaky faucet in the resident's room was still not fixed. The NHA spends the next 45 minutes in a department head meeting. She announces that the state had accepted the plan of correction submitted in response to the last inspection. To thank the department heads, she would like to plan a luncheon at a nice restaurant. Going forward, the facility should implement some changes to ensure future compliance with federal regulations. After the meeting, she receives a phone call from the local chapter of the American Red Cross inquiring whether the facility would participate again in the annual health fair. At 3:00 p.m., the NHA informs the receptionist to hold all phone calls and not to disturb her unless there is some urgent matter because she needs to set aside some undisturbed time to work on the budget for next year. Before going home at 6:00 p.m., the NHA tours the nursing areas and dining room and talks with a few residents. As she drives back home, she makes a mental note about setting up a luncheon meeting with the state representative for her area to discuss budget cuts proposed by the state's governor that may affect Medicaid reimbursement.

On the basis of his observation of managers on the job, Henry Mintzberg identified 10 different but highly interrelated roles:

1. The *figurehead* role is symbolic and ceremonial. At the annual picnic, the NHA may grill hamburgers for the associates. Later, he or she may give out service awards.
2. Role of the *leader* is associated with staffing, motivation, training, performance evaluation, and disciplining.
3. The *liaison* role deals with relationship building, mainly outside the organization. For example, the NHA builds relationships with the local fire department and the local hospital and is an active participant in civic associations. The relationships pay off in terms of expertise and support that external agencies can provide.
4. In the *monitor* role, the NHA keeps him- or herself informed of changes occurring in the legal, political, economic, social, and technological areas. This information could be of strategic importance. For example, remaining current on legal and regulatory changes, learning about what the competition is doing, and understanding social and cultural changes taking place in the industry can have implications for the nursing facility's long-term success.
5. As a *disseminator*, the NHA provides information to others. In this role, the NHA keeps the board informed on important matters, discusses issues with the department heads, and highlights the facility's services to educate the local community.

6. In his or her *spokesperson* role, the NHA represents the organization to outsiders. For example, the NHA may discuss plans for future services with the chamber of commerce. The NHA may be invited to discuss the nursing home's rehabilitation program with the physicians at the local hospital, or she may address the local media on the opening of a retirement center adjacent to the nursing facility.
7. In the *entrepreneur* role, the NHA initiates plans to bring about certain desirable changes. For example, the NHA may plan to convert some of the existing beds for specialized care.
8. As a *disturbance handler*, the NHA solves problems and addresses areas that require corrective action. Certain problems arise unexpectedly. For example, the DON resigns abruptly. Other problems may be chronic in nature and call for long-term solutions. For example, absenteeism and turnover are chronic problems in many nursing homes.
9. As a *resource allocator*, the NHA must decide how to distribute limited resources. Here are some examples: Should the facility hire a janitor or a certified nursing assistant (CNA)? Should it create the position of a medication aide? Should it spend money on an electronic medical records system, or should that money be spent on a new whirlpool bathing system?
10. In the *negotiator* role, managers bargain to gain certain advantages. For example, the NHA may approve a new bathing system provided overtime in the nursing department is cut in half. The NHA may approve a dollar per hour extra pay for nurses and CNAs who agree to come in to work at short notice on their days off to alleviate short staffing.

Management Tasks

Classical management theory has identified four categories of tasks: planning, organizing, leading, and controlling.

Planning

Planning includes defining or clarifying the organization's mission, establishing objectives, and planning a course of action to achieve those objectives. Planning is forward looking. It requires deciding in advance what to do, how to do it, when to do it, and who is to do it.

Plans can be routine, periodic, or strategic. While driving to work, NHAs routinely think about certain things they plan to address that day. In a more formal way, they plan agendas for the regular department head meetings. The annual budget is an example of periodic planning. Strategic plans are long-range plans that are generally in response to changes occurring in the legal, political, economic, social, and technological areas. They often require a cost-benefit analysis. For example, given that many nursing facilities have incurred lawsuits and financial penalties for lapses in quality, would it make economic sense to invest in an electronic medical records system that incorporates assessment, care planning, and decision making in accordance with clinical practice guidelines? Various short-range plans are needed to accomplish the long-range plans. For example, major renovations of the facility would require short-range plans about hiring a decorator, engaging a contractor, making alternative arrangements for the continuity of services, etc.

Organizing

Organizing includes determining what tasks are to be done, who is to do them, how the tasks are to be grouped, who reports to whom, and where decisions are to be made (Robbins, 2000). Even after an organization has been functioning for a while, the organizing function becomes necessary. For example, a decision to operate a laundry in-house instead of relying on contracted services calls for organizing. It requires decisions such as how many associates need to be hired, what functions each will perform, who will manage them, and so forth. In other areas of nursing home operation, new technology may eliminate certain positions or may alter their job responsibilities.

NHAs should pay attention to certain well-established principles of organization:

- *Departmentation and division of work* is a long-established principle to organize related functions within departments and assigning responsibilities to various positions within those departments. Organizational changes are made as needs change because of technology, growth of the organization, or launching into new services. Cross-trained self-managed work teams may be organized to change traditional functions when necessary.
- *Line and staff relationships* clarify who reports to whom and who in the organization have formal supervisor-subordination relationships. In an organizational chart, the solid lines indicate **line relationships**, showing the chain of command. Dotted lines indicate **staff relationships**, which are

advisory in nature. The medical director, for example, formally reports to the administrator in a line relationship. There is staff relationship between the DON and the medical director. In other words, the medical director is not the DON's boss; the administrator is. Conflicts often arise when line and staff relationships are confused. An organizational chart should include every position in the facility to show where employees should go when they need answers. Within the formal structure, members are granted authority over certain tasks, held accountable for the results, and given incentives for achieving those results (Griffith & White, 2002).

- The principle called **unity of command** means that a subordinate should report to only one supervisor. Otherwise, the subordinate may be subjected to conflicting demands and priorities. On the other hand, unity of command is not absolute. A subordinate may have encountered problems with his or her superior. Efforts should first be made to resolve issues directly with the superior. However, associates need appropriate mechanisms to have their grievances addressed at a higher level when necessary. For example, associates should be able to bypass the chain of command to address problems related to harassment by a superior, favoritism, unethical conduct, corporate compliance issues, and other situations in which a superior may be misusing his or her authority.
- *Delegation of authority* is another organizational principle. *Authority* refers to the right of making decisions without having to obtain approval from a higher-up (Ivancevich et al., 1980). Worker empowerment is characterized by a greater degree of delegation than traditional management, particularly for decisions regarding resident care.

Leading

Leadership and management are closely intertwined, but the two are not the same. Leadership is an essential tool for effective management. Through leadership, managers influence, inspire, and motivate associates to deliver the various services according to established organizational policies and standards. Management, however, goes beyond being a leader. Management requires skills in planning, organizing, and controlling.

Controlling

To ensure that things are going as they should, the NHA must monitor the organization's performance against goals and standards. The process of monitoring, evaluating, and correcting constitutes the task of **controlling** (Robbins, 2000). It is about controlling the structures and processes, not about controlling or manipulating people.

The functions of planning, organizing, and controlling are closely intertwined. Planning determines what results will be achieved, organizing specifies how those results will be achieved, and controlling determines whether the results are achieved (Ivancevich et al., 1980). In nursing home administration, the control function is perhaps best illustrated by compliance with the Requirements of Participation. The NHA must ensure that those standards are understood. Staffing, equipment, policies, and procedures must be in place to comply with the standards. Training must be provided as needed. Associates must be motivated through leadership to "buy into" compliance with the standards. Internal review and monitoring systems must be established to evaluate compliance. Finally, reasons for noncompliance must be investigated, and corrective steps must be taken to ensure future compliance.

Tools for Effective Management

In this section, some of the main tools of effective management are discussed. These tools provide the necessary means for planning, for converting plans into actions, and for day-to-day management of the facility.

Organizational Vision and Mission

How does the administrator, and for that matter the other members of the organization, know that a certain course is indeed the right direction for a nursing facility? Operating an organization without a clearly defined vision and mission is like navigating in the open seas without a compass. The vision and mission comprise an organization's guiding philosophy (Collins & Porras, 1998). In terms of focus, a vision is about the organization, whereas a mission is about key stakeholders—the customers, the community, and the associates.

The **vision** is a compelling picture of how an organization will look and function when its main objectives are achieved (Ciampa & Watkins, 1999). The purpose of a vision statement is to clarify what an organization should become and to provide a long-range direction to the organization. For example, a nursing home's vision may be to excel in the delivery of person-centered care by transforming its socio-residential environment, complying with all regulatory and ethical standards in the delivery of clinical services, and creating a thriving human environment for the residents and associates.

An organization's **mission** defines its basic purpose and enunciates why the organization exists. A nursing home's mission statement should incorporate its distinct competencies, its clients' needs, and its relationship to the community. The mission should emphasize the benefits that would accrue to residents and their families, the associates, and the community as the organization goes about the business of achieving its vision. **Exhibit 15–1** provides an example of a mission statement.

Exhibit 15–1 Example of a Mission Statement

We pledge uncompromising dedication to excellence in helping older adults grow in spirit, live with a sense of fulfillment, experience dignity, and meet the challenges of their changing lives.

We aspire to be consistent in the quality of our care, distinctive in our approach, and outstanding in performance and to provide leadership in the field of service to older adults.

We welcome others who will join us in pursuit of our mission.

Accomplishing the vision and mission is not just a managerial activity. Organizational purposes and direction must be widely shared within the organization. A turning point occurs when the associates begin to share the vision of what can be accomplished and to put their energies behind it (Ross et al., 2002, p. 49).

Organizational Values

The way in which the members of a facility collectively think about what they do—and how they relate to residents, families, and coworkers—is based on certain beliefs and assumptions. Individuals have personal beliefs and values, which guide their thinking and behaviors in various social settings, including work. Such individual beliefs and values are likely to permeate the workplace in a sort of conflicting network unless the NHA clearly defines and communicates the core values on which the facility will base all its decisions, judgments, and actions.

Values constitute principles and ideologies “held sacred” by an organization. Organizational values underscore the moral principles by which the organization will be governed as it goes about the business of realizing its vision and mission. Once the values have been defined and communicated, they are viewed by the stakeholders as standards that define the attitudes and philosophies according to which the members of the organization can be expected to behave. When values are clearly defined, communicated, and integrated into decision making and actions, over time they become the main driving force of an organization's culture. Following are examples of some of the relevant core values:

- *Respect*: How administration and associates are expected to treat coworkers, clients, and other stakeholders.
- *Honesty*: How administration and associates will conduct their affairs so that their ethics are beyond reproach.
- *Openness (or transparency)*: What information the stakeholders can expect facility administration to share with them.
- *Fairness*: How administration and associates will conduct their affairs to promote equality and justice.

- *Quality*: How quality is defined and how it will be incorporated into the services provided.
- *Economic gain*: Articulation of why profits are important and how profitability would accrue benefits for relevant stakeholders, such as better technology that would improve clinical care.

Organizational values also play a vital role in hiring key associates. Besides considering a potential jobseeker's qualifications and other desired characteristics, the jobseeker's values should match those of the facility. Dissonance occurs when employees' values are incompatible with those of the organization, and this mismatch creates cultural discord. A discord in values can eventually lead to dissatisfaction and turnover, which in turn create organizational instability (Singh & Schwab, 1998). Conversely, value congruence is positively associated with nursing home employees' job satisfaction and organizational commitment (Ren, 2013), and it positively affects employees' self-motivation so that it enhances their devotion to the organization's mission (Ren, 2010).

Business literature affirms that matching of values is a critical factor in achieving organizational success. For example, studies by Fernández and Hogan (2002) concluded that "the most effective CEOs were those whose values were most like those of the firm, rather than those who had the greatest knowledge of the firm's industry" (p. 26). The lesson here is that, when hiring NHAs, governing boards must take into account a candidate's core values besides their other qualifications. Similarly, candidates seeking NHA positions should try to discover the organization's values by asking appropriate questions during the job interview and should evaluate the organization's values against their own values to see whether a good match exists.

Decision Making and Problem Solving

Decisions are made by people at all levels in an organization, and decisions made at lower ranks are not necessarily less important than those made by the NHA. The main differences between decisions made by lower-level employees and those made by the NHA are in the quantity and complexity of decisions, in their strategic or tactical significance, and in the processes used for making them. Decisions at lower levels are routine and are often guided by established goals, rules, policies, and procedures that facilitate decision making. Routine problems are also better addressed by workers who are closest to their own areas of responsibility.

Decision making is commonly defined as choosing from among different alternatives. Problem solving also requires decision making, although not all decisions involve problem solving. The processes followed for setting objectives, for exploring different alternatives to achieve the objectives, and for selecting from among stated alternatives often involve a rather complex interplay of facts, opinions, judgments, and dissenting views, as well as consensus. These factors are carefully weighed to arrive at a decision. Often, input from others about possible alternatives as well as information and opinions provided by participants are valuable. An explanation of how and why a particular decision was made may help people understand that their thoughts and views were valued.

The NHA should always be aware that the decision-making process may be tainted with personal biases. Personal biases are not always easy to acknowledge. People's opinions and judgments incorporate biases that may emanate from their own value systems, past experiences, likes and dislikes, and emotions.

Intuition generally plays a role in decision making because few ideas are subject to factual analysis. Informed opinions and judgments must therefore be taken into account. On the other hand, data-driven decision making can help reevaluate old assumptions or challenge conventional wisdom. Certain decisions require analysis of facts, such as a careful recounting of events as they had occurred, official interpretation of a regulation, information on what competitors are doing, or data on the facility's financial performance. Sometimes, organizations must stray from the norms and look for the "wild card" when making decisions on key issues. The wild card is the instinct for the right time to act—or not to act—in spite of data that may indicate the contrary. Taking some risk and acting according to unconventional approaches can stimulate organizational innovation (Ross et al., 2002, p. 235).

The principal criterion for weighing alternatives is the consequences a particular course of action is likely to produce. Another key factor that must be considered while evaluating alternatives is the feasibility of implementation. Sometimes the best alternative has to be rejected because resources needed for its implementation are not available, or it may be too costly to implement, or it may not fit the time schedule for action.

Once a decision has been made, it must be implemented. Finally, its progress and outcomes must be evaluated to determine whether the desired objective is being reached. **Figure 15–4** presents a general model for decision making and problem solving. **Rational decision making**, as opposed to intuitive decision making, is a systematic process that begins with carefully evaluating the status of a given situation and articulating what is desired.

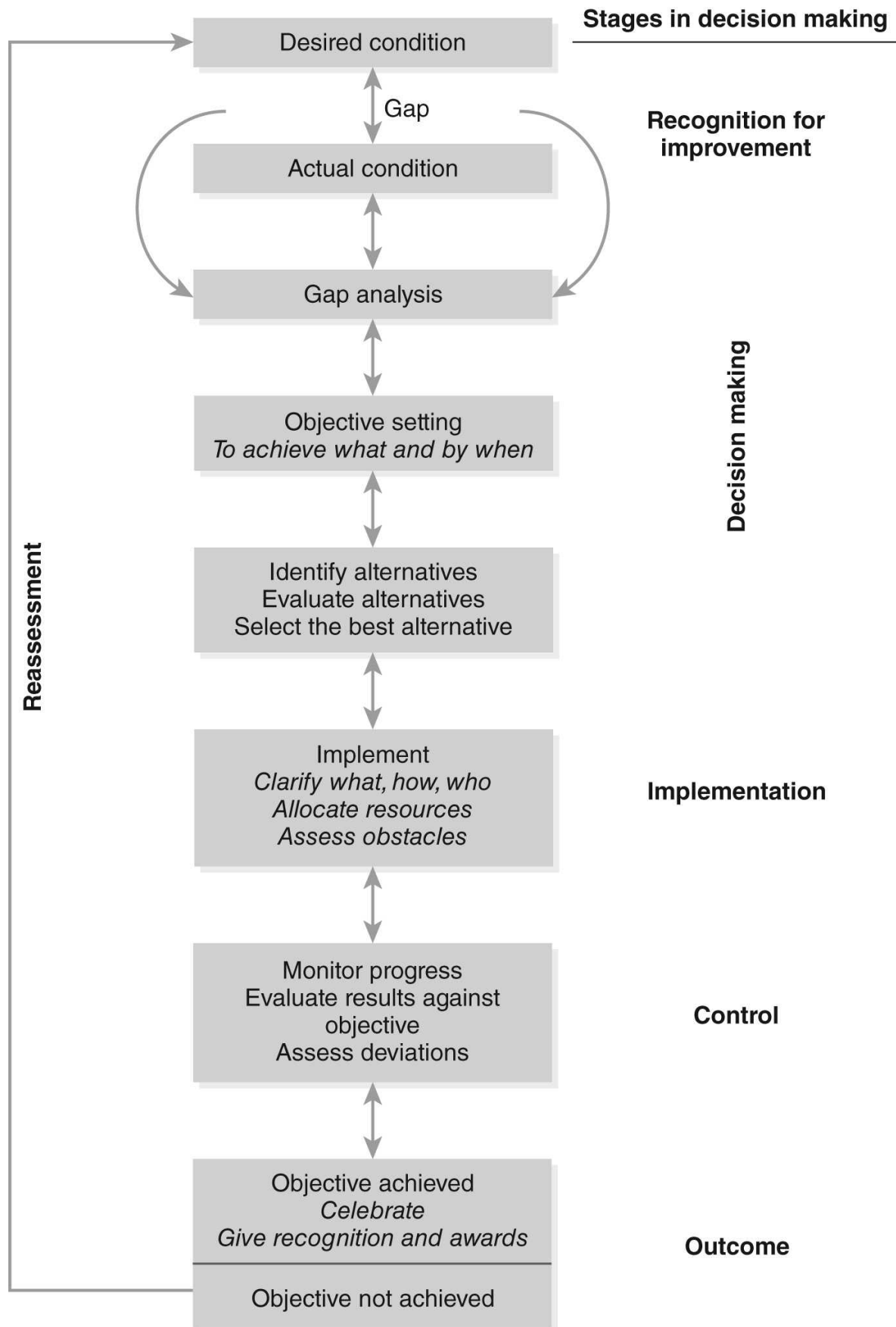


FIGURE 15-4 General model for rational decision making/problem solving

Implementation of the chosen alternative requires clarifying what steps will be taken and who will do what and deciding on how progress will be monitored. Managerial control is necessary to monitor progress, evaluate results against the objective, assess deviations, and take corrective action.

Effective Meetings

Meetings are an essential tool for management because they promote participation and personal interaction. Open-ended discussion of issues is often richer and more creative than isolated thought and action (Ware, 1992). Meetings can be a valuable tool when important information must be disseminated to people, particularly when personal interaction such as comments from people or gauging people's reactions are important to managers. Examples of when personal communication may be a better alternative than written memos include announcement of some change that may have a significant effect on others, achievement of a major goal by the facility, and reinforcing the organization's vision, mission, and values.

Meetings are also essential when input from others is considered vital for decision making or problem solving. Such meetings may be either for the purpose of information exchange or for actually making a group decision. Problem-solving meetings provide an opportunity to combine the knowledge and skills of several people at once, and participants are selected on the basis of their potential for contributions (Brody, 2000). Generally, information exchange and problem solving should not be combined in the same meeting (Ware, 1992). Other meetings may be routine. In such meetings, "keeping in touch" on a regular basis is valued by the participants. Department head meetings generally fall in this latter category, although they are also used for keeping members abreast of any changes, discussion of operational issues, information exchange, and problem solving.

Whenever people get together as a group, some socializing and casual exchanges occur naturally. Open-ended meetings often have a tendency to drift along almost endlessly without accomplishing much of anything. However, even informal meetings can be given a sense of direction by having an *agenda*, which may or may not be formally written. An agenda helps the NHA focus on the meeting's purpose, and it provides a plan that helps sort out relevant and irrelevant topics during the discussions. Another effective technique is to distribute ahead of time an annotated meeting agenda called a *docket*. A docket differs from an ordinary agenda in that the docket lists not only the items to be discussed but also provides pertinent explanations and details for each item. By saving time, a docket can be effectively used to cover a number of items in a short time (Brody, 2000). The participants can also place items for discussion on the agenda or the docket.

Every meeting with a clear purpose behind it needs some preparation, such as collecting relevant information. The NHA should also think about how the information will be communicated, whether it will be communicated verbally, on a flip chart or chalkboard, in a handout, or using a PowerPoint presentation. If information from other participants is needed, they should be notified ahead of time and advised as to what exactly they should bring to the meeting. At other times, participants may be asked to review certain materials before the meeting.

Before a meeting ends, clarifying what should happen next is important. All items requiring follow-up should be reviewed. If certain individuals have responsibility for following up on something, that responsibility should be clarified along with any time schedules by which certain actions ought to be taken. If a follow-up meeting is necessary, it should be scheduled then and there (Ware, 1992).

The administrator is also likely to be involved in meetings with external stakeholders. In such meetings, the NHA should keep in mind a clear purpose but be willing and open to new ideas and face reality, ask questions, and, if it is relevant, explain how the facility can deliver value or how a proposal can materialize into a win-win outcome for both the facility and the other party.

Conflict Management

Conflict is unpleasant, but it is an unavoidable aspect of an organization. Conflict is often dysfunctional to the organization, but it can also be functional if it stimulates innovation and adaptability. Conflict can be psychologically healthy for people when it enables them to vent frustrations in a constructive manner. According to modern organizational theory, too little conflict can lead to unhealthy conformance, poor decision making, and stagnation, whereas too much conflict can lead to uncooperative behavior, loss of productivity, turf battles, and sabotage.

An understanding of conflict can be used as a managerial tool to assess how strongly certain people may feel about an issue, to discern individual personalities and dispositions, to evaluate relationships among people, and to gauge territorialism and power struggles. Conflict may expose certain problems that may otherwise go unnoticed, such as a chronic shortage of supplies or equipment. An investigation may show that the current supplier frequently backlogs needed items or that the maintenance department is far behind in keeping up with repairs. Evaluating conflict may also help administrators understand their own leadership styles, which may prompt them to change the way they handle their interpersonal relationships.

Conflict resolution and administrative intervention become necessary when conflict may create disorder or pose a threat to the achievement of organizational goals. However, no one best way has been devised to manage interpersonal conflict. The NHA may be involved as an adversary, as would occur when a family member barges into the office very upset about some service-related issue. In other situations, the NHA may

act as a third party to mediate differences between two or more individuals, such as when an angry associate comes in all upset about a supervisor "playing favorites." In almost all situations, the NHA must keep strong personal feelings under control and remain objective.

Listening attentively is often the first step in resolving a conflict. The administrator must first understand the nature of the conflict and get perspectives from all sides. In many situations people are not expecting immediate action. Time taken for further investigation, fact gathering, and getting the "other side of the story" can result in better decisions when mediating conflicts between others. Also, when emotions are high, a "cooling off" period often gives time to reevaluate the situation from a fresh perspective. In other situations, accommodation or capitulation may make sense by giving one side what it wants, particularly when that side is right.

Other strategies for resolution of conflicts include negotiation, keeping the conflict controlled within certain boundaries, and constructive confrontation (Ware & Barnes, 1992):

- Negotiation can be used if a compromise is desirable. Negotiation can produce a win-win outcome, especially when the pursuit of opposing goals by the two sides would be counterproductive.
- Adversarial relationships may be controlled by separating two individuals, such as assigning the two adversaries to work on different units or on different shifts. If the two must work together because such a separation is not practical, control over their conflict ought to be exercised by adopting clear guidelines of behavior and following through with an impartial attitude.
- Constructive confrontation is a strategy that begins not with a confrontation but with an attempt by each party to explore and understand the other party's feelings and perceptions. As such, constructive confrontation may result in a new definition of what the problem was initially perceived to be, and it may forge new motives for seeking a common solution.

When the NHA is one of the parties involved in a conflict, he or she can retain control of a confrontational situation by focusing on the problem and issues and not engaging in personal attacks even when the other party may initiate such attacks. Depending on the nature of the conflict, the NHA may withdraw or remain neutral. Capitulation or "giving in" may also be a good idea if the NHA considers the issue of conflict to be relatively minor or when the other side has more power than the NHA does.

Relationship with Superiors

Management textbooks almost always ignore the important aspect of "managing the boss." In this context, the term *boss* may mean the governing board, the owner(s), or a corporate official. Managing the relationship with corporate officers becomes even more critical in large multifacility corporations in which the administrator is often distanced from the corporate office.

The boss-subordinate relationship is based on mutual dependence. The boss needs the administrator's help and cooperation, and the administrator needs the boss's help and support. According to suggestions by Gabarro and Kotter (1992), the corporate boss can play a critical role in linking the NHA to the rest of the organization; in making sure the NHA's priorities are consistent with organizational goals; in securing the resources the NHA needs to perform well; and in providing inside information about corporate thinking, culture, and values. Administrators should not adopt the attitude that they are self-sufficient, no matter how well qualified they may be in terms of education and experience.

The first step in managing the boss-subordinate relationship is to understand the boss's leadership style, strengths, weaknesses, preferred means of communication, priorities, and need for information about facility operations. Some bosses prefer to be more closely involved in the facility's operations than others. Such bosses may want the NHA to frequently touch base with them. Others do not want to be closely involved but would like to be kept apprised of important issues or changes. The NHA should also understand his or her own needs, strengths, weaknesses, and personal styles (Gabarro & Kotter, 1992).

The potential for friction often exists. The NHA may make a decision or proceed with some action only to be thwarted by his or her boss. Often, the reality is that bosses have their own pressures and concerns that are sometimes at odds with the wishes of the NHA. Depending on their own personalities and predispositions, some NHAs may become resentful (a counterdependent behavior) and at some point may even become openly rebellious; others may submissively comply (an overdependent behavior). In both instances, the NHA should try to provide more information than the parties in conflict have at the beginning. In some instances, the boss's mind may change. In other situations, a compromise may be reached. At the very least, the NHA may gain insights into the boss's thinking regardless of the outcome.

The second critical step for the NHA in managing the boss-subordinate relationship is to understand mutual expectations. The boss may not always be straightforward in expressing what his or her expectations are. Questions asked during face-to-face meetings may lend important clues about the boss's expectations. The NHA can pose questions such as: "Am I providing you all key information you need?" "Do you have any particular comments on this?" "How often should I do this?" "Do I need to check back with you on this?" "How important is this to you?"

Gabarro and Kotter (1992) suggested that managers often underestimate what their bosses need to know. Keeping the boss informed is an important rule to follow. Few things are more disabling to bosses than NHAs on whom they cannot depend or NHAs they cannot trust. Inconsistent behavior and unreliability can erode an NHA's credibility very quickly. Shading the truth a little or playing down problems and concerns is a bad idea. Such behavior can at some point create surprise problems, when the boss is likely to ask, "Why did you not tell me about this earlier?"

Finally, the NHA should discuss needs for help, guidance, and support with the boss. There should be open discussions about issues that could potentially turn into major concerns. It is alright for the NHA to acknowledge, "I really don't know how to address this. I need some help."

Risk Management

The health care environment, particularly the long-term care sector, has been characterized by an upsurge in litigation (Folk & Haciski, 2013). Regardless of the outcome, legal action against a facility is costly when the direct costs of defense, distraction from daily operations and care of residents, and the indirect costs from loss of reputation are factored in. Hence, risk management has become a critical domain of nursing home administration. **Risk management** means identifying, analyzing, and reducing or preventing risks (Becker, 2001). For an administrator, the primary focus of risk management is on risks affecting residents and their care, but a risk management program should also include potential risks to associates, contracted staff, visitors, and facility assets. An effective risk management program should be based on a three-pronged approach: Risk identification and reporting, risk analysis, and risk prevention.

Risk identification involves collecting information about all incidents. An **incident** is any unexpected negative occurrence involving a resident, associate, or visitor. Examples of incidents include adverse clinical outcomes, accidents involving anyone in the facility, errors in treatment, and complaints from residents or family members. Associates must be trained to report all incidents, no matter how small, to the appropriate supervisors. Supervisory personnel should receive training on how to document incidents. The language used in documentation should be accurate, objective, and factual; it should avoid opinions, confessions, or accusations. Inconsistent explanations or remarks to residents or families by different members of staff should be avoided. A trained person should be designated to handle questions from residents, family members, associates, and external parties (Becker, 2001). Honest, above-board conversations with the family can often result in greater understanding of a situation and have a calming effect once facts are properly communicated (Folk & Haciski, 2013). Potential as well as actual lawsuits should be reported to the facility's insurance carrier. Folk and Haciski (2013) recommend other insurance-related safeguards. Some of the risk can be transferred by leveraging another party's insurance. Certificates of insurance must be obtained for all contracted professional services, such as rehabilitation, beautician, and any other contracted services. The facility's existing liability insurance policy must also be reviewed to ensure adequate coverage.

Risk analysis requires a thorough investigation of all negative occurrences, no matter how small. The investigation should focus on what exactly happened and why. Documentation should include what was done in each situation.

Risk prevention begins with written policies, procedures, and practices. Such policies should address informed consent, handling of disruptive residents, resident transfers, restraint use, confidentiality, and other concerns discussed in previous chapters. Meticulously documenting resident care assessments, care plans, and progress notes is also essential. Plan of care for each resident must be followed exactly. Evidence-based practices should be formally adopted in the delivery of resident care. Ongoing training of the staff and monitoring the staff's work are necessary for compliance with established policies. Analysis of incidents should lead to corrective actions to prevent future incidents. Risk prevention also requires looking for early warning signs that may appear in security reports, quality improvement studies, licensure and certification inspections, and client complaints (Kavaler & Spiegel, 1997). Once warning signs are identified, action must be taken to prevent potential risks.

Terminology for Review

controlling
corporate compliance
decision making
docket
governance
governing body
incident
leadership
line relationship
management
mission
organizing
planning
productivity
rational decision making
risk management
situational model
staff relationship
unity of command
values
vision

For Further Thought

1. Achieving the right balance among what Drucker described as managing a business, managing work and workers, and managing the facility in community and society will vary from one facility to another. As the NHA of a nursing home, how would you decide which area should be given more emphasis than the others?
2. Critically evaluate the mission statement in [Exhibit 15–1](#).
3. You are the administrator of a skilled nursing facility. You open an envelope left in your mailbox and learn that your DON is resigning, giving you one month's notice. You have tried to persuade the DON to stay, but her decision is final. Employ the decision-making model in [Figure 15–1](#) to address this situation.

CASE

Fire the Facilities Manager?

John Faber is the facilities manager employed at a 240-bed nursing home for the past 3 years. Before John, the facility had one supervisor over both housekeeping and laundry and a separate maintenance supervisor. Hiring John to supervise all three departments resulted in an annual savings of \$7,000 in labor and materials. Prior to joining this facility, John was the maintenance supervisor at a 120-bed skilled care nursing home. Before that, he was a small business owner of a home cleaning service that employed six people. He sold that business 4 years ago. John's background also includes ownership of a coin laundromat that he disposed of several years ago.

It is time for the annual performance review for all associates. For department heads, the corporate office has authorized a wage increase of between 0% and 6% based on performance. As the administrator (NHA) mulls over John's performance during the past year, she is pleased with the ongoing cost savings and on-budget performance in facilities services. However, the NHA thinks that she has to hold John accountable for the citation in housekeeping during the certification survey just 2 months ago (rated as E on the Severity/Scope Grid—pattern indicating a potential for more than minimum harm). Last year also the facility had been cited for housekeeping (rated as H on the Severity/Scope Grid—occurrence of actual harm), and a resident who had tripped and fallen over a vacuum cleaner cord had sued the facility. Earlier this year, the corporation had settled the claim for \$20,000.

The corporate vice president of operations just called and suggested that John should be fired for his poor performance, but the NHA does not share the same view. Her response to the VP of operations was, "I would like to think it over and get back to you tomorrow." Now, the day has arrived for the NHA to have a phone conference with the VP of operations and a face-to-face meeting with John.

Questions

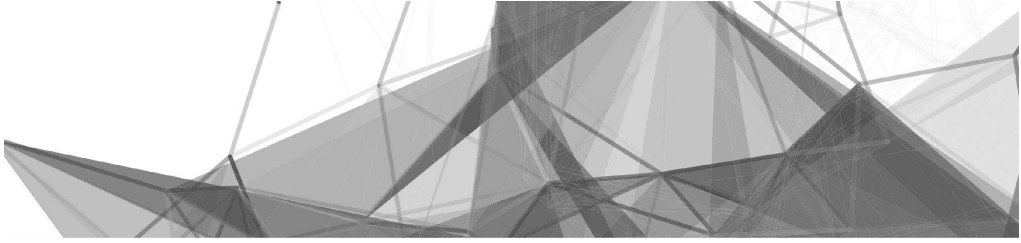
1. How should the NHA resolve the conflict with the vice president of operations? Provide adequate details, and incorporate in your response the leadership style you suggest using with John.
2. The NHA's decision is to not give John a wage increase, which leads to a disagreement between John and the NHA because he regards it as unfair. How should the NHA handle this conflict in which the objective should be to arrive at a win-win solution? Again, provide adequate details.

For Further Learning

You can take a 100-question test to understand your leadership potential.
http://www.queendom.com/tests/access_page/index.htm?idRegTest=702

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CHAPTER 16

Effective Human Resource Management

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WHAT YOU WILL LEARN

- Human resource management deals with the planning for human resource needs, recruitment, selection, compensation, development, evaluation, handling of grievances, and labor relations.
- Long-term care facilities face human resource challenges, such as employment laws and regulations, labor competition, and workforce diversity.
- Staffing levels in nursing, as recommended by the Centers for Medicare and Medicaid Services, are associated with quality outcomes and five-star nursing home ratings.
- To confront staff shortages, creative approaches for recruitment are necessary.
- A multipronged approach is necessary to confront absenteeism, presenteeism, and turnover.
- Staff development should extend beyond providing training and knowledge in job skills. Performance appraisal should focus primarily on staff development.
- Self-managed work teams can improve job performance, workers' self-esteem, and job satisfaction. They also result in less burnout and turnover.
- Problems related to performance and work-related behaviors should be addressed through counseling and disciplining. Dismissal is used as a final step in a progressive disciplining approach.
- The National Labor Relations Board has established procedures for workers to unionize. Management should guard against certain well-defined unfair labor practices. Good-faith bargaining, contract administration, and dealing with strikes and picketing are aspects of managing unionized facilities.
- Employment laws give various types of rights to today's workers. Violation of any of these laws amounts to discrimination.

Introduction

To function effectively, an organization must rely on three main resources: human, financial, and material. *Human resource* refers to the associates employed by the organization. It is the people in the organization who manage and use the other resources to serve the organization's clients. Hence, a nursing facility's staff is its most important asset. An organization with a superior workforce undeniably gains a competitive advantage in the marketplace.

A skilled, motivated, and committed workforce creates value for the organization. The main objective of leadership is to harness this value and deploy it to provide high-quality care to the residents and to realize cost efficiencies while doing so. Leadership and management are crucial for influencing and shaping human behaviors through training and development, fair compensation, grievance practices, performance appraisal, termination practices, and other employment policies.

Human Resource Management

Human resource management can be defined as the organizational function of planning for human resource needs, recruitment, selection, compensation, development, evaluation, and handling of grievances and labor relations (Boone & Kurtz, 1984). It is also known by other terms, such as “personnel management” or “employee relations.” Large nursing homes generally have a designated position, such as a human resource director, to handle human resource functions, or the responsibility is assigned to the assistant administrator. In most facilities, however, the nursing home administrator (NHA) assumes these responsibilities. In facilities affiliated with a hospital or a multifacility chain, the NHA receives some human resource support from the corporate office. Some human resource responsibilities may be delegated to the nursing department, especially the responsibility for hiring and training licensed nurses and certified nursing assistants (CNAs). Other department heads who supervise employees—such as the food service director, business office manager, and activity director—also have some degree of latitude in hiring, evaluating, training, and disciplining staff members.

Goals, Main Functions, and Challenges

Human Resource Goals

The primary goal of human resource management is to maintain desired staffing levels by having a well-qualified and stable workforce. Other human resource functions dovetail into this overarching goal. Griffith (1995) proposed that success in attracting and retaining employees tends to be self-sustaining; organizations with a satisfied and well-qualified staff are able to attract capable and enthusiastic people.

Human Resource Functions

De Cenzo and Robbins (1996) classified human resource management into four main functions:

- *Staffing*: Recruitment of qualified associates, planning staffing levels in accordance with resident needs, and scheduling to maintain adequate staffing while taking into account associates' needs for time off
- *Training and development*: Orientation of newly hired associates, ongoing coaching and mentoring by senior associates and supervisors, formal training to maintain and advance skill levels, and developing associates for career advancement
- *Motivation*: Addressing the issues of job performance, job satisfaction, and labor relations
- *Maintenance function*: Building employee commitment, reducing absenteeism and turnover, and retaining productive associates

Many associates in the nursing home come into frequent contact with residents, family members, and visitors, so associates have an unusual degree of influence over these stakeholders. "What they say and do for patients and visitors will have more influence on competitive standing than any media campaign the organization might contemplate" (Griffith, 1995, p. 662). Research shows a relationship between resident care outcomes and resident satisfaction and worker job satisfaction and employee retention rates (Boakye-Dankwa et al., 2017).

Human Resource Challenges

Managing human resources is a complex task. First, complex labor laws and regulatory mandates govern almost every aspect of human resource management. A second challenge comes from labor competition. Most nursing home associates are CNAs, housekeepers, laundry workers, and dietary aides. To recruit these associates, long-term care facilities compete against fast-food restaurants, discount stores, hotels, motels, and hospitals. Local hospitals and other health care organizations also present substantial competition for skilled workers such as nurses, social workers, and therapists. Such skilled workers often prefer to work for hospitals and for other agencies in which pay, benefits, and opportunities for training and career growth are better than in nursing facilities.

A third challenge is gender based. Nursing home workers are predominantly female, which requires a particular sensitivity on the part of a facility's administration to the needs of female associates because their needs are often intertwined with those of their families.

A fourth challenge is driven by diversity. In most regions of the country, the workforce is becoming more diverse because of an increasing proportion of minority workers. Diversity presents special challenges because various cultural characteristics—such as language, customs, and beliefs—affect how workers relate to residents, family members, fellow employees, and supervisors. Miscommunication and misunderstandings can have negative consequences for residents.

Human Resource Planning

In the human resource context, the planning function can be defined as the process of systematically reviewing staffing requirements to ensure that the desired number of associates with the required skills is available when needed (Mondy & Noe, 1993). NHAs must also be cognizant of the investment returns in human resources. Research shows that survey deficiencies related to quality of care can be improved most by increasing registered nurses (RNs) and social service staff (Bowblis & Roberts, 2020). In several studies, higher RN staffing levels have been shown to positively affect a number of quality measures, such as fewer pressure ulcers, decreased infections, and lower restraint use (Harrington et al., 2020). Quality of life deficiencies can be improved most by increasing social service and activities staff (Bowblis & Roberts, 2020).

Staffing Levels

The biggest staffing challenge lies in the nursing department. The necessity for adequate staff hours for a given resident volume makes intuitive sense; however, skill mix is even more important. **Skill mix** refers to the ratio of licensed nurses hours to total nursing staff hours. Research shows that simply adding more staff is not a sufficient means of improving quality of care; improving the skill mix is necessary (Castle & Engberg, 2008). Federal regulations require nursing facilities to have sufficient nursing staff with the appropriate competencies, on a 24-hour basis, to deliver services that ensure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population (federal regulation F725).

Research sponsored by the Centers for Medicare and Medicaid Services (CMS) provides guidelines for adequate staffing in nursing. In 2001, the CMS recommended slightly different staffing levels for short-stay and long-stay residents (**Table 16-1**). The hours per resident day are threshold staffing levels below which facilities are likely to have quality issues. Although quality improved with increments in staffing up to these thresholds, no significant improvements in quality were observed for staffing levels above these thresholds (Feuerberg, 2001).

Daily staffing hours = Threshold hours per resident day × Number of resident

TABLE 16-1 Threshold Staffing Levels, 2001

	Long-Stay Residents (90+ Days) Hours/Resident Day	Short-Stay Residents Hours/Resident Day
RN	0.75	0.55
Licensed practical (vocational) nurses (LPN/LVN)	0.55	0.60
CNA	2.80	2.40
Total nursing hours per resident day	4.10	3.55

Data from Feuerberg, M. (2001). *Appropriateness of minimum nurse staffing ratios in nursing homes*. Report to Congress: Phase II Final. Centers for Medicare and Medicaid Services.

https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf.

Daily staffing hours = Threshold hours per resident day × Number of resident

For 2019, the CMS further refined its staffing guidelines for the purpose of assigning star ratings on Nursing Home Compare,¹ without regard to short or long stay. If a nursing home has at least 7 total days of no RN time within a quarter, CMS automatically downgrades such facility's staffing star rating to 1 Star (Office of Inspector General, 2020). Star rating staffing thresholds are given in **Table 16-2**.

TABLE 16-2 Star Rating Staffing Thresholds (Hours per Resident Day)

	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
RN	<0.32	0.32–0.51	0.51–0.73	0.73–1.05	≥1.05
Total nursing	<3.11	3.11–3.58	3.58–4.04	4.04–4.41	≥4.41

Note: Figures have been rounded to the 100th decimal place.

Data from the CMS. Nursing Home Compare Technical Users Guide April 2019.

Daily staffing hours must be balanced among the day, evening, and night shifts. There is generally little variation in assigning licensed nursing staff hours to the nursing units. For CNAs, the traditional staffing distribution in which the ratio of the number of residents per CNA is 8:1 on day shift, 10:1 on evening shift, and 20:1 on night shift (resulting in an equivalent of 2.2 hours of CNA staffing per resident day and well below the threshold levels given in [Table 16–1](#)) results in long waits for service and the inconsistent implementation of care even under conditions when staff are working at unrealistically high productivity levels (Feuerberg, [2001](#)). Apart from the need to rebalance the hours on different shifts, specialized care units, such as dementia care units, need higher staffing than the thresholds provided by the CMS.

Scheduling

Scheduling can be viewed as the final step in human resource planning. Associates in each staff category are assigned to fill the time slots on the various shifts for all 7 days of the week. Scheduling should take into account four main factors:

- All slots in the schedule must be filled, which depends on having a sufficient number of full-time and part-time associates on the payroll.
- Requests for personal time off for holidays and vacations must be scheduled.
- Even when all the slots in the schedule are filled, actual shortages in staffing occur because of absenteeism, which is a substantial problem in many nursing homes. Shortages in staffing also occur when people leave their positions without giving advance notice or when the facility is unable to fill vacant positions. Unplanned absenteeism and turnover call for scheduling additional staff beyond what a full schedule calls for. On occasion, this approach will result in overstaffing, but more frequently, it will offset shortages arising from severe absenteeism or turnover. From an economic perspective, the additional net costs of overstaffing, if any, should be relatively small because such scheduling would reduce overtime costs and the use of temporary staffing agencies. The payoffs of extra scheduling are high in terms of consistency, quality of care, and staff satisfaction. For example, use of agency staff compromises quality of care (Castle & Anderson, [2011](#)).

Necessary hours for training and orientation should be incorporated in the schedule.

¹ Results of certification surveys and other quality measures pertaining to individual facilities are public information. The CMS provides web-accessible information on all Medicare and Medicaid certified facilities through Nursing Home Compare.

Staff Recruitment and Compensation

Creative Recruiting

In many labor markets, the long-term care industry faces staff shortages because the demand for qualified staff members is greater than the supply. Some actions that may help nursing homes overcome such imbalances include creative recruiting, compensation incentives, and training programs (Caruth & Handlogten, 1997). Recruitment and retention often go hand in hand; both can be enhanced by having a well-designed student nurse training program, family friendly policies, and a learning environment that values and nurtures its staff (Chenoweth et al., 2010). Creativity also involves a more effective use of recruitment resources that already exist. For example, a facility's current associates, local schools and colleges, churches, neighborhood newspapers, and the local employment agency can be effective resources for staff recruitment. Other creative approaches may include a job fair or open house at the facility, where current associates are available to explain various job opportunities.

Nursing assistant certification programs are organized by many facilities to attract candidates who otherwise would be unemployable for lack of marketable skills. Other avenues for training include tuition assistance and continuing education for promising associates and financial assistance and scholarships for students currently enrolled in nursing programs. Such direct investments in training, consistently undertaken over time, can help alleviate future staff shortages by providing a steady stream of qualified workers.

Compensation

Compensation should match market rates of pay. Paying a high premium over market rates can trigger a bidding war, which can raise hiring salaries to artificially high levels and can send ripple effects throughout the organization or through the local long-term care industry. Hence, during periods of critical shortages, many organizations use sign-on bonuses, because they can be discontinued at any time without creating negative economic effects for the rest of the organization. Other forms of nonmonetary rewards can appeal to many people. Four-day work weeks, flexible working hours, and on-site child care are attractive incentives for female workers (Caruth & Handlogten, 1997). Market rates of pay apply mainly to starting wages. Once employees are on the job, additional perks can be used to reward them for personal development, job performance, and supplementary responsibilities.

Staff Licensure, Certification, and Registration

Recruiting RNs, LPNs/LVNs, and CNAs requires compliance with regulatory mandates. RNs and LPNs must be licensed by the state in which they wish to practice. The nursing facility must verify current licensure status of all its RNs and LPNs and must maintain a copy of the license in each employee's personnel record. Similar documentation must be maintained for all other licensed associates—such as therapists and therapy assistants—regardless of whether these workers are directly employed by the facility or are contracted through an agency.

CNAs must have current certification, which is earned through a state's standardized nurse aide training and competency evaluation program as mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA-87). The objective of this mandate is to establish minimum qualifications for CNAs and to evaluate whether a person possesses basic competencies to work as a CNA in a long-term care facility. Even though CNAs are not required to have a state license, the effect of this legislation is the same as if there were such a requirement. CNA training programs are offered by nursing facilities, community colleges, and the American Red Cross. Certification is conferred by the state's nurse aide registry after an applicant passes an examination. Noncertified nurse aides employed in permanent positions have a 4-month window during which they must receive the required training and receive certification. Laws in many states also require criminal background checks and drug testing when nursing personnel are hired.

A [nurse aide registry](#) is a registration system for CNAs that all 50 states and the District of Columbia maintain. The registries enable facilities to verify the certification status of a nurse aide. The registry also provides information on resident abuse, neglect, or misappropriation of personal property in which an aide may have been involved. Before employing a CNA, a facility is required to contact the registries in all states in which the individual is believed to have worked.

Managing Absenteeism and Turnover

Absenteeism and turnover are twin problems. Lower rates of absenteeism, for instance, are associated with higher seniority on the job (Cohen-Mansfield & Rosenthal, 1989). Both absenteeism and turnover are associated with quality issues. For example, high staff turnover is associated with resident maltreatment and mental and physical neglect (Ben Natan & Ariela, 2010). Similarly, high levels of absenteeism have a negative impact on quality of care (Castle & Ferguson-Rome, 2014). Turnover of both licensed nurses and CNAs is associated with higher survey deficiencies, indicating quality lapses (Lerner et al., 2014). Furthermore, for improving quality of care, staff turnover is even more important than staffing levels and skill mix (Trinkoff et al., 2013).

Effectively managed facilities measure absenteeism and turnover rates on a regular basis. These measures are useful in projecting future staffing needs. They help management gauge the outcomes of any new programs or policies and also provide an ongoing proxy for staff satisfaction. Adverse trends, for example, may indicate the presence of underlying human resource problems that need probing and investigation.

Absenteeism

Some absenteeism occurs for legitimate reasons, such as sickness. Much of it, however, is associated with apathy, low morale, and a low sense of self-worth among the workers.

Measuring Absenteeism

Maintaining records on individual absenteeism is essential; so is keeping track of absenteeism rates for the purpose of staff planning and scheduling, as mentioned earlier. Absenteeism rates are calculated as follows:

$$\text{Absenteeism rate (\%)} = \frac{\text{Number of workdays missed per time period}}{\text{Average number of employees} \times \text{Number of workdays in the same time period}} \times 100$$

Managing Absenteeism

Absenteeism is managed by having written policies, which should include a distinction between what the facility considers an excused absence and an unexcused absence. Policies should also specify what level of absenteeism is considered excessive and the consequences associates will bear when their absenteeism is excessive. Absenteeism should be addressed both individually and for the organization as a whole. At an individual level, a counseling session should be held between the employee and the supervisor to seek out the underlying problems and determine how management may be able to assist the employee to overcome those problems. Additional key areas discussed in the next section can also help minimize absenteeism.

A related issue is **presenteeism**—coming to work despite illness or unsuitability to work. There is some evidence that frequent presenteeism may lead to subsequent long-term absenteeism (Hansen & Andersen, 2009). Directly or indirectly, presenteeism accounts for 60%–75% of lost productivity for an organization (Burton et al., 2005). Presenteeism is also believed to have a greater impact than absenteeism on the quality of care (Letvak & Ruhm, 2010). Hence, nurse managers should address presenteeism by taking sick workers off the schedule and suggesting ways to help them.

Turnover and Retention

Most nursing homes have a relatively small core of very stable and dedicated associates. But most facilities are also plagued by enormous rates of turnover, which generally exceed those in other industries. For example, the 12-month turnover rate may be close to 60% for nursing assistants, and 36%–37% for licensed

nurses (Donoghue & Castle, 2009). Hence, staff turnover remains one of the most daunting problems for the nursing home industry.

Turnover and retention are flip sides of the same coin—that is, increased staff retention translates into lower rates of turnover. Research has consistently demonstrated that job commitment and intent to stay are strong predictors of actual future turnover.

Measuring Turnover and Its Costs

Turnover in a facility can be calculated by using the following formula, which can be applied to a particular position, or to the entire organization:

$$\text{Turnover rate (\%)} = \frac{\text{Number of separations per time period}^*}{\text{Average number of employees during the same period}} \times 100$$

* Any period can be used, but a year is the most common. However, keeping track of turnover for each month or for each quarter can help administrators better understand the trends.

$$\text{Functional turnover rate (\%)} = \frac{\text{Number of separations of employees who would not be rehired}}{\text{Average number of employees}} \times 100$$

$$\text{Dysfunctional turnover rate (\%)} = \frac{\text{Number of separations of employees who would be rehired}}{\text{Average number of employees}} \times 100$$

Turnover is expensive. Costs directly associated with turnover include recruitment costs, training costs for the new worker, and additional staffing while the new employee is being trained. A rough estimate of these direct costs is two to three times the monthly salary of the departing employee (Sherman et al., [1998](#)). Additional indirect costs include overtime paid to cover vacant positions, temporary staffing agency fees, management time used to find replacements, low productivity before employees quit, low morale among associates created by high turnover, and costs associated with deterioration of the quality of services.

Managing Turnover

No single approach exists for increasing staff retention, and piecemeal efforts to address the issue have produced little success. The main reason for a lack of success is that isolated strategies have been used as “band-aid” measures (Riggs & Rantz, [2001](#)), instead of a multipronged, comprehensive approach that requires coordinated support from governing boards, administrators, and key department heads.

Leadership Stability

Unfortunately, with few exceptions, turnover permeates the typical facility from top to bottom. At the industry level, turnover among NHAs has been estimated to be at least 40%, with the median length of employment at a facility just over 2 years (Singh & Schwab, [1998](#)). Turnover of NHAs and directors of nursing tends to precipitate turnover among caregivers (Berridge et al., [2020](#); Kennedy et al., [2020](#)). Similarly, in the nursing department, it has been demonstrated that turnover among RNs is linked to turnover among CNAs (Brannon et al., [2002](#)). Hence, stability of key leadership positions should be pursued as a major goal. NHA turnover is a governance issue that the boards must address.

Selection, Orientation, and Mentoring

From the administrator’s standpoint, attention to recruitment practices may be the first step in reducing staff turnover. Many people who apply for jobs in nursing homes do indeed have a desire to help the elderly, but they soon become discouraged and disenchanted. As a result, much of the turnover in health care facilities occurs within the first 90 days of employment. Lescoe-Long ([2000](#)) cited two main reasons for this phenomenon:

1. The job turns out to be different from what the employee had expected it to be; perhaps the job was made to appear more glamorous than it truly is.
2. Employees feel abandoned after the first few days of employment, and they lack skills to cope with many of the demands of the new job.

The first of these two reasons points to the need for a more in-depth selection process, in which the facility should try to explore the potential employee’s expectations in relation to the realities of what the job entails. The second reason underscores the importance of developing coping skills. Technical training, such as a nurse aide certification program, focuses mainly on how to perform certain job-related functions correctly. Even though such training is essential, it does not prepare workers to handle nonroutine and stressful situations. For example, unexpected verbal or physical abuse from a resident or sudden criticism from a family member can leave the employee bewildered and overwhelmed. A new job that already places heavy emphasis on meeting quality expectations often becomes frustrating when the employee must face unexpected situations but does not know how to deal with those situations. It is also demoralizing for associates when they have to face consistent staffing shortages, and even presenteeism, and pick up the slack. Such experiences leave the associates feeling disillusioned, powerless, and incompetent.

To overcome early burnout among new associates, a peer mentoring program can be instituted by identifying, training, and rewarding experienced CNAs who are committed to helping new caregivers “learn the ropes.” Besides helping retain new associates, such a program cultivates teamwork and enhances understanding of roles and expectations (Hoffman, [2001](#)). Research also shows that decentralized decision making and empowerment of work teams improve performance, promote job satisfaction, and may reduce absenteeism and turnover (Yeatts & Cready, [2007](#); Kim et al., [2014](#)).

Peer mentoring is also labeled the “buddy system”; it makes peer resources available to help new associates fit in and to handle frustration during the most critical period of employment. The new associate generally starts in such a program by observing and following the “buddy,” an experienced CNA. The new associate then starts working independently while still in frequent contact with the buddy, and the new associate receives ongoing support from the buddy.

A buddy’s duties should be clearly outlined. These duties can include explaining how to use the organization’s systems, such as developmental resources and personnel resources. A variation of the buddy system can be used in the preselection process: a job candidate is given the opportunity to spend time informally with a current employee so that the candidate can find out firsthand what the job actually entails (“Buddy system can lower turnover, raise morale,” [2002](#)).

Positive Supervision

Bishop et al. ([2008](#)) demonstrated that an important factor that promoted job commitment was the CNAs’ perception that their nurse supervisors were respectful and helpful and provided useful feedback. Other aspects of supportive supervision from RNs and LPNs—such as providing fair treatment, paying prompt attention to CNAs’ concerns, giving clear instructions, and disciplining nonperformers—are associated with increased job satisfaction and retention (Choi & Johantgen, [2012](#)).

Staff Input into Decisions

In a study that included 2,900 nursing homes, Donoghue and Castle ([2009](#)) found that low turnover rates for nurses and CNAs were associated with the greatest degree of input from the staff in decision making and yet put some rational limits on the extent to which such inputs are used in decision making. In the resident-

centered care model, for example, staff are given adequate latitude to make decisions about caregiving. Implied in this approach is flexibility and a nonpunitive approach to errors. Future creativity and willingness to participate are reduced when a punitive approach is taken (Riggs & Rantz, [2001](#)).

Social Support

An atmosphere of social support and a sense of belonging are highly conducive to staff retention. Social exchange theory suggests that a caring and supportive social system within the nursing home will produce improved staff satisfaction, commitment to the organization, and consequently, improved staff retention (Riggs & Rantz, [2001](#)).

The philosophy of social support can be reinforced by policies and practices that promote the workers' ability to meet their own family obligations. Examples include flexible scheduling, and employee benefits such as child-care and health insurance coverage.

Working Conditions

Work environments must be made safer and both worker- and resident-friendly by adopting the concepts of enriched environments and culture change. Evidence also suggests that nursing homes that improve their quality may have a positive impact on job satisfaction of associates and thereby reduce their turnover rates (Castle et al., [2006](#)). Compliance with the Occupational Safety and Health Administration (OSHA) standards is a regulatory requirement. Nursing homes must go beyond these regulations and invest in labor-saving and safety technology. Cross-training and adoption of the self-managed work team approach (discussed later) can also bring about a better worker environment and build their self-esteem.

Training

Research shows that the federal guideline requiring 75 hours of nurse aide training is not sufficient to prepare CNAs to deliver adequate levels of care. Studies have also found that inadequate training is one contributing factor that leads to high turnover of CNAs. Subsequent research based on nurse aide training programs in 10 states has suggested that the length of training should be at least 100 to 120 hours, of which 50 to 60 hours should be devoted to clinical training (Hernández-Medina et al., [2006](#)). In the Green House model of culture change, for example, CNAs receive 120 hours of additional training after they become certified.

Career Paths and Opportunities

Opportunities for advancement promote job commitment (Bishop et al., [2008](#)). Similarly, personal opportunity to be involved in work-related issues and prospects of professional growth are significantly related to both overall job satisfaction and turnover among CNAs (Parsons et al., [2003](#)). Managers should make an effort to learn about each individual's needs and goals. On the basis of the findings, career paths can be created for growth-oriented individuals. Some employees may be recognized for their skills in training others and groomed for becoming peer mentors. Others may be able to provide insights into process improvement, such as safety enhancement, disaster planning, or quality improvement. In nursing facilities, which typically have few opportunities for career growth, employee contribution to self-development and achievement must also be rewarded. Hoffman ([2001](#)) observed that increased compensation by itself would not slow turnover but that increased compensation tied to professional development can be very effective in promoting self-worth and thus slowing turnover.

Administrative Support

Other ways to reduce turnover include supporting the staff with adequate resources, such as staffing, supplies, and equipment. Chronic resource shortages and unreasonably heavy workloads promote the feeling that management does not care. Employees do not feel that they ought to be the ones to pay the price for inadequate resources in the form of frustration and stress. In multifacility chains, NHAs often assign blame to the corporate office and try to portray the governing body as the villain in the eyes of the staff. In most instances, however, governing bodies remain unconvinced with a mere request for additional resources; they want data and analysis to justify the need for additional resources. The point here is that the ultimate responsibility for resource allocation remains largely with the NHA, but the governing board also must develop a more realistic understanding of the challenges of resident care.

Pay and Benefits

In research findings, frontline workers such as CNAs almost always state that their ability to care for residents is what is most important to them and that it keeps them coming back day after day. However, this does not imply that pay and benefits are not important (Bishop et al., [2008](#)). In fact, compensation may be a factor CNAs are least satisfied with when compared with other factors such as job content, training, and coworkers (Castle, [2007](#)).

Staff Development

Staff development typically means training associates to enhance their knowledge and expertise. Enhanced knowledge and expertise of a workforce play a critical role in building internal organizational strengths that a facility needs in a competitive environment. However, staff development must go beyond improving technical skills. The overarching goal of staff development should be to make associates productive citizens of the organization and of society. Approaching staff development from this broad perspective can pay rich dividends in better quality, improved morale, higher commitment, and greater retention.

Training should also help assimilate the workers into the organization's culture through a clear understanding of the organization's vision, mission, and values. New associates in particular should receive appropriate training in the facility's rules, policies, and procedures. Training should also include other key areas, such as resident relations, family relations, teamwork, stress management, conflict resolution, work safety, and quality management. Finally, training should help people become responsible citizens of society. This last element may not appear at first to be work related, but it is. Associates who act responsibly in their social and home lives are also likely to be responsible and committed at work. Administrators know all too well that associates' personal problems frequently become work problems. Nursing home associates predominantly come from low socioeconomic backgrounds. Many have low self-esteem and lack the skills they need to address social and personal conflicts. For many associates, balancing their home lives with the demands of the job is a daily struggle. Money management, family budgeting, problem solving, child care, nutrition, and wellness are only a few areas in which most associates can benefit from training.

Performance Appraisal

Instead of being a judgmental and punitive tool, the performance appraisal process should focus primarily on staff development. Achieving this objective requires the participation of both the associate and the supervisor who does the evaluation. Performance appraisal is a part of [management by objectives \(MBO\)](#). Simply put, MBO is based on a joint agreement between supervisors and associates on what specific and measurable objectives will be accomplished over a given time. At the end of that time period, the supervisors evaluate individual associates according to whether they have accomplished these objectives (Bounds & Woods, 1998). However, when employee performance is viewed from the lens of staff development, performance becomes a shared responsibility of supervisors and their subordinates. Both must be jointly held accountable for improving performance.

Performance appraisal should result in a personal development plan that helps supervisors in tailoring training and education programs according to the needs of the staff. An evaluation of skills and competencies should also identify staff members with the abilities for certain clinical and leadership positions in which they would become trainers and mentors for others (Brown, 2008). Rewards are linked to participation in training, evidence of personal development, and objective measures of performance.

Self-Managed Work Teams

In self-managed work teams (SMWTs)—also called self-directed work teams—a group of associates, the “team,” are together responsible for performing a range of tasks that include scheduling, planning, and monitoring the team’s performance. The use of SMWTs in traditional nursing homes is rare. However, in the emerging models of care that reflect culture change, such teams play a pivotal role. The Green House model, for example, relies on cross-trained, SMWTs that are responsible for providing all basic and routine services to all elders. The teams are also responsible for certain support services, such as housekeeping, in each Green House. In this model, the typical supervisor–subordinate relationships are minimized.

All members of SMWTs are CNAs. These CNAs routinely work together to perform all daily tasks, and they routinely depend on each other to get the tasks accomplished and to make management decisions related to their work (Yeatts & Seward, 2000). As shifts change, the teams engage in information sharing and coordination for continuity of care. Team members also decide who would serve which residents and what specific services should be provided to each resident (Yeatts & Seward, 2000). Teams generally hold a scheduled “sit-down” meeting once per week for approximately 30 minutes, and impromptu “stand-up” meetings as needed. The latter are used to address any immediate concerns. The weekly scheduled meetings typically follow a set agenda and mainly include discussion of work procedures and review of residents’ condition and needs. Issues to be addressed may be brought up by the team members themselves or by the nurses. The teams provide weekly written notes that include their suggestions and concerns to nursing management. In turn, members of nursing management review the notes and provide written feedback (Yeatts et al., 2004).

The effectiveness of SMWTs depends on how well the program is implemented. Yeatts and Hyten (1998) recommend paying attention to several general rules that are important for SMWTs to function effectively:

- *Establish a team charter.* The purpose of the team charter is to clarify the team’s overall purpose and to establish some ground rules for making decisions. The rules are established with substantial input from team members as well as supervisors.
- *Goals and priorities.* These are established by team members with support from management. The goals should be clear, challenging, and measurable.
- *Work responsibilities and training.* SMWTs are able to match the team members’ talents and preferences to the tasks to be performed. This type of matching results in a more specific allocation of responsibilities for individual team members and allows for accountability. The matching process also helps identify the specific areas in which further training is necessary. For example, the entire team may need training in decision making, or a particular team member may need training in carrying out routine maintenance rehabilitation therapies.
- *Team leader.* The teams determine who will be the team leader. Team leaders rotate within each group as other team members are given the opportunity to take on the role of a team leader. Some teams may require all members to rotate; others include only those who are interested in the position.
- *Work procedures and problems.* Team members identify the most appropriate procedures and find effective solutions to work-related problems. By monitoring their own performance against measurable goals, SMWTs tend to take ownership of any performance problems and take action to improve performance.

Because SMWTs are given the authority to make all or most decisions related to their work, the process results in an enriched work environment and staff empowerment (Yeatts & Hyten, 1998, p. 17). The quality of services is positively affected when team members are able to discuss resident desires and needs among themselves (Yeatts & Seward, 2000). Communication links between employees and supervisors are kept open. When midlevel managers, such as unit charge nurses, are receptive to advice and input from CNAs and involve them in care planning and group problem solving, turnover rates are reduced (Banaszak-Holl & Himes, 1996). Worker empowerment has been found to increase job performance factors such as effective work procedures, resident care processes, and support for other team members. Among CNAs, SMWTs also produce higher levels of self-esteem, less burnout, and greater satisfaction with their jobs and schedules. These CNAs also indicate fewer intentions to leave their jobs (Cready et al., 2008).

Counseling, Disciplining, and Terminating

The three steps discussed in this section are progressive and sequential and are undertaken when problems surface in conjunction with associate performance and work-related behaviors. Subsequent steps in the disciplinary process become unnecessary when performance or behaviors improve. But the probability of salvaging an associate becomes increasingly small as the process continues (**Figure 16-1**).

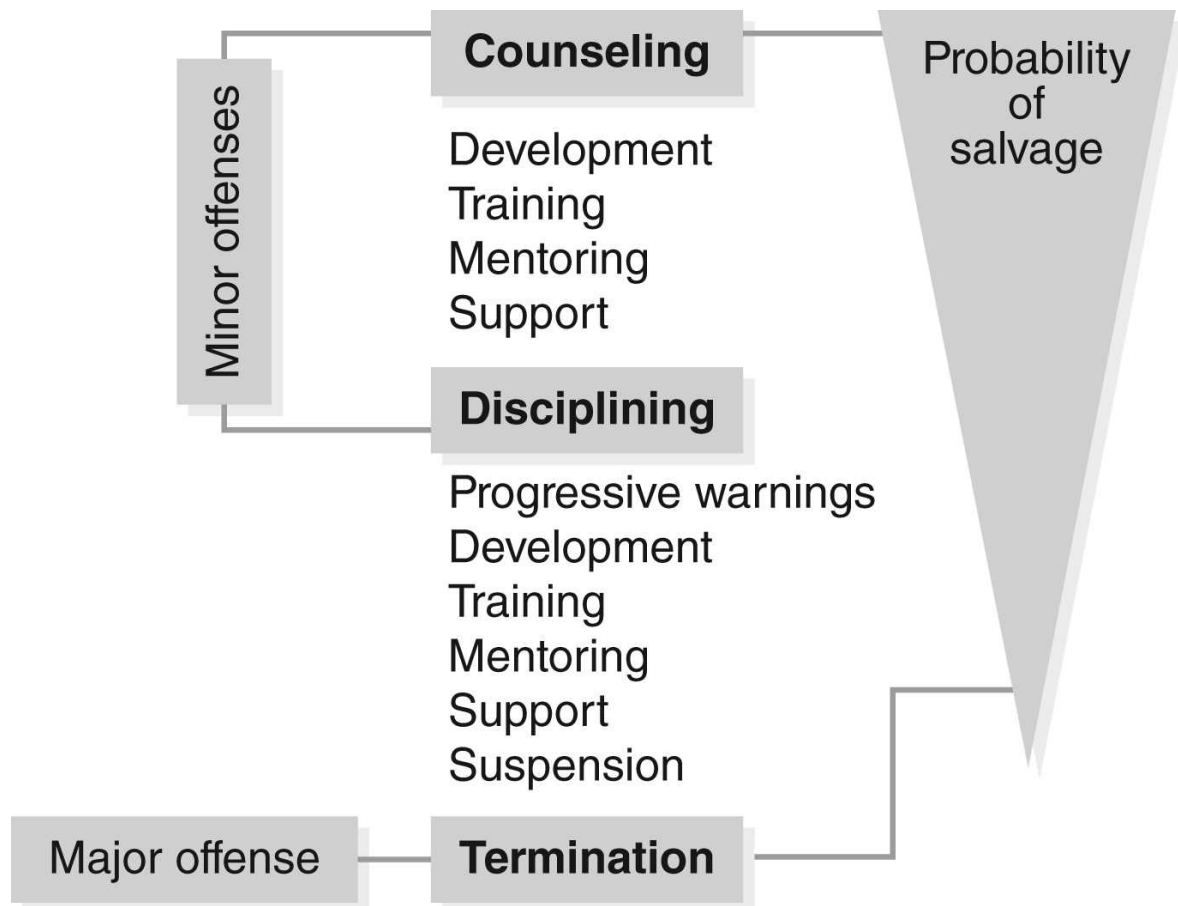


Figure 16-1 Progressive corrective steps and the probability of salvage

Counseling

Counseling, which encompasses elements of coaching, entails an informal discussion between the associate and the supervisor when an associate needs to make improvement. Almost all associates at one point or another require some type of counseling. Counseling is a mild form of attention-getter that is devoid of threats to an individual's sense of job security. Expressions such as, "I have been through this myself," or "It is not uncommon for new associates to face this," or "It generally takes some time to get this right, but let's keep working at it," or "It can be serious, so let's focus on this some more" are commonly used by trained supervisors to address issues realistically and constructively and yet address those issues in a context that puts the associate at ease. Even though some "hand-holding" may be involved, the goal of counseling is to help associates "take responsibility for and manage their own decision-making" (Bolton, 1997, p. 212). However, at this stage, the manager must identify the need for further development and training and find ways to provide those for the associate. Achieving these goals in a nonthreatening way requires tact and skill on the part of the manager.

Disciplining

A facility's staff development efforts can be regarded as successful when most associates employ self-discipline by adhering to rules and standards of acceptable behavior. But a few associates will not take on the responsibility of self-discipline. Such associates will require some form of extrinsic disciplinary action (De Cenzo & Robbins, 1996).

Disciplining involves a more formal approach to work-related problems than counseling. Management's right to discipline others first assumes that the managers themselves have exercised self-discipline and have set the right example for their staff. Starting with the administrator, the department heads and nursing supervisors should set an example before they can expect the associates to engage in positive behaviors. Otherwise, disciplining becomes hypocritical, and associates can see through any double standards.

Common disciplinary problems identified by managers can be classified into four categories: (1) attendance and tardiness problems, (2) dishonesty, (3) substandard work performance, and (4) behavioral problems such as violation of rules (Sherman et al., 1998). Failure to take disciplinary action only compounds a problem that eventually has to be dealt with. By then, inaction will have already done some damage to group morale. Inaction also implies that behaviors and work performance have been acceptable.

Fairness should be the primary guiding principle in any type of disciplinary action. Fairness requires that managers take into consideration some key factors to guide their decisions (De Cenzo & Robbins, 1996):

- *Seriousness of the problem.* For example, dishonesty is more serious than occasional tardiness.
- *Duration and frequency.* For example, repeat offenses are more serious than a first occurrence. Discipline should take into account the associate's past work record.
- *Extenuating circumstances.* For example, a car breaking down on the way to work may be a legitimate excuse for tardiness or absence.
- *Orientation, training, and counseling.* For example, the extent to which an associate may have received assistance in adapting to the organization should be reviewed before that associate is disciplined. Disciplining should also be used as an opportunity to assess the need for additional training.
- *Associate's viewpoint.* Before any action is taken, the associate must be given the opportunity to explain his or her position. The associate may not have been aware of the existence of a particular rule. In some situations, an investigation may be necessary to determine whether the associate was at fault. For example, an associate may have failed to give a scheduled shower to a resident because of the family's request to wait another day so the resident could have a shower just before her birthday celebration.
- *Privacy.* All discussions and actions pertaining to disciplining should be carried out in private. In effective management practices, humiliating someone in front of other people is never acceptable.

Once disciplinary action is deemed necessary, the approach to disciplining should be positive. A positive approach requires emphasis on the corrective, rather than punitive, nature of disciplinary action. This emphasis does not mean, however, that punishment can never be a part of disciplinary action. It means that punishment may be employed with the objective of correcting behavior; otherwise, it may lead to adversarial relationships between associates and their supervisors. Sherman et al. (1998) suggested that in **positive disciplining**, the total responsibility for correcting a problem is placed on the associate. Although the supervisor and the associate engage in joint discussion and problem solving, nothing is imposed by management; all solutions and affirmations are jointly reached.

As a matter of general practice, disciplining should be progressive. Progressive action may be bypassed only for the most serious offenses. Progressive discipline evolves verbal and written warnings, suspension without pay, and dismissal. Written warnings should document facts that identify the problem and what corrective action the associate needs to take within a specified period.

To keep the system fair and balanced, facility administrators should consider instituting an appeals system to resolve any disagreements between associates and supervisors over disciplinary matters. An appeals system that is likely to be most trusted by associates consists of a committee composed of an equal number of worker representatives and management staff. A small committee of no more than four to six members is recommended. The committee renders decisions, either upholding or rescinding a particular disciplinary action, based on reviewing facility policies, examining the evidence, and separately hearing the supervisor and the associate (McCabe, 1988).

Terminating Employment

Terminating employment is the final step in progressive discipline when all efforts and opportunities fail to bring about the desired behavior. If progressive discipline is followed, the associate's personnel record should have adequate documentation supporting the decision to terminate employment. At times, however, dismissal becomes necessary for a serious one-time offense, such as theft, resident abuse, deliberate destruction of facility property, or using alcohol or illegal drugs on the premises.

Regardless of how serious the offense, dismissing an associate on the spot, or proclaiming, "You are fired," is never a good idea. Such an action often raises questions about objectivity and perceived fairness. The associate may disagree with an allegation, and yet management may not want the associate to continue on the job while serious questions remain unanswered, as would be the case if management believed an associate abused a resident. The answer to such a dilemma is found in placing the associate on suspension

pending further investigation. The associate is told that he or she is being taken off the schedule and will be notified of a decision as soon as an investigation has been completed. If the associate is called back to work, reinstatement is with full back pay. If a decision is made to dismiss the associate, a letter notifying the associate of the decision is sent by certified mail. In all disciplinary actions, including dismissal, the associate should be treated with courtesy.

Labor Relations and Unionization

The National Labor Relations Act (NLRA) of 1935, also known as the Wagner Act, gave workers the right to organize and join unions without fear of retribution from their employers. The law specifically defined certain conduct as unfair labor practices. The NLRA also required employers to bargain in good faith with a union representing the workers. The National Labor Relations Board (NLRB) was established under the NLRA. Headquartered in Washington, D.C., the NLRB has 26 regional offices. The NLRB has the authority to conduct union recognition elections and to investigate complaints of unfair labor practices. Since 1974, employees of nonprofit health care institutions, who were previously prevented from joining unions, have been extended the same rights as employees in other private businesses.

Collective Representation

Unionization is a collective choice of an organization's employees, who have the collective right to join a union, and they also have the collective right not to join a union. If a union is voted in, however, it then has the exclusive right to represent all the employees in a given bargaining unit, which covers categories of employees a union can legitimately represent.

Employees seek union representation mainly because of their ongoing dissatisfaction with employment conditions and their belief that a union would be effective in alleviating at least some of those negative conditions. The main working conditions employees seek to improve include wages, benefits, and perceived unfair treatment from management. In the final analysis, employees who seek to form a union feel powerless to change things that are important to them. They hope to achieve those results through collective representation. Hence, preventive action through effective leadership and sound human resource practices are the administrator's best defenses against unionization.

Union Organizing Campaign

Once employees decide to unionize and contact between a small group of employees and union leaders is established, an organizing campaign begins: Union leaders hold employee meetings away from the nursing home premises, and informal leaders among the employees try to persuade their coworkers to sign authorization cards. Signing an [authorization card](#) is deemed to indicate the employee's willingness to join the union. In reality, however, peer pressure often plays a role. Some employees sign the card just to get a coworker "off their backs." For the NLRB to hold an election, at least 30% of the employees in the proposed bargaining unit must sign the authorization cards. As a matter of practice, however, unions seek a much higher number because, to win, the union must get more than 50% of the votes in a secret-ballot election.

Before an election, the NLRB determines the makeup of the [bargaining unit](#), which is a distinct group of employees who have common employment interests and who may reasonably be grouped together for the purpose of collective bargaining. For example, all nonsupervisory personnel—CNAs, cooks, dietary helpers and aides, activity assistants, housekeepers, etc.—are generally part of the same bargaining unit. Licensed nurses and other personnel may be exempt only if they routinely exercise some supervisory authority, such as giving work assignments, evaluating performance, and disciplining, etc.

During the campaign, union organizers can meet with employees to promote unionization. Unions are also teaming up with residents and their families over staffing issues (Palthe & Deshpande, [2003](#)). Management has the right to hold meetings with employees and inform them why they should not join the union. Management's information must be factual. For example, management can inform workers how much the union dues cost; it can share information on the union's past practices, such as strikes, etc. Management representatives also have the right to express their opinions but should not engage in deliberate misrepresentation. The facility's administration, for instance, can make appeals in an effort to convince the associates that joining the union would not be in their best interest. Typical appeals include the following (Bounds & Woods, [1998](#)):

- The union can make promises, but it cannot guarantee that it would succeed in delivering on those promises.
- Wages are already good and equal to or better than what the union could negotiate. If the union is voted in, wages and benefits will become negotiable. They may go down, stay the same, or increase.
- Union dues and other costs, such as loss of wages during a strike, outweigh the benefits of belonging to a union.
- The union is an outsider, not really attuned to associates' best interests.
- Associates may have to strike even when they do not want to.

In making such appeals, managers must be careful that they do not engage in any [unfair labor practices](#). These are actions declared as illegal under the National Labor Relations Act. Engaging in unfair labor practices during a unionization campaign carries grave risks. For instance, the union may petition the NLRB to set aside the election and enforce recognition of the union. Unfair labor practices are categorized into four areas:

1. *Promise*. The union can make promises, but management cannot. For example, management cannot promise employees pay increases, better benefits, or other types of rewards if the employees would not join the union. The administrator should, however, continue to follow any preestablished wage increase programs.
2. *Threaten*. Management cannot make any type of threats. For example, it is illegal to state that the facility will close down if the union is voted in or that health insurance benefits will have to be curtailed. Intimidating employees with discipline or discharge is also an unfair labor practice. However, supervisors have the right to take any reasonable action to prevent employee solicitation at work stations and during work time. Employees, on the other hand, are free to engage in union solicitation in a break room during break or lunch time.
3. *Interrogate*. Supervisors cannot ask employees about how they intend to vote, about their past union affiliation, or about what may have been discussed at the union meetings. On the other hand, if an employee volunteers information to a supervisor, listening is not illegal. It is only illegal for a supervisor to solicit information.
4. *Spy*. It is illegal for management to spy on union meetings or other activities related to the unionization campaign.

Collective Bargaining

Once a union has been certified to represent employees, labor laws mandate that both the union and management negotiate in good faith, a process called [collective bargaining](#). Bargaining in good faith means that both parties must engage in a genuine process to reach an agreement, even though reaching an agreement cannot be guaranteed. When an agreement is reached, it must be ratified by a majority vote of the employees in the bargaining unit, and the union has to sway the employees into accepting the terms of the contract. The contract specifies the terms and conditions of employment for the workers affected by it. Some typical areas covered under a contract include duration of the contract, description of the bargaining unit, wages, benefits, work rules, rights of management, jurisdiction of various jobs, and grievance procedures. Typically, a contract is negotiated for a 3-year term. Every contract must be renegotiated at the end of the period it covers.

Union Contract Administration

Once a union contract has been ratified, the administrator is responsible for ensuring that all supervisors understand its terms. It is important to emphasize the management's rights, which typically include the right to allocate and use resources in a way management sees fit; to give work assignments; to hire, discipline, and dismiss employees; and to formulate policies and procedures.

Grievance resolution is an important element of any collective bargaining agreement. "A [grievance](#) is a formal expression of employee dissatisfaction about some job situation" (Bounds & Woods, 1998, p. 413). The union may also protest the way that management has interpreted and enforced certain provisions of the contract. Bringing a complaint to an employee's immediate supervisor is the first step in any grievance procedure. Many grievances can be effectively handled at this level, provided the supervisors are trained in handling grievances.

If the complaint is not resolved, the employee takes the complaint to the union steward. A [union steward](#) is a unionized employee who works at the facility and officially represents the union to his or her fellow unionized employees at the workplace. Stewards can employ a lot of discretion in handling grievances and can often be more effective than the employee in getting problems resolved by being more objective. If a grievance is not resolved at this level, a union official meets with the administrator in an effort to reach a compromise. If the issue cannot be resolved in this way, it is submitted to arbitration, a costly process that both parties try to avoid. [Arbitration](#) is a process in which a neutral third party—generally, but not necessarily, a retired judge or attorney who is recognized by a court jurisdiction or is associated with an arbitration service—hears both sides and renders a decision that is binding on both parties (Bounds & Woods, 1998).

Strikes and Picketing

Work stoppage as a concerted effort by unionized employees is called a [strike](#). The law requires unions to give a 10-day notice to a nursing facility before calling on the employees to go on a strike. The purpose of this requirement is to allow health care facilities to make plans for continuity of patient care. Striking employees often patrol the perimeter of the facility displaying placards that call attention to the labor dispute they have with management. This concerted action is called [picketing](#).

An [economic strike](#) is the most common type of strike. It occurs when the union and management fail to reach an agreement; that is, an [impasse](#) occurs in the negotiations. Management has the right to hire replacement workers during an economic strike. Striking employees can be replaced either temporarily or permanently. Reinstatement of an employee may occur when a striker makes an offer to return to work with no conditions attached. Reinstatement is not automatic after the strike is over, but preference is given to those who wish to return to work as job vacancies occur.

As a general rule, striking and picketing are not to interfere with the management's right to provide resident care. For instance, picketers may not prevent nonstriking workers and supervisors from entering the facility or obstruct trucks delivering essential supplies and food to the facility. Legal remedies are available for dealing with violent strikes and picketing.

Employment Laws

The purpose of employment laws is to protect the rights of individuals in an employment relationship, which mainly includes hiring, wages, benefits, promotion, and discharge. Hence, many of the legal requirements discussed here are loosely referred to as *antidiscrimination laws*. These laws are based on the theory that employment practices should be governed by criteria that are job related; management's employment decisions should not be based on personal characteristics that have little to do with an individual's ability to do the job. **Employment discrimination** is generally defined as discriminatory action in failing or refusing to hire; in discharging or otherwise discriminating against an individual with respect to terms, conditions, or privileges of employment; or in limiting, segregating, or classifying employees in a way that deprives an individual of employment opportunity, training, advancement, or status.

Employment-at-Will

Employment laws provide for exceptions to a longstanding legal doctrine called employment-at-will. Historically, the **employment-at-will** doctrine has asserted that employment is at the will of both the employer and the employee and that either party may terminate the employment relationship at any time for any reason or for no reason, except when the termination violates a contract or a law. As described previously in this chapter, however, sound human resource practices incorporate an implied covenant of good faith and fair treatment. Hence, employee manuals and handbooks should outline the broad conditions under which an associate can be terminated "for cause," and the disciplinary procedure that would be followed. Statements to this effect in a personnel handbook could be viewed as a binding commitment by the employer (Gely et al., 2016).

Equal Employment Opportunity

Title VII of the Civil Rights Act of 1964 prohibits discrimination on account of race, color, religion, sex, or national origin in any term, condition, or privilege of employment. The Civil Rights Act of 1991 provided for increased financial damages against organizations found guilty of discriminatory practices. The Equal Employment Opportunity Commission (EEOC) has the authority to enforce the various antidiscrimination laws discussed in this section and to conduct investigations when complaints of discrimination are brought before this agency.

Pregnancy Discrimination

The Pregnancy Discrimination Act of 1978 came about as an amendment to Title VII of the Civil Rights Act of 1964. The law describes pregnancy as a disability and requires management to regard an employee's pregnancy as any other medical condition. Accordingly, it makes it illegal to deny sick leave or family medical leave for a pregnancy-related condition. The law also prohibits discrimination against pregnant women in hiring, promotion, or dismissal, provided that they are able to perform the job.

Age Discrimination

The Age Discrimination in Employment Act (ADEA) was passed in 1967. This act prohibits discrimination in any aspect of employment against persons 40 years and older. The law does not afford protection to people below the age of 40.

Equal Pay

The Equal Pay Act of 1963 addresses the issue of wage disparities based on gender. Simply stated, the law requires that men and women be given equal pay when both perform equal work in the same establishment. Wages between men and women in the same jobs may differ on the basis of factors such as qualifications, seniority, and job performance, but not on the basis of gender alone. Generally, male and female CNAs or licensed nurses perform similar work and should be paid according to the same wage scale.

Protecting the Disabled

The Americans with Disabilities Act (ADA) of 1990 protects disabled workers against discrimination. The law defines a *disabled employee* as one who has a physical or mental impairment that substantially limits one or more major life activities, who has a record of such impairment, or who is regarded as having such impairment. A variety of conditions can be classified as disabilities, including hearing loss, emotional illness, heart disease, cancer, and acquired immune deficiency syndrome (AIDS). The ADA Amendments Act of 2008 requires a broad interpretation of the term *disability* to include impairments that substantially limit a major life activity.

The ADA requires employers to make reasonable accommodation for disabled persons unless such accommodation presents undue hardship. [Reasonable accommodation](#) includes altering facilities and the work environment, job restructuring so that the disabled employee is able to perform the essential functions of the job and altering or eliminating nonessential aspects of a job. In some situations, it does not matter whether or not the facility's job description calls a function an essential function of the job duties. For example, the job description may state that lifting patients is an essential requirement of an RN's job duties. Under the ADA, however, lifting patients will not be considered an essential function if RNs spend just a few minutes per day repositioning or lifting patients.

Generally, the employee has to request the accommodation unless the disability is obvious. An oral request is considered sufficient. The employer can ask for supporting medical information related to the disability.

Alcohol or Drug Abuse

The ADA protects current and past alcoholics. For example, the ADA requires an employer to accommodate a qualified applicant or employee with past or present substantial limitations relating to alcoholism if this person can competently perform the job and can comply with uniformly applied workplace rules that prohibit employees from drinking alcohol at work or being under the influence of alcohol at work. Accommodation, for example, would require the employer to grant time off to seek treatment for the alcoholism. As a safeguard, workplace rules must clearly define essential job functions; attendance and punctuality are viewed as essential job functions. Hence, an alcoholic must comply with the facility's absenteeism and tardiness policy that applies to all employees. The employer can discipline an alcoholic for poor work performance or infringement of other work rules just the same as any other employee can be disciplined.

The law protects past drug abusers, but not those who currently use illegal drugs. Someone who currently engages in the illegal use of drugs is not considered disabled. Accordingly, he or she may be denied employment, disciplined, or fired on the basis of the current illegal use of drugs. The ADA protects those who have been successfully rehabilitated, or those currently participating in a rehabilitation program and are not using illegal drugs.

Alcohol and Drug Testing

Employers in the private sector, that is, nongovernment sector, have the freedom to screen employees for drug use. However, state laws often differ. For example, some states require employers to have a written drug testing policy. Many states allow drug testing only for certain occupations or under certain circumstances. Hence, nursing facilities should have a written policy that complies with the state law. Under the ADA, which is a federal law, an alcohol test cannot be given to job applicants before they are hired. Subsequently, an alcohol test may be given only if the employer has a reasonable belief based on objective evidence that an employee has been drinking on the job or is under the influence of alcohol. Even without such evidence, an employer may require random alcohol testing of an employee who has undergone alcohol rehabilitation and is employed in a position that may pose safety risks. Such a policy would apply to most nursing home employees.

Medical Exams

Prior to an offer of employment, the ADA prohibits all disability-related inquiries and medical exams, even if they are related to the job. After an applicant is given a conditional job offer, but before starting work, an employer may make disability-related inquiries and conduct medical exams as long as it does so for all entering employees in the same job category. After employment, an employer may make disability-related inquiries and require medical exams only if they are job-related and consistent with business necessity (Ong, 2018). Recently, the Eighth Circuit Court of Appeals confirmed that an employer in the health care field may require that employees undergo health assessments/screenings or receive mandatory vaccinations² in order to ensure employee and patient safety by decreasing the risk of communicable disease exposure and transmission (Sues, 2019).

Family and Medical Leave

The Family and Medical Leave Act (FMLA) of 1993 allows employees 12 weeks of unpaid leave in a 12-month period for qualified reasons. Qualified reasons include birth of a child, care of a child up to 12 months of age, adoption or foster care for a child, care of a spouse or care of a parent with a serious health condition, or the employee's own serious health condition that prevents the employee from performing the essential functions of the job. For example, under FMLA, an employee may be given unpaid medical leave to seek treatment for alcoholism. To be eligible, the employee must have completed at least 1 year of employment and worked for the employer for at least 1,250 hours. The law requires that after this unpaid leave, the employee be allowed to return to his or her original position or an equivalent position with the same terms of pay, benefits, and working conditions that the employee had before taking FMLA leave.

Harassment

In a general sense, harassment at work occurs in the context of what is termed a [hostile environment](#) in which behaviors of managers or coworkers create severe stress that interferes with an individual's ability to perform his or her job. The Civil Rights Act of 1991 amended Title VII of the Civil Rights Act of 1964 to specifically include unlawful harassment on the basis of gender, religion, national origin, race, and disability (Sherman et al., [1998](#)). Even though sexual harassment has received a lot of attention, harassment may also take other forms based on the categories protected under Title VII. In determining harassment, it may sometimes be difficult to decide what may or may not be hostile or offensive. Employee complaints may be one clue to whether something is offensive. Note that harassment may not necessarily come from supervisors. An employee may be harassed by coworkers, visitors, salespeople, or clients. Questions that are likely to arise in any litigation over harassment may include whether management knew about the problem (or should have known about it) and if anything was done to stop it.

² At the time of this writing, it was not clear whether the COVID-19 vaccine, which was authorized by the U.S. Food and Drug Administration for emergency use and was not formally approved, could be mandated by employers. Pending court cases will have to settle this issue.

Terminology for Review

arbitration
authorization card
bargaining unit
collective bargaining
economic strike
employment-at-will
employment discrimination
grievance
hostile environment
human resource management
impasse
management by objectives (MBO)
nurse aide registry
picketing
positive disciplining
presenteeism
reasonable accommodation
self-managed work teams (SMWT)
skill mix
strike
unfair labor practices
union steward

For Further Thought

Many experts believe that implementing SMWTs in nursing homes is not easy. What do you think may be some necessary elements for implementing SMWTs? What main problems might a nursing home administrator encounter when implementing SMWTs?

CASE

Staff Cutbacks

Contributed by Cindy K. Manjounes, MHA, EdD, Lindenwood University.

Hometown Gardens was built in the 1950s as a traditional 100-bed skilled nursing facility. The facility used to be owned and managed by a husband/wife team, but 10 years ago the couple gifted it to their two sons. Located in a small town of 50,000, bordering a large metropolitan area, the nursing home used to remain full because of its excellent reputation in the community. Even at a ratio of 60% Medicaid to 40% private-pay occupancy, the business had been very profitable. More recently, however, the census had taken a downturn.

Two years ago, the brothers decided to make some strategic moves: (1) make the facility 100% private pay because of the growing regulatory burden and cuts in Medicaid reimbursement, (2) modify the facility's mission to serve a growing number of clients in need of assisted living, and (3) adopt some of the concepts of culture change in the facility's physical aspects as well as delivery of services. After evaluating the demand for long-term care, the owners borrowed funds to undertake some major structural modifications and improvements, which are scheduled to be fully operational in about 3 months.

One of the wings originally had 40 double-occupancy beds that were converted to 15 single-occupancy skilled-nursing facility (SNF) beds. In the future, these beds could be easily converted to assisted living, if needed. The remaining double-occupancy rooms on this wing were converted into a spacious lounge/activity room and a household-style kitchen and dining room. The other 60-bed unit was converted to 14 studio apartments and 8 one-bedroom apartments for assisted living. Plans for this section include household-style kitchen/dining and lounge/activity areas along with a small library.

The facility gradually reduced its staffing from 80 full-time equivalent (FTE) to 50 FTE, not counting administrative and clerical personnel. Johanna, the facility's executive director, did some staffing calculations and estimated that the facility should operate with 35 FTEs to cover nursing, housekeeping/laundry, dietary, maintenance, and activity/social services when the entire facility is operating at 100% census. At present, the SNF section is full, with remodeling fully completed. The assisted living section has 12 residents (55% occupancy). Johanna thinks that it could take up to 1 year to fill the apartments after the renovations have been completed.

With just 3 months left to complete the renovations, Johanna has felt some urgency to start laying off some people. Rumors of staff cutbacks are already flying. On Monday morning, Johanna sees an anonymous note taped to her office door, which says, "In this bad economy any cutbacks will give us no choice but to unionize."

Questions

1. What factors should Johanna keep in mind when making decisions to eliminate positions? How should she go about making the cuts?
2. Should the threat of unionization deter the executive director from making staffing cuts? Why or why not?
3. Would you address the rumors and the note you received about unionization? If so how?
4. Millie is a 52-year-old CNA who has worked at the facility for the past 25 years. Johanna knows that Millie will not hesitate to update her on union activity. Should Johanna use Millie as a confidante? Explain.

For Further Learning

The Equal Employment Opportunity Commission (EEOC).

<http://www.eeoc.gov/>

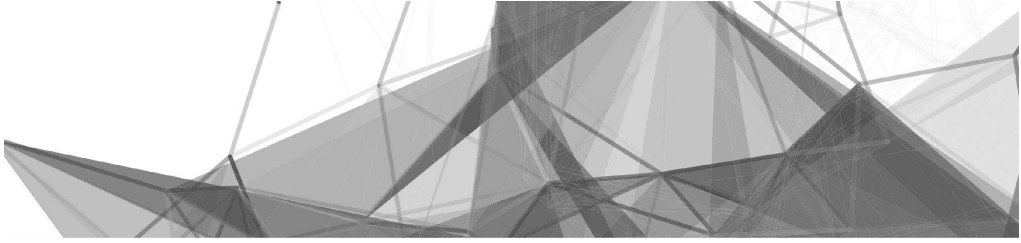
The National Labor Relations Board (NLRB).

<https://www.nlr.gov/>

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CHAPTER 17

Effective Marketing Management

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WHAT YOU WILL LEARN

- Marketing involves a comprehensive approach that can give a nursing facility long-range competitive advantages.
- Creation of exchanges based on value, and understanding how customers evaluate value, are at the heart of marketing.
- Marketing must focus on the needs and wants of customers and how best to satisfy them.
- Depending on the size and nature of the long-term care market, segmentation can help identify the target market from which the nursing facility will draw customers.
- Market targeting depends on the characteristics of the segments and the facility's competencies.
- Semantic differential can help management focus its efforts on improving the facility's position in the target market.
- The marketing mix provides the tools necessary for positioning a facility in the target market. Product, price, place, and promotion have numerous applications that are specific to long-term care.
- Most nursing facilities can be differentiated in one form or another to create a perception of value.
- The preadmission inquiry process is about personal selling but using a social services approach. The facility's entire staff must be trained in customer relations.
- A variety of promotion and public relations tools can be used in nursing home marketing.

Introduction

Effective marketing distinctively places a facility's offerings before consumers. Marketing is often neglected by nursing home administrators (NHAs), because many NHAs fall victim to what can be called the "word-of-mouth syndrome." Word of mouth is not a marketing strategy, yet its hidden potential can be unleashed through marketing. Facilities that use a marketing strategy can, in time, gain a clear-cut competitive advantage over facilities that do not.

Because of a fairly widespread misunderstanding of what marketing is, it remains, for many health care facilities, nothing more than a "buzz" word, and some well-intentioned NHAs merely undertake a few haphazard steps and call it marketing. Some random "marketing" efforts are frequently undertaken when new competitors enter the market and an existing nursing facility has an increasing number of empty beds that become more and more difficult to fill. In a state of panic, NHAs may launch an advertising campaign, start renovating the facility, or plan a facility open house. Such haphazard efforts may produce temporary results, but they often fail to change the long-range outlook.

Marketing is often equated with customer service, advertising, selling, or community relations. These activities are merely some of the action components of marketing, which is much broader in scope. Marketing incorporates a comprehensive approach that calls for developing a plan, carrying out that plan, and taking corrective action as necessary. Marketing must also permeate all aspects of a facility's operations. Marketing is not a quick fix for a major census decline. Marketing involves consistent effort.

This chapter elaborates on business marketing principles and applies them to the nursing home context.

Marketing: A Value-Driven Process

The American Marketing Association has furnished one of the most widely accepted definitions of marketing: “**Marketing** is the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational goals” (Bennett, 1995). In a general sense, the marketing process—its planning and execution—is undertaken with the goal of creating exchanges between two or more parties in which each party gives something of value to the other party or parties in the exchange. All parties in the exchange perceive benefits from entering into the exchange.

From the nursing home’s perspective, all parties in the exchange must be viewed as key stakeholders or customers. For example, the nursing home provides services to its residents, but the decision to select a nursing home is made by their relatives; the recommendation to admit the resident to a nursing facility is often made by a physician; some physicians devote a significant part of their practice to nursing home care; and discharge planners (case managers) at a hospital suggest the names of two or three nursing homes to the resident’s family. Thus, the resident’s family, physicians, and hospitals become the nursing home’s customers.

The term **value** signifies the worth that is perceived by each party in an exchange. Family members search for a facility that will provide the “best” care and relieve them of caregiving burdens and anxiety. They often have time constraints—only a day or two (Shugarman & Brown, 2006)—to select a nursing home. The physicians who treat residents in nursing homes look for a level of quality that they can depend on when placing their own patients in a nursing facility. They expect staff stability and a staff that is well-trained in carrying out physicians’ orders, timely communications, and nursing support when they see residents in the facility. As part of the value-based payment model, hospitals now operate under Medicare’s Hospital Readmissions Reduction Program (HRRP) in which penalties are assessed for readmissions to the hospital subsequent to discharge. Adequate staffing, high-quality care in skilled nursing facilities (SNFs), and care coordination between the hospital and SNF can help prevent readmissions back to the hospitals. On the flip side, SNFs also receive financial incentives or incur penalties under Medicare’s value-based purchasing program.

Value Evaluation and Creation

Nursing home shoppers may determine value by evaluating a number of variables. For example, perceived value can vary according to a facility’s size, layout, décor, amenities, location, reputation, and ownership status (whether the facility is for profit or nonprofit—a common perception that nonprofit businesses give better value to customers). In an Australian study, both residents and family members ascribed value to attributes such as feeling at home in the resident’s own room and in shared spaces, caregivers spending enough time with residents, flexibility of staff in care routines, and engagement of residents in activities that improve their self-esteem (Milte et al., 2018).

More recently, use of online consumer review websites for businesses has increased. One of the most popular sites is Yelp, where reviewers post their personal experiences. One study (Kellogg et al., 2018) found that more than half of Yelp reviewers had posted comments related to staff attitudes and caring and nearly a third had posted comments about staff responsiveness. Consumers had also posted comments about the physical environment, such as cleanliness, aesthetics, and meals. Although Medicare’s 5-star ratings as well as online reviews by consumers have their drawbacks, they cannot be ignored from a marketing standpoint.

Customers do not always know how they should evaluate health care services, and many things are not obvious to people when they first visit a facility. Proximity to home and prior experience with the facility most often influence choice of SNF. However, many clients are willing to travel further to another SNF if they have more information, but many do not know where or how to get help (Gadbois et al., 2017). Helping potential clients overcome information barriers adds value. At a very fundamental level, the client should be able to understand how the facility’s services would be tailored to address the potential resident’s clinical and social needs, what different options are available to pay for the services, and which option might be best.

Marketing has much to do with the creation, promotion, and delivery of value demanded by the customer. Clients’ expectations for long-term care have evolved toward more independence, greater control over lifestyle, and living arrangements that are less institutional. The next generation of well-educated, health-conscious, and financially well-off nursing home consumers will demand emphasis on health promotion, improved amenities and comfort, and having a voice in the facility’s operation. Astute NHAs will create value through innovative solutions in nursing home design, furnishing, and service delivery.

The Marketing Function and Its Goals

Marketing practices embrace two interrelated principles: (1) marketing is a function that incorporates a set of marketing activities and (2) marketing is an attitude that must permeate the entire organization (Majaro, 1993).

Marketing Activities

Marketing is a continuous process that remains dynamic. First and foremost, marketing includes all activities that are necessary for understanding customer wants and needs and for aligning existing services or creating new services to meet those wants and needs. Second, marketing activities include developing a strategy, plans to carry out the strategy, putting the plans into action, and evaluating results. Both are “carefully formulated programs, not just random actions” (Kotler & Clarke, 1987, pp. 5–6).

Organizational Attitudes and Orientation

Marketing is also a client-focused attitude that must permeate the entire organization. An old business axiom fittingly illustrates the organization-wide attitude that is necessary for marketing, “The sales department isn’t the whole company, but the whole company had better be the sales department” (Czinkota, 2000). Positive leadership and human resource practices are essential for building an organizational culture in which all associates behave according to the values and philosophies desired by management. Nursing homes often neglect the critical role of what is termed internal marketing, that is, to train and motivate the staff to provide better services. Negative staff attitudes generally have a ripple effect that negates the effectiveness of an external marketing campaign. Hence, internal marketing must precede conventional marketing campaigns if the latter are to succeed (Cooper & Cronin, 2000).

Organizational values provide the underpinnings that define and direct a nursing facility’s orientation and thrust. For instance, Majaro (1993) emphasized “customer orientation” as an organizational value above “profit orientation.” Customer orientation requires all personnel to focus their activities and behaviors on satisfying the needs and wants of residents, family members, and visitors. In essence, customer orientation is a proactive approach that is centered on offering solutions to the problems customers now face; it also anticipates new issues and concerns that may emerge. Customer orientation presupposes that a primary focus on profits is unwarranted because by making customer satisfaction its primary mission, a facility can achieve higher profits than by placing its primary focus on profits.

Marketing Goals

According to a well-known marketing theorist, Philip Kotler (1991), “Marketing consists of actions undertaken to elicit desired responses to some object from a target audience” (p. 7). Kotler’s definition highlights actions or activities that must achieve certain results.

The desired response from a target audience is the consummation of an exchange based on the value expected and perceived by the target audience. An exchange results after the nursing facility has successfully communicated value that the client is seeking. Successful communication will lead the client to perceive that the expected value will be realized. Satisfaction with the exchange, however, continues only when the delivered value equals the value that was communicated to the client.

Besides attracting residents, marketing exchanges would also result in successfully recruiting qualified associates; obtaining finances at attractive terms for a new construction project; preserving the facility’s licensure, certification, and accreditation status; attaining higher levels of clinical quality, staff satisfaction, and profits; and achieving goodwill in the community. Thus, marketing has broader goals that are interrelated.

Most marketing activities are designed to address issues of market competition. Other marketing activities are intended to elicit decisions from family members, such as the grown up children of the elderly who would need care. The rest of this chapter focuses on this goal.

Marketing Strategy

Successful marketing requires a core strategy, which is a comprehensive game plan. Simply put, a marketing strategy outlines where and how the nursing facility will compete in the marketplace (Bovée et al., 1995), which requires spotlighting the target customers. How well the nursing facility will compete depends on how well the facility positions itself in the target market by using an appropriate marketing mix. **Figure 17–1** illustrates the steps necessary for developing a marketing strategy.

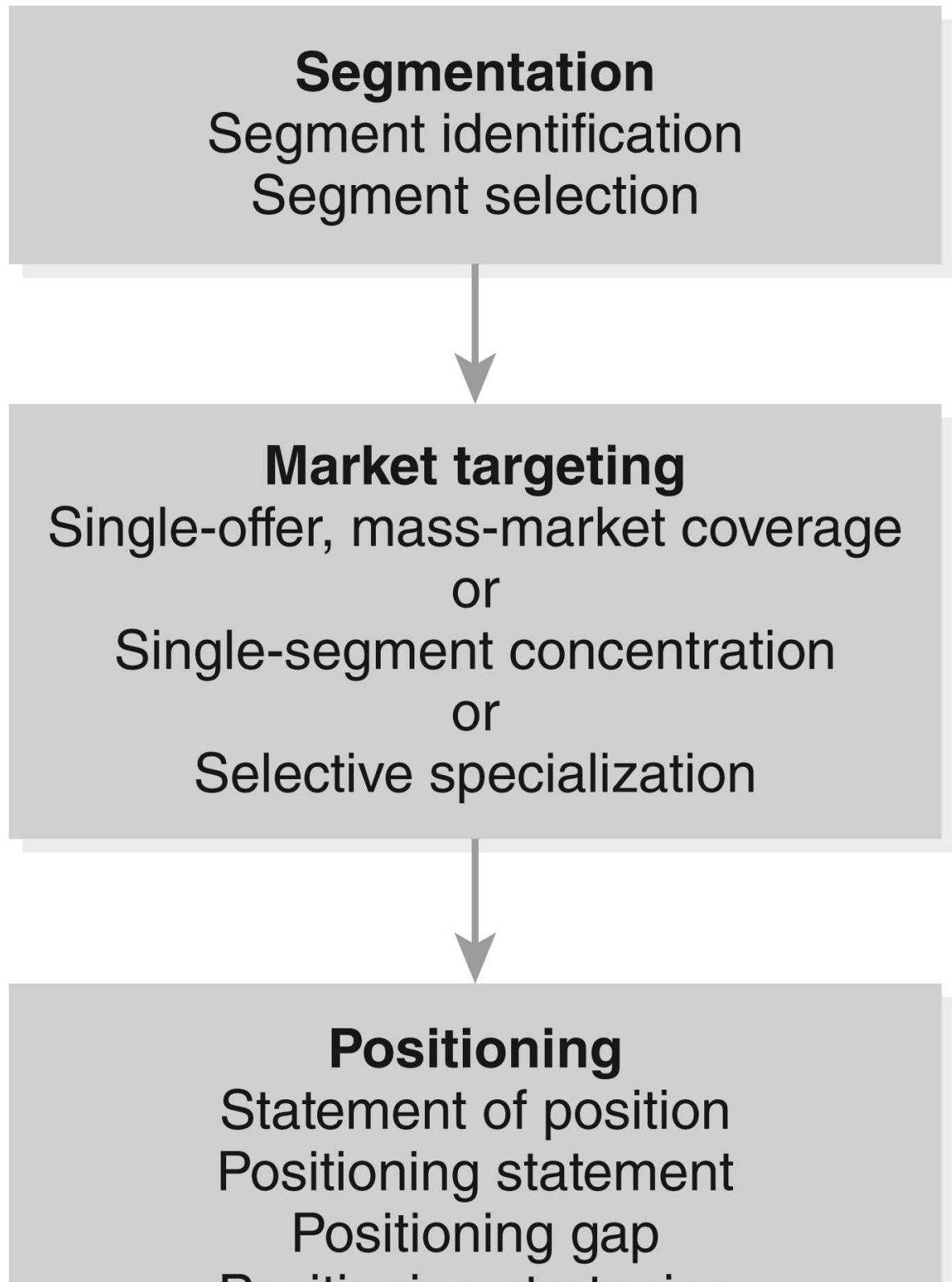




FIGURE 17–1 Steps in developing a marketing strategy

Segmentation and the Target Market

The long-term care market is very diverse, because it includes various community-based services and a continuum of institutional settings. Therefore, identifying and selecting appropriate target markets becomes a necessary strategic step. To some extent, community-based and institution-based services represent natural segments in the long-term care market, but these broad markets should be further segmented, as discussed in subsequent sections.

Segmentation and Its Purpose

A large heterogeneous market should be divided into smaller, more homogeneous segments of customers and potential customers. This process of dividing a large market into smaller segments, each with its distinct characteristics, is called **market segmentation**. Its purpose is to identify distinct market segments of which one or more will constitute the **target market**, which is that part of the overall market from which the nursing facility will attract customers. One of the main goals of targeting a small number of market segments is to better understand the needs and desires of customers and to better match the facility's package of services to meet those needs. This goal is easier to accomplish in a client group that is more or less homogeneous, in terms of services needed, than it is to achieve in a diverse group. Once the needs of the target market are clearly defined, the nursing facility gains the advantage of creating or redesigning services most appropriate for those residents. The more closely a nursing facility can match its services to the value clients are seeking, the more successfully it can market its services.

Segmenting by Demographics, Needs, and Preferences

The nursing home market should be segmented first by demographics, then by clinical needs, and again by client preferences (**Exhibit 17–1**). For instance, pediatric and geriatric care cannot be mixed unless the facility has distinct areas for such services. Institution-based services have some natural segments according to care levels, such as retirement living, assisted living, skilled nursing, specialized care, and subacute care. Although most nursing homes are confined to delivering skilled nursing care, many have captured other segments of the market by adding assisted living, retirement living, or other services along the continuum of care, such as adult day care. Continuing care retirement communities (CCRCs) cover the entire continuum, yet they segment the market on the basis of whether residents have the means to pay an entry fee and whether they desire to receive continuing care as their health declines. Within the private-pay market itself, some subsegments are based on clients' sensitivity to price. Some clients are looking for high-end services and amenities for which they are willing to pay more, whereas other clients are content with more basic services at a cheaper price. Specialized niches for services such as head trauma care, ventilator care, intensive rehabilitation, and Alzheimer's care also present an approach to segmenting the market. Clearly, a nursing facility administrator should decide which particular segment(s) of the market the organization can most adequately serve.

Exhibit 17–1 Market Segments Based on Demographics, Needs, and Preferences

- Demographics
 - Pediatrics
 - Older adults
 - Young disabled
 - Women only
 - Pay source: personal funds, private insurance, Medicare, Medicaid
 - Clinical Needs
 - Short-term rehabilitation
 - Intensive rehabilitation
 - Skilled nursing care
 - Independent retirement living
 - Assisted living
 - Alzheimer's care
 - Wound care
 - Head trauma care
 - Ventilator care
 - AIDS care
 - Adult day care
 - Client Preferences
 - Facility close to home
 - Menu selection
 - High skill mix of staff
 - High-end private pay
 - Low-end private pay
 - Private room
 - Flexible personal routines
 - Décor and furnishings
 - Transportation services
 - Safety
 - Amenities
 - Desire for continuing care
-

Selecting Market Segments

Choice of market segments should not be driven by what the nursing home thinks it would like to have as its target market. Rather, the facility's choice should be based on a careful evaluation of the needs and desires of the target market and on the extent to which the facility possesses the location, physical structures, equipment, staff competencies, and other resources. Second, market segments can be identified in areas in which unmet needs exist or in areas in which the competitors may be weak. For example, if the target market is large enough for an upscale facility in which clients would receive pampered treatment, such as private rooms, individual telephones and flat-screen television sets, and restaurant-style table service in a plush dining room, such an operation can fill unmet demand.

To be useful, market segments must be evaluated according to four criteria (Kotler, 2000). Each segment must be:

1. *Measurable*. The size and other characteristics of the segments, such as ability to pay and client preferences, must be measurable. In other words, there must be some way to assess the number of potential clients with desired characteristics in the segment. Nationally, the size of the private-pay market has shrunk quite considerably over time. Further, for-profit facilities have significantly fewer privately financed days compared to nonprofit facilities (Thomas et al., 2018). Hence, facilities in the latter group can leverage this characteristic to market to the private-pay clientele.
2. *Sizable*. A segment should be the largest possible homogeneous group worth going after with a tailored marketing program. In smaller communities, for example, segmenting the nursing home market will make sense only if there is a sizable number of clients who may need a particular type of service. Otherwise, segmenting the market will not be appropriate because it will simply result in several segments too small to go after.
3. *Accessible*. The facility must be able to effectively reach and serve the market. Because accessibility is governed mainly by the facility's location, the facility should evaluate the needs of its surrounding community. It should also assess how far people may be willing to travel to receive certain services not offered by competitors and whether clients will travel to the facility's particular location to get those

services. For example, people may travel some distance to get specialized services. On the other hand, clients may not want to travel to a facility located in a working-class neighborhood if they are looking for high-end private-pay services.

4. *Differentiable*. The segments should be differentiable according to client needs and preferences. For example, some of the architectural designs and the Green House concept are highly differentiated from traditional nursing homes. But differentiation can be achieved in a number of different ways, as discussed later in this chapter.

Market Targeting

Market targeting follows segmentation. Market segmentation does not imply that the facility must target only one segment. How many segments and which particular segments to target will depend on (1) the segment's overall attractiveness, such as its size, growth potential, and profitability and (2) the organization's mission, objectives, and competencies (Kotler, 2000). In most instances, a nursing facility can pursue three types of targeting strategies:

- Single-offer, mass-market coverage
- Single-segment concentration
- Selective specialization

Single-Offer, Mass-Market Coverage

Most nursing homes go for a single-offer, mass-market coverage, in which market segments are ignored. These facilities offer standard skilled nursing care, and they try to attract anyone in order to increase the occupancy. As illustrated in **Figure 17-2A**, one generic product is designed to suit everyone's needs, and little room is given to accommodating unique client preferences. Such a strategy may work well in communities where the segments are indistinguishable or the size of the overall market is too small to render profitable segments. In most large urban and suburban markets, however, a mass-market approach may not produce the results an organization desires.

	Segment 1	Segment 2	Segment 3
A. Generic offering			

Single-offer, mass-coverage

B. Single specialized offering			

Single-segment concentration

- C. Targeted specialized offerings

Offering 1			
Offering 2			
Offering 3			

Selective specialization

FIGURE 17-2 Market targeting patterns

A mass-market approach can fall victim to regulatory constraints. Nursing homes that cater predominantly to Medicaid residents often face financial distress and provide lower quality care. This is because Medicaid reimbursement rates are lower than Medicare or private payers; therefore, nursing homes disproportionately serving Medicaid residents have lower revenues (Park & Martin, 2018). It would also be illegal for certified facilities to give preference in admission to private paying clients over those receiving Medicaid. Yet, all certified facilities are subject to complying with the same regulatory nursing home standards. Nursing homes located in neighborhoods with higher concentrations of low-income and racial minority residents—a proxy for higher Medicaid dependency—are particularly susceptible to financial stress (Park & Martin, 2018).

Single-Segment Concentration

Single-segment concentration (**Figure 17-2B**) is a targeting strategy in which the facility produces one specialized offering for a single segment. Examples of this strategy include a specialized rehabilitation facility; a facility specializing in services such as head trauma, wound, and ventilator care; or a facility catering only to high-end private-pay clients. Such a strategy can pose high risks, particularly if a facility launches into specialized offerings on the basis of hunches and assumptions rather than on a thorough research of the market.

Selective Specialization

Depending on a facility's size, layout, location, and resources, a selective specialization approach may be the most desirable. In this strategy, a facility produces specialized offerings tailored to the needs and desires of different market segments (**Figure 17-2C**). As an example, the same nursing facility can offer high-end décor and amenities for wealthy private-pay clients in one section of the facility, short-stay rehabilitation and postacute services in a separate Medicare section and Alzheimer's care in a distinct specialized unit. By improving its payer mix, selective specialization can improve a facility's financial position.

Positioning

Every facility holds a certain position in the marketplace. Potential customers and key stakeholders form mental images and perceptions of the nursing facilities that they are familiar with, have seen advertised, or have heard about in a media report or from friends and neighbors. People use such perceptions to mentally rank a particular facility and its services while comparing it to other facilities in terms of how favorably they view a given facility.

Kotler and Andreasen (1996) define **positioning** as “the act of designing the organization's image and value offer so that the organization's customers understand and appreciate what the organization stands for in relation to its competitors” (p. 191). Positioning mainly involves what a marketer does to create a favorable image about the product in the minds of the prospective clients.

The NHA should find out how the facility is positioned, that is, what people think of it and its services, and what type of reputation the facility has in the community. Two important questions need to be asked:

1. To what extent do people in the target market recognize the facility?
2. How favorably do people feel toward the facility?

Obtaining more detailed information about how people may have arrived at forming a particular image of a nursing facility is often necessary. Such detailed information can be collected using techniques such as **semantic differential** (Kotler & Andreasen, 1996). In this technique, market researchers select a relatively small set of dimensions that are important to people. The dimensions may include items such as quality of care, reputation, friendliness of the staff, comfort, and décor. Information on key dimensions that are important to customers can be gleaned from various online reviews of long-term care facilities. Potential clients are asked to rate the facility and its competitors on each of these dimensions. The results show a facility's rank on each of the dimensions in relation to its competitors. Management can then decide whether the facility is appropriately positioned. If the facility is not desirably positioned, semantic differential can help management focus its efforts on improving its areas of weakness.

Market repositioning becomes necessary when a change in the existing position is desired. Before a facility can be effectively positioned, the NHA should put down in writing a “statement of position” and a “positioning statement” (Luther, 2001). The **statement of position** specifies how the facility is currently positioned. The **positioning statement** highlights how the facility should be repositioned. The size of the gap between the current and desired positions will dictate the amount of effort and resources necessary for repositioning the facility.

To position a facility, the NHA should first identify one or two major benefits that the facility's residents and their families derive from its services. Ideally, these benefits differentiate the facility from its competitors and are difficult to duplicate. Then, the facility's distinct competitive advantages should be clearly articulated through various communicative channels—advertising campaigns, the facility's website, news stories, etc.

Marketing Mix

A marketing mix provides the tools necessary for positioning a facility in the target market. The four factors of the marketing mix—product, price, place, and promotion (known as the 4 Ps—**Figure 17-3**)—are well known, but they pose special challenges for implementation in health care marketing. Product, price, and place are differentiating elements; promotion refers to various channels of communication to reinforce or change what potential clients think about the facility (positioning). The next section explains how to use the 4 Ps in the nursing home context.



FIGURE 17-3 The marketing mix

Implementing the Marketing Mix

In health care marketing, the 4 Ps of the marketing mix do not operate in the same manner as they do for a manufactured product that people can touch, see, try out, and even return if they are not satisfied. The health care product, with the exception of the facility's amenities, is—for the most part—intangible. The people who make the buying decision and evaluate value are often not the residents themselves, but their surrogates (such as family members). Services are produced only when customers are there to receive them, and care delivered to the residents goes mostly unobserved by family members. The product's most desired features, such as quality, are not simple for the clients to objectively define and evaluate. Pricing is often beyond the facility's control because the facility relies heavily on third-party reimbursement. Place is generally fixed in terms of where the facility is located, its size, and its layout. Promotion presents challenges because the product is difficult to showcase. Yet, despite these drawbacks, the 4 Ps can be successfully implemented.

Product

The long-term care *product* is a package of some tangible but mostly intangible elements. The socioresidential structures of the person-centered care model comprise the main tangible component. People can see and feel the living environment. Clients can also taste the food being served, notice the building's cleanliness, smell odors, and observe staff members' attitudes and responsiveness. Family members who regularly visit the facility can also observe the resident's personal hygiene and some of the services being provided, such as rehabilitation therapies. However, a lot more goes unobserved, because families cannot be in the facility all the time. By extrapolating from what they can observe and feel, clients formulate judgments about the care elements that they do not see. They also evaluate the product by looking at Medicare's 5-Star ratings and by reading online reviews by other clients.

Through the NHA's efforts in leading, coaching, training, and coordinating, the various departments of a facility can work together to deliver what customers want in quality, timeliness of service, and responsiveness to their needs. Reports of inspections by the health department should also be objectively reviewed to identify and address areas of deficiency.

Price

Price refers to the cost a consumer bears in exchange for the product or service. Generally, price signifies a direct cost to the customer. In health care, however, third-party financing and reimbursement insulates the customer from the price of services. The NHA has little to no control over how much Medicaid and Medicare will pay. Although the consumer bears some out-of-pocket costs to cover deductibles and copayments, these costs are the same regardless of which nursing home the customer chooses. Hence, pricing as a marketing strategy becomes inconsequential in many instances.

Pricing strategies are pertinent in some market segments, such as private pay, and also in managed care and Veterans Administration (VA) contracting. Pricing decisions in these market segments are based on factors such as buyers' willingness and ability to pay, the facility's production costs, and market competition. In the private-pay market, high prices are sometimes used to create a top-of-the-line image, whereas low prices can be used to undercut the competition (Bovée et al., 1995). In contracting with managed care and the VA, pricing can be tricky because contracts are generally awarded to the lowest bidder in closed-bid contests. A low cost of production relative to its competitors can enable a facility to offer a price that can win a contract. Sometimes, especially in managed care contracting when open negotiation rather than closed bidding is used, the NHA has more flexibility in pricing.

Customers also assess three main types of indirect costs that they weigh against the benefits in determining the value of the product they consider purchasing:

1. Family members face the opportunity cost of time required in traveling to the facility for regular visits.
2. Psychological costs are attributed to feelings of anxiety and guilt family members may have.
3. Clients also incur social costs from the embarrassment of placing a loved one in a facility with a poor reputation.

Although travel time is a function of the facility's location in relation to where the family members live, the facility can take steps in helping people overcome their anxiety and guilt through social service counseling, regular communication, and family support groups. The facility should develop such programs and market them to the community and to prospective and current clients. When a facility is spartan in appearance, other features such as friendliness of staff members, security, and other quality of life elements should be emphasized.

Place

Place is where services can be purchased, that is, the facility's physical location (Majaro, 1993). Choosing the site for building a new facility is a strategic decision, but location also deserves close study when acquiring an existing facility to enter a new market. Another situation in which location becomes a critical factor is when deciding whether to add more beds to an existing building or to open a new facility at a different location. The cost of capital is often the driving consideration in such decisions because expanding an existing facility is cheaper than building a new one. But even in growing markets, facilities can face low occupancy after adding new beds when the critical factor of location has not been adequately studied. The trend in recent years has been to locate nursing facilities near growing suburban populations, whereas in the past, facilities were often located close to hospitals to maintain ongoing contact with hospital discharge planners, facilitate transfer of patients, and make it convenient for doctors to visit their patients in the nursing home after they had finished making rounds in the hospital.

Although location is the most obvious factor when one thinks of place, in marketing strategy place also refers to the **channels of distribution**—the mechanisms used for bringing products and customers together to create an exchange. For example, a long-term care facility may offer noninstitutional services, such as home health care, hospice services, and Meals on Wheels; these services are taken to wherever the people reside, regardless of where the facility itself is located. Some of these clients could later choose the nursing home should institutional care become necessary.

Place also refers to physical access. For example, accessibility and clearly marked signs on adjacent access roads make it easy to find the facility. An adequate number of parking spaces as close as possible to the facility should be reserved for clients. Well-manicured landscaping and lawns, flower beds, and adequate lighting draw attention and create a welcoming appeal. Access also refers to the times when a resident can be admitted to the facility. For example, is the facility equipped to admit residents in the evenings and on weekends? What does the facility do when a resident needs to be admitted but no beds are available? The nursing home should develop relationships with hospitals and other long-term care facilities and have policies that facilitate resident admission at all hours. When a facility is full, it can temporarily place the resident in another facility and work out a smooth transfer when appropriate accommodations become available.

In long-term care, place also includes regular contact between the resident and family. Many facilities have unrestricted visiting hours and staff support to facilitate family visits.

Promotion

Majaro (1993) defines **promotion** as “the communication system that creates awareness of the product, its features and benefits, and its location of purchase, and also reassures the customer after the purchase has taken place” (p. 22). Promotion can also be defined as a controlled and integrated program that uses communication methods to effectively present an organization and its services to prospective customers and highlights need-satisfying attributes to facilitate sales (Engel et al., 1994). Bovée and colleagues. (1995) pointed to several objectives to be achieved through promotion:

1. *Providing information.* Information creates awareness, but it also educates and explains how a facility's unique array of services can address problems that potential customers may be facing.
2. *Stimulating demand.* The ultimate goal of all promotion is to influence behavior. Promotion should instill a desire in potential customers to lead them to a purchasing decision when the time comes for placing a relative in a nursing facility.
3. *Differentiating products.* Many nursing homes are alike. A strong promotional program highlights a facility's unique features and their benefits to set itself apart from competitors.
4. *Reminding current customers.* Even existing customers need to be reminded of the facility's benefits in order to prevent them from switching to a different facility. Also, once a resident has been admitted to the facility, family members need reinforcement that they made the right choice.
5. *Responding to negative news.* On occasion, even the best nursing homes are likely to become victims of negative publicity focusing on an unforeseen event—or even something that could have been prevented. In such circumstances, not saying anything can be perceived as admission of guilt and create negative public opinion.
6. *Building image.* Positive news stories of events can be powerful elements in building a facility's image.

Promotional strategies and tools are discussed later in this chapter.

Competitive Differentiation

Undifferentiated marketing purposefully ignores market segmentation and targets the aggregate market using the same marketing mix. As discussed previously, the single-offer, mass-market approach can work well in some markets. In many situations, however, this strategy leaves the facility vulnerable to competitors that can differentiate their products.

When nursing facilities operating in the same market provide commonplace services, marketers refer to it as the “me-too” syndrome (O'Malley, [2001](#)). A market in which most other nursing homes are me-too, a facility can gain competitive advantage by distinguishing itself from its competitors. Kotler ([1991](#)) asserted that every product and every service, no matter how commonplace, can be differentiated. Differentiation can be used effectively for positioning a facility in the target market.

Differentiation Strategy

Differentiation is a competitive strategy in which a facility modifies its product or service so that customers can clearly see added value and distinguish the facility's offer from that of its competitors. For example, two nursing facilities may be similar in their quality of clinical care, but one facility may be able to differentiate itself by offering a selective menu, restaurant-style dining experience, family-style dining, or a brunch buffet. Other facilities achieve differentiation by offering an array of support services for family members. In fact, by thinking through their marketing mix, administrators can find numerous opportunities for differentiation. A facility's affiliation with a hospital or other recognized agency, its layout and atmosphere, its quality-of-life or safety features, flexible schedules for residents, recreation and activity programs, staff skill mix, and staffing levels can all be used for differentiation. According to Berry and Lampo ([2004](#)), developing and communicating a unique image that highlights quality-of-life values and a strong service orientation have proven to be effective strategies that help a nursing home differentiate itself from competitors.

Personal Selling

Personal selling, called “salesmanship” in marketing literature, requires one-on-one contact with clients. In long-term care, generally the buying decision is made only after a personal contact, and often a visit at the facility.

The main objective of personal selling is to understand individual needs and offer solutions tailored to meet those needs. In the process, the facility often learns firsthand how its image is being perceived by the clients that it comes in contact with. One of the aims in personal selling is to reinforce a positive image; another aim is to change a negative perception with information.

If the facility is not equipped to adequately address what a prospective resident needs, one must be forthright about it. A relentless pursuit to fill vacant beds (census chasing) with little regard for the residents’ needs and the facility’s ability to serve those needs often turns out to be the wrong approach and backfires in the form of dissatisfaction, negative publicity, and even lawsuits when things go wrong.

Making people feel at ease and taking the time to listen is an art. Only genuine empathy and mutual trust will make people comfortable enough to disclose some very personal information. Private issues—such as the resident’s incontinence, dementia, or combativeness—are not generally shared with total strangers, nor is information on personal finances. Hence, some “icebreaking” conversation is necessary before discussing sensitive issues.

The facility tour is used primarily to build credibility. This tour should be designed to give a firsthand look into how the facility would meet the multifaceted needs of a resident. Key features and services of the facility should be given particular emphasis. For example, a visit to the physical therapy area where other residents are receiving active treatments can be reassuring. The potential client is often positively impressed when the intake worker introduces the therapist who takes a few minutes to give simple explanations of the therapeutic procedures the prospective resident is likely to receive. Similarly, other key associates, such as the supervising nurse on the nursing unit, should be introduced to the visitors.

The post-tour interview must conclude with what is referred to as “closing the sale.” Simply put, closing of a sale is an unobtrusive offer to admit the resident. Closing the sale is an art and requires confidence. A simple statement, such as, “We would be delighted to serve Mrs. Kemple’s needs through our trained staff; when can I call you back?” is all that is required, unless the prospective clients clearly are not interested. The next day, a follow-up telephone call is appropriate.

Customer Relations

Administrators who manage some of the most elegantly furnished and well-decorated facilities sometimes wonder why they lose residents. These facilities often have customer relations problems. On the other hand, some plain-looking nursing facilities are able to maintain full occupancy while their competitors struggle.

Kotler and Clarke (1987) consider the personnel of an organization as the 5th P of marketing (the other four being product, price, place, and promotion, as discussed earlier). Clients often judge quality and their satisfaction with services by how employees interact with them rather than by the technical quality of services, something that clients generally cannot assess. Customers observe the staff's behaviors and attentiveness to tasks; they evaluate the staff's responsiveness to the residents; they notice whether the employees are friendly and cheerful; and they rely on the staff for information on their loved one's condition. When they visit the facility, family members also notice how other residents are treated. Family members use such clues to form opinions about the facility's reliability and dependability because they cannot be at the facility all the time. Negative observations create psychological stress that dilutes the perception of value.

Following are some suggestions for building better customer relations:

- *Acknowledgement and helpfulness.* Associates should not only greet and smile when they pass family members and other visitors, but also offer assistance. The receptionist should acknowledge with a cheerful greeting anyone who enters the facility and inquire how they can be assisted. Kotler and Clarke (1987) point out that the airlines are known to run all flight attendants, sales agents, and other staff members who have customer contact through "smile school." In the hospitality industry, employees are trained in customer relations and client interactions. Nursing facilities must do the same.
- *Empathy and compassion.* True compassion requires associates to "be in the customer's shoes" and imagine what the other person must be going through and interact accordingly.
- *Contact and communication.* Regular contact with factual updates on the resident's condition and what is being done to address the resident's needs build trust. Timely follow-up by associates on questions and concerns raised by family members is critical. Professional staff members should not merely inform, they must also educate clients so that expectations are maintained at a reasonable level without making it sound like staff members are giving excuses. This education should include explanations of why certain expectations may be unreasonable.

Promotion and Public Relations

The main objective of a promotion and public relations campaign is to position the nursing facility (discussed earlier) and to build and maintain a positive image of the facility through effective communication. Promotional efforts are targeted at would-be customers, whereas public relations—also called community relations—are directed at other key stakeholders and the community at large. Examples of these stakeholders include the facility's associates, community health care agencies such as hospitals, physicians, the local media, and legislators and other public officials. Promotion and public relations work hand in hand, and many of the promotional tools can also be used for public relations. The NHA should establish a budget for promotional activities and should also allocate resources for advertising and for managing online contents. The NHA should also decide which channels of communication will be the most cost effective in achieving the promotional goals. When necessary, the facility's budget and resource allocation should also allow for expenses related to hiring a professional marketing firm or a public relations firm.

Advertising and Publicity

Advertising includes all forms of paid, non-face-to-face communication with a target audience. An advertising campaign should use all available media—print, airwaves, and electronic. **Publicity** refers to nonpaid communication of information that would be of interest to the audience at large. Advertising and publicity often go hand in hand.

An ideal advertising message encompasses the AIDA framework: It gets *attention*, holds *interest*, arouses *desire*, and obtains *action*. A facility should compare its clinical outcomes, such as the effects of a fall prevention or pressure ulcer prevention program, to national data and capitalize on areas that it excels in. When used in advertising, simple facts are excellent attention getters. A focus group consisting of family and staff members can be used to test the effectiveness of advertising messages. Extensively used in marketing research, a **focus group** consists of about 8 to 12 people who participate in an unstructured session with a skilled moderator to discuss their thoughts and feelings about something they are likely to be familiar with.

It is important that advertised messages be free from any misleading statements or claims that may be construed as warranties or promises about clinical outcomes or the quality of care (Becker, 2001). A facility may also invite legal action for disparaging a competitor.

Some basic information must be included in all advertisements. For example, all advertisements and promotional materials must contain the facility's name, logo, street address, location, telephone number, and web address. Publicity can include announcements for programs such as health fairs, health screenings, and educational seminars. Local newspapers and radio stations often accept such announcements in the interest of public service. Human interest stories and follow-up reports on various events are also of interest to the community. Examples include noteworthy events in the lives of certain residents in the facility; nursing students from the local college training at the facility; fund-raising events organized by the facility or carried out in collaboration with other local agencies to support foundations such as the American Heart Association, the Alzheimer's Association, or the Arthritis Foundation; or a celebrity's visit to the facility. Other news events can include celebration of the facility's landmark anniversary, accreditation by the Joint Commission, appointment of a new administrator, ground breaking for a new facility, or ribbon cutting for a new service.

Promotional Channels

Brochures, business cards, newsletters, photo albums, DVDs, and websites are commonly used as promotional materials. The quality and content of these materials must be developed with the aim of accomplishing the facility's positioning goals. Promotion and advertising must clearly show how to get to the facility as well as how to contact the facility by telephone and online.

For privacy reasons, obtain written consent for taking and using photographs and videos of people, and avoid identifying individuals in promotional materials (Miller & Hutton, 2000).

Color brochures are used in a variety of ways: They are included in the packet of information that is handed to prospective clients during the preadmission inquiry; they are kept in the facility's lobby to be picked up by visitors; they are left with hospital discharge planners and physicians to be handed out to prospective clients; and they can be distributed to the public during events such as health fairs. The facility's newsletter is a vehicle for regular communication with the associates, current residents and their families as well as key stakeholders. Videos or DVDs can be effectively used during speaking engagements to supplement an oral presentation before groups such as the Rotary Club and other organizations.

Online Channels

The internet is a powerful channel for advertising and promotional activities because people routinely turn to the internet to find information and make purchasing decisions. A professional can help develop a strong search engine optimization (SEO) strategy using keywords that can help rank a facility higher than its competitors in search engines. Listing the facility on third-party websites, such as A Place for Mom and Senior Advisor should not be ignored.

Modern promotional tools include a professionally designed website that is easy to navigate, uncluttered, and mobile device and smartphone friendly. The website must highlight key information but also prompt visitors to take action, such as signing up for an email newsletter, scheduling a visit, and calling in or emailing questions (Strom, [2018](#)). Visitors to the website must be able to take a virtual tour of the facility.

The importance of social media (Facebook, Twitter, etc.) cannot be overemphasized. Social media platforms should be used to post videos, interviews, positive stories, informative blogs (short, to-the-point articles covering specific topics), and reviews/testimonials from clients. Some of the content can overlap between the facility's own website and social media posts. Emails should be sent to contacts, such as those who toured the facility, and provide links to the facility's website, blogs, and worksheets or checklists to prepare for an admission to the facility.

Event Promotion

Event promotion is accomplished by organizing programs and special events at the facility—programs and events to which the community is invited. This strategy serves two main purposes: (1) It can, depending on the type of event, generate free publicity, often both before and after the event; and (2) it creates promotional opportunities by letting key stakeholders and the public see firsthand what the facility is like. Certain events are targeted at specific stakeholder groups, such as a reception for referral agents, such as physicians or hospital social workers; a special event for nursing students from area colleges; a recognition program for nursing assistants pursuing certification; or an event to honor community volunteers. Other events include wider audiences. An open house in conjunction with the dedication of a new facility or a new addition attracts interested audiences. A facility's landmark anniversaries, such as the fifth and the tenth, present excellent opportunities for special celebrations to which the local community should be invited.

Terminology for Review

advertising
channels of distribution
differentiation
focus group
internal marketing
market segmentation
marketing
positioning
positioning statement
promotion
publicity
semantic differential
statement of position
target market
undifferentiated marketing
value

For Further Thought

How do you distinguish between the concepts of differentiation and positioning? In what way are both critical to strategic marketing?

CASE

Sometimes It Works, Sometimes It Doesn't

Jim Beaufort was appointed as the administrator of Marshall Nursing Center, a 230-bed skilled nursing facility located in a large metropolitan area. The facility's occupancy rate had gradually declined from 82% (188 residents) a year ago to 74% (170 residents). Three months ago when Jim was hired for the job, the company's vice president of operations, Ronald Ortner, was upfront about the declining census. Ortner was particularly impressed with Jim's business degree in marketing and how Jim had enthusiastically talked about using a "mystery shopper"* to get information on the competitors of a nursing home he had previously managed. Jim knew that his work was cut out for him. When offering the job, Ortner had said, "I am giving you a 20% raise over what you were making at your old job; I want this facility turned around in a year's time." To that Jim had confidently responded, "Oh, you will see a trend change much before that."

Jim spent the first 3 months on the job getting to know the staff, residents, and some of the family members. He made written notes on some of his observations:

- The certification survey 6 months ago was satisfactory. There were no serious deficiencies.
- Some issues with building cleanliness have been addressed with the housekeeping supervisor.
- Department head meetings had been sparse and irregular.
- Food was the most common complaint from residents and family members, but so it is at every other facility.
- The licensed nursing staff is stable, but high turnover of certified nursing assistants (CNAs) creates some staffing shortages. Overtime is high, and the director of nursing says that there is some burnout among both nurses and CNAs.
- The facility's expenses are below budget; the previous administrator must have been a "penny pincher."
- Residents are scattered throughout the building. Many of them are occupying private rooms, whereas Medicaid pays only for semiprivate accommodations.

Jim thinks that he has just 9 months left to increase the census and keep his job. So, he embarks on formulating a marketing plan:

- Free up as many resident rooms as possible in one section of the building by moving residents to other occupied parts of the facility. Start an adult day care center by using some of the empty rooms.
- Hire one additional registered nurse and one licensed practical nurse to alleviate the feelings of burnout among the staff. Start a CNA training program at the facility.
- Send a mystery shopper to the three main competitors to evaluate how they handle the inquiry process. Have the mystery shopper evaluate Marshall's inquiry process as well. Improve the admission coordinator's personal selling skills.
- Purchase advertising at the local newspaper, radio station, and TV station that would say:

Marshall Nursing Center has excelled in providing high-quality nursing and rehabilitation care in this community for more than 20 years. Our staff's caring is like a healing touch. We are accepting new residents. Bring your loved one here and see the results for yourself.

"That will get people's attention," Jim thought to himself:

- Discard the black and white brochures and replace them with a four-color brochure with some pictures and the same message used in advertising. Place these brochures in hospital waiting rooms and doctors' clinics.
- Invite the hospital's discharge planners to dinner at a fine restaurant. Explain to them the facility's new marketing plan and ask for their help in referring patients.
- While the marketing plan is being implemented, Jim will personally handle all preadmission inquiries, using the admission coordinator for backup.

Jim was confident that in another 6 months the facility's census would start turning around, but it only deteriorated further. Frustrated, he starts looking for another job. Sitting in his office, he moans, "Marketing is just a theory: Sometimes it works, sometimes it doesn't."

Questions

1. How should Jim have handled his job interview with regard to the declining census?

2. Do you agree with Jim's statement: Marketing is just a theory: Sometimes it works, sometimes it doesn't? Explain why marketing may not work.
3. Evaluate Jim's marketing plan. What main improvements would you make?
4. Critically evaluate the promotional message.

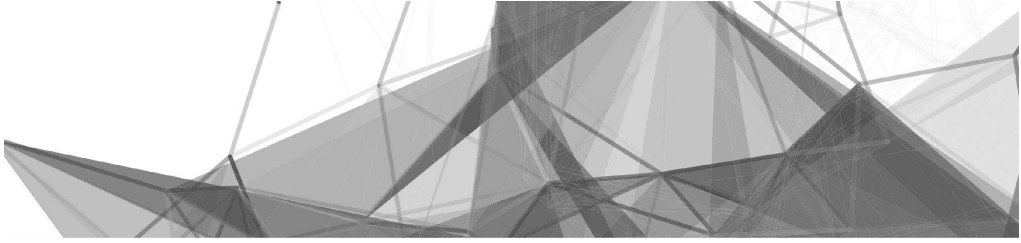
* A mystery shopper, also referred to as a "secret shopper," is a marketing professional who specializes in visiting and evaluating business practices, posing as a potential client.

For Further Learning

Pierre & Vacances Center Parcs Group. A case study from the French travel industry.
<https://hootsuite.widen.net/s/jkvpvqggsf>

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CHAPTER 18

Effective Financial Management

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WHAT YOU WILL LEARN

- Financial management is essential for making vital resources available to the organization. Budgeting and financial control are the two main functions of financial management.
- Financial management begins by understanding the organization's profitability. Additionally, the nursing home administrator must have detailed reports to monitor the facility's operations and make decisions.
- Variances between what has actually happened and what was planned in the budget are useful for managing revenues and controlling costs.
- Revenue management is based on two main factors: maintaining expected census levels and achieving the expected payer mix.
- Cost control begins with an understanding of fixed, variable, and semifixed costs. These differences help identify controllable and noncontrollable costs.
- The labor-hour report and the labor-cost report should use variance analysis for monitoring labor costs.
- Three main techniques—variance analysis, accounts payable report, and inventory management—are used to control nonlabor expenses.
- Management of accounts receivable is critical for cash flow. Procedures are necessary to prevent lost revenues and to minimize write-offs. The collection cycle is a measure of efficiency in collecting the receivables.
- Budgeting involves making projections for the next fiscal year on the basis of reasonable assumptions. Revenues, labor costs, and other expenses are budgeted in that order. Operating margin indicates the organization's profit goal.

Introduction

Financial management is critical for ensuring an organization's success over the long run. An organization's financial strength gives it the resources necessary to deliver value and carry out other vital functions such as marketing, staff development, and quality improvement. A nursing facility's vital resources are controlled and conserved through effective financial management.

Financial management encompasses two classical functions of management: planning and controlling. Financial planning incorporates two types of decisions:

1. What future financial objectives are desirable and achievable?
2. What resources are needed and how will they be allocated so that the objectives are achieved?

Such a process of financial planning is called **budgeting**. The final **budget** becomes a financial plan and a tool for exercising financial control. Managers exercise financial control when they compare the actual operating results against the budget, identify unacceptable variances, evaluate reasons for the variances, and take appropriate corrective action. In addition to the planning and control functions just described, financial management also includes controlling cash and other assets, such as food and supplies inventories.

The planning and control functions call for managerial decision making. Sound decisions require good information. Hence, effective financial management is driven by well-designed systems that not only report on the organization's performance but also facilitate financial analysis. One basic financial information system is the accounting system. Accounting is a professional field in its own right. The nursing home administrator (NHA) does not need to be an accountant, but he or she must be able to understand the basic accounting statements produced by the accounting system.

Accounting and Financial Statements

Accounting, more precisely called **financial accounting**, entails recording all financial transactions and preparing standard reports known as financial statements. Each financial transaction is recorded following the well-established double-entry system of debits and credits and a set of standards called *generally accepted accounting principles (GAAP)*. Examples of common financial transactions include revenues derived from providing services; purchases of food, supplies, and other items; expense for salaries and wages; receipts of cash; and payments by cash, check, or electronic transfers. Most of these routine transactions are recorded by the nursing home's bookkeeping personnel. In addition to the recording of routine transactions, which a bookkeeper can generally handle, a professional accountant makes additional financial entries, such as those pertaining to lease or rental agreements, loans, tax payments, depreciation of assets, and income from investments. Generally, at the end of a specified period, all the financial transactions for that period are summarized in three main types of financial statements: the income statement, the balance sheet, and the cash flow statement. As discussed in subsequent sections, these statements provide concise information on the facility's profitability as well as its economic resources and obligations. The income statement is of primary importance to the NHA. The balance sheet and the cash flow statement are important to corporate officers and owners.

The Income Statement

The income statement is also called the operating statement, the profit and loss statement, or the P&L. **Exhibit 18–1** provides an example of an income statement. The **income statement** furnishes a summary of revenues, expenses, and profitability for a given period, such as a month, a quarter, or a year. It has three main sections. The first section is a listing of the revenue derived from each payer source and the total revenue. The second section lists various expense line items, such as salaries, supplies, raw food, utilities, and advertising. The third section consists of operating income, income taxes, and net income. For nonprofit and public facilities that do not pay income taxes, operating income equals net income. In general, net income, also called net profit, equals total revenue minus total expenses (although shown separately on the income statement, income tax is actually an expense). Thus, the income statement provides valuable information on the profitability of an organization. By identifying revenues by each payer source and by identifying expenses by each type, the income statement provides a summary of how the bottom-line profit was derived. On the other hand, if total expenses exceed total revenue the bottom-line result is a net loss.

Exhibit 18–1 XYZ Nursing Care Facility Income Statement for Year Ended 2020

Net patient revenues	
Private pay	1,395,540
Private insurance	132,030
Medicaid	1,858,490
Medicare	943,160
Veterans contract	74,600
Total net patient revenue	4,403,820
Other service revenues	262,120
Rental income	8,040
Income from investments	43,620
Total revenue	\$4,717,600
Operating expenses	
Administrative salaries	182,740
Advertising and promotion	14,400
Other administrative	12,240
Nursing salaries	2,294,950
Medical supplies	511,910
Equipment rental	26,400
Dietary salaries	300,370
Raw food	147,020
Dietary supplies	26,400
Dietary chemicals	25,700
Environmental service salaries	274,460
Environmental supplies	38,160
Social services salaries	42,900
Activity salaries	75,220
Activity supplies	5,040
Contracted services	194,290
Fees	46,210
Utilities	53,670
Depreciation	93,650

Provision for bad debt	70,230
Other expenses	23,400
Total expenses	\$4,459,360
Operating income	258,240
Provision for income taxes	77,470
Net income (loss)	\$180,770

The Balance Sheet

A **balance sheet** summarizes the financial position of a business organization on a given date, such as the last day of a month or the last day of a year. A balance sheet has three sections:

1. A summary of all the **assets** or economic resources of the facility appears in the section on the left or at the top (based on the layout of the balance sheet). Total assets constitute the financial value of everything the facility owns.
2. The right-hand or bottom section of the balance sheet shows an organization's liabilities. **Liabilities** constitute the facility's economic obligations or debts. Total liabilities constitute the financial value of everything the facility owes to other entities.
3. The third section, **equity**, appears just below the liabilities. It is also called owners' equity or stockholders' equity, and represents the interests or rights of the owners in a for-profit corporation. In a nonprofit organization, no ownership interest exists. Therefore, **net assets** is the term used by nonprofit organizations for the equity portion of the balance sheet.

According to the fundamental accounting equation, total assets equal the sum of total liabilities and equity (or net assets). Hence, equity equals assets minus liabilities. See **Exhibit 18–2** for an illustration of the balance sheet.

Exhibit 18–2 XYZ Nursing Care Facility Balance Sheet on December 31, 2020

Assets		Liabilities and Equity	
Current Assets		Current Liabilities	
Cash	\$62,350	Accounts payable	\$44,170
Accounts receivable	\$981,260	Accrued salaries	\$32,140
Less allowance for bad debts	\$70,230	Current maturities of long-term debt	\$41,330
Inventories	\$57,600	Long-term debt	\$13,364,390
Prepaid expenses	\$24,400	Less current maturities	\$41,330
Land, buildings, and equipment	\$23,670,190	Total Liabilities	\$13,440,700
Less accumulated depreciation	\$8,521,260		
Other assets	\$258,990	Equity	\$3,022,600
Total Assets	\$16,463,300	Total Liabilities and Equity	\$16,463,300

The Cash Flow Statement

The **cash flow statement** is a summary of transactions that increase or decrease cash during a given period, such as a month, quarter, or a year. It identifies the sources of incoming cash and the uses of outgoing cash. Preparing a cash flow statement is necessary because businesses commonly use an accounting method called **accrual-basis accounting**, a method in which revenues and expenses do not match cash inflows and outflows. Revenue is recognized at the time services are rendered, although the bulk of payments for those services is received at a later date from various payers. Similarly, expenses are booked as they are incurred, even though payments to vendors are generally made at a later date. Certain expenses, such as advertising

and insurance, may be prepaid for a whole year. In such a case, a cash outflow would occur at the beginning of the year, but the expense would be spread out over the entire year.

Note that cash flow is not an indicator of profitability. Cash flow is, however, an important measure of an organization's financial health. A positive cash flow—in which inflows exceed outflows—means that the organization has the ability to meet its cash obligations in a timely manner. The facility must have cash to pay the employees on every payday, make payments to vendors according to the terms of credit, make lease payments for building and equipment, and pay loan installments to banks—to give some examples. An organization can face serious financial trouble if it does not have adequate cash to meet such financial obligations when they become due.

Management Reports

The three types of financial statements just discussed do not provide all the information that the NHA and department managers need to control facility operations. **Management accounting** is the term used for the process of preparing reports considered useful for managerial control and decision making. Several types of routine management reports may be prepared for the NHA and department managers. In addition, certain nonroutine reports may be necessary from time to time. For example, a *pro forma* report that forecasts anticipated volume of clients, expected revenues, and anticipated expenses is often necessary before a facility launches a new service, such as adult day care. Such a report can help management decide whether the facility should commit the resources to develop the new service that is being considered.

Financial accounting systems are standardized, and the format of financial statements varies little among different nursing home organizations. Management accounting systems, on the other hand, can have a great deal of variation regarding report formats and the level of detail contained in them.

The Technique of Variance Analysis

Variance analysis is an examination and interpretation of differences between what has actually happened and what was planned in the budget (Gapenski, 2002). A **variance** is the difference between an actual (realized) numeric value and a budgeted (expected) value.

The technique is used for managing revenues and for controlling costs. Negative variances signify that the actual results are worse than what was projected in the budget. Large negative variations threaten the expected profitability; hence, they require follow-up, particularly in areas in which costs are controllable. Such controllable areas are those areas of the operation in which management intervention to reduce costs would not jeopardize quality or violate regulations. For example, staff hours cannot be cut below what is necessary for meeting residents' needs. Hence, negative variances require careful evaluation and judicious action. Variance analysis and other types of management reports are discussed later in greater detail. A variance analysis for revenues is illustrated in **Exhibit 18-3**.

Exhibit 18-3 Payer Mix and Revenue Report for Month of October, 2020

Available beds: 135

	Budget				Actual				Variance		
	Resident days	%	Rates	Revenue	Resident days	%	Rates	Revenue	Resident days	Rates	Revenue
Private pay	903	26.0%	\$196.55	\$177,430	854	24.6%	\$196.55	\$167,854	-49	\$0.00	-\$9,576
Private insurance	104	3.0%	\$156.00	\$16,249	73	2.1%	\$156.00	\$11,388	-31	\$0.00	-\$4,861
Medicaid	1,805	52.0%	\$136.00	\$245,540	1,885	54.3%	\$136.00	\$256,360	80	\$0.00	\$10,820
Medicare	521	15.0%	\$182.00	\$94,786	526	15.1%	\$182.00	\$95,732	5	\$0.00	\$946
Veterans contract	139	4.0%	\$170.00	\$23,610	134	3.9%	\$170.00	\$22,780	-5	\$0.00	-\$830
TOTAL	3,472	100.0%	\$160.60	\$557,615	3,472	100.0%	\$159.59	\$554,114	0	-\$1.01	-\$3,500
Average daily census	112				112				0		
Occupancy rate	83%				83%				0.0%		

Note: Occupancy rate = (Average daily census/Available beds) × 100.

Managing Revenues

Management of revenues is based on two factors:

- *Maintaining expected census levels.* **Census** refers to the number of residents in a facility on a given day. Each day spent by a resident in the nursing facility is called a patient day or resident day. Hence, resident days over a period represent the cumulative number of days spent by all residents. **Resident days**, also referred to as **days of care**, amount to a cumulative census over a specified period. **Average daily census** is the average number of residents per day over a specific period, such as a week, a month, or a year. It is calculated by dividing the days of care over a period by the number of days in that period (see **Table 18–1**).

TABLE 18–1 Days of Care and Average Daily Census for a 7-Day Period

Day	Daily census
Day 1	121
Day 2	119
Day 3	118
Day 4	117
Day 5	120
Day 6	118
Day 7	120
Resident days (days of care)	833 (Total census for days 1 through 7)
Average daily census	119 (833/7)

- *Achieving the expected payer mix of residents.* **Payer mix** is also called census mix. It is the mix of residents by payer type, such as Medicaid, Medicare, and private pay. **Table 18–2** illustrates the payer mix for a facility, which is also graphically illustrated in **Figure 18–1**.

TABLE 18–2 Payer Mix for the Year 2020

Pay type	Resident days	Payer mix
Private pay	10,998	25.6%
Medicare	5,370	12.5%
Medicaid	25,695	59.9%
Other	861	2.0%
TOTAL	42,924	100.0%
Average daily census (366 days)	117.3	

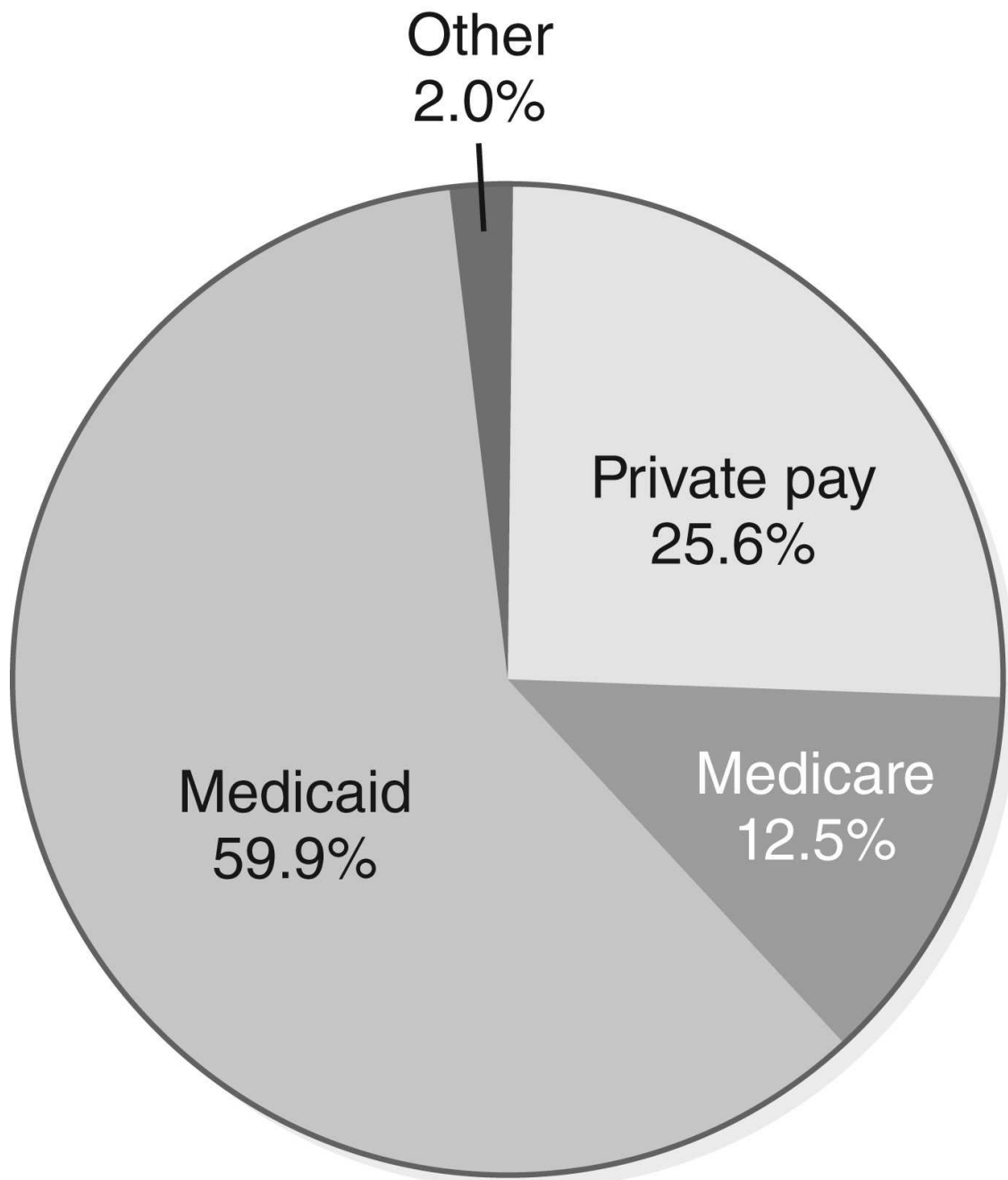


FIGURE 18–1 Payer mix for 2020

Although the objective of census management is to keep the facility's beds filled, simply having more residents is not always enough for achieving revenue targets. This is because of wide variations in the amount of reimbursement from the various sources of financing. Medicaid generally has the lowest reimbursement rates. Private-pay charges, which are established by the facility, are generally the highest. [Exhibit 18–3](#) illustrates the effect of payer mix on revenues. Notice that the facility has actually met its budgeted resident days target of 3,472 and its budgeted 83% occupancy rate in the month of October. However, shortfalls (indicated by negative variance signs) in achieving targeted private-pay and private-insurance resident days have resulted in a revenue shortfall of \$3,500 for the month. Notice that the actual payer mix produces an average reimbursement rate of \$159.59, which is \$1.01 lower than the average budgeted rate of \$160.60 for each resident day, and is also a negative variance.

One way to eliminate the revenue shortfall in this case is to increase the overall census by 22 resident days for the month (99% occupancy). In that case, 22 resident days times the average reimbursement rate of \$159.59 per resident day equals \$3,511, which is sufficient to cover the revenue shortfall. Another way to achieve the revenue objective is to realize higher reimbursement rates than the rates projected in the budget. Higher reimbursement rates, however, are often difficult to achieve because the NHA has little or no control over third-party reimbursement rates. For a substantial number of residents, the rates are established by third

parties such as Medicaid and Medicare. Private-pay rates are under management's control, but market factors such as competition from other facilities often limit the administrator's ability to unilaterally raise private-pay rates.

Controlling Costs

Cost control requires an understanding of three main types of costs: fixed, variable, and semifixed (also called step-fixed or step-variable). The three types of costs behave differently within a certain **census range**, which is an anticipated range of resident census. Associating costs with a census range is central to controlling costs without jeopardizing quality of care or demoralizing the associates with staffing shortages. Because no one can exactly predict the census for a future time, cost expectations are established for an anticipated range of the facility's census.

Types of Costs

The nature of a particular type of cost can be evaluated on the basis of its relationship to a change in the facility's census. Suppose that costs are budgeted for a census range of 108 to 116 residents. Some costs remain unchanged, regardless of whether the facility has 108 or 116 residents. Costs that do not vary with the number of residents within the census range are called **fixed costs**. Fixed costs are noncontrollable. For example, regardless of whether the facility has 108 or 116 residents, the facility must still have the same number of registered nurse (RN) hours per day (**Figure 18-2**). Administrative costs, telephone and utilities, rent or lease costs for the building, and maintenance and repairs are other examples of fixed costs.

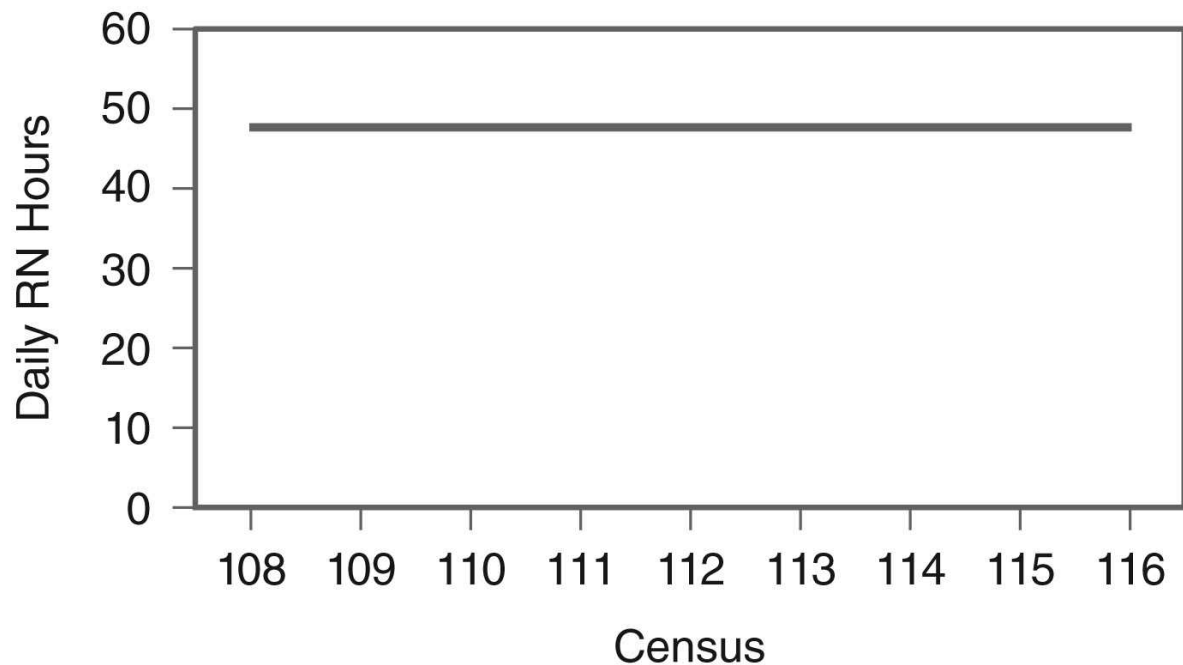


FIGURE 18-2 RN hours within a census range of 108 and 116

Variable costs, on the other hand, vary with the change in the number of residents within the census range. For example, if the cost of raw food is \$8.00 per resident per day, the food cost would be \$864 per day when the facility has 108 residents; it will be \$928 per day when the census is 116. Other costs that are considered variable include medical and nursing supplies, dietary supplies, temporary staffing, linens, and laundry chemicals. Note that for variable costs, the variable cost rate (also known as the cost per unit) remains constant. The variable cost rate is expressed as a per-resident-day cost (PRD cost) [or per-patient-day (PPD) cost], which is a constant amount per resident per day. In the food cost example, the PRD food cost remains constant at \$8.00. To get the total food cost, the PRD cost is multiplied by the number of residents. The total variable costs are controllable. Suppose the facility has been operating with a daily census of 114, and the census drops to 110. The facility must reduce its spending on food from \$912 per day to \$880 (**Figure 18-3**), even as the PRD cost remains constant at \$8.00. This cost control technique is not applicable to fixed costs discussed previously.

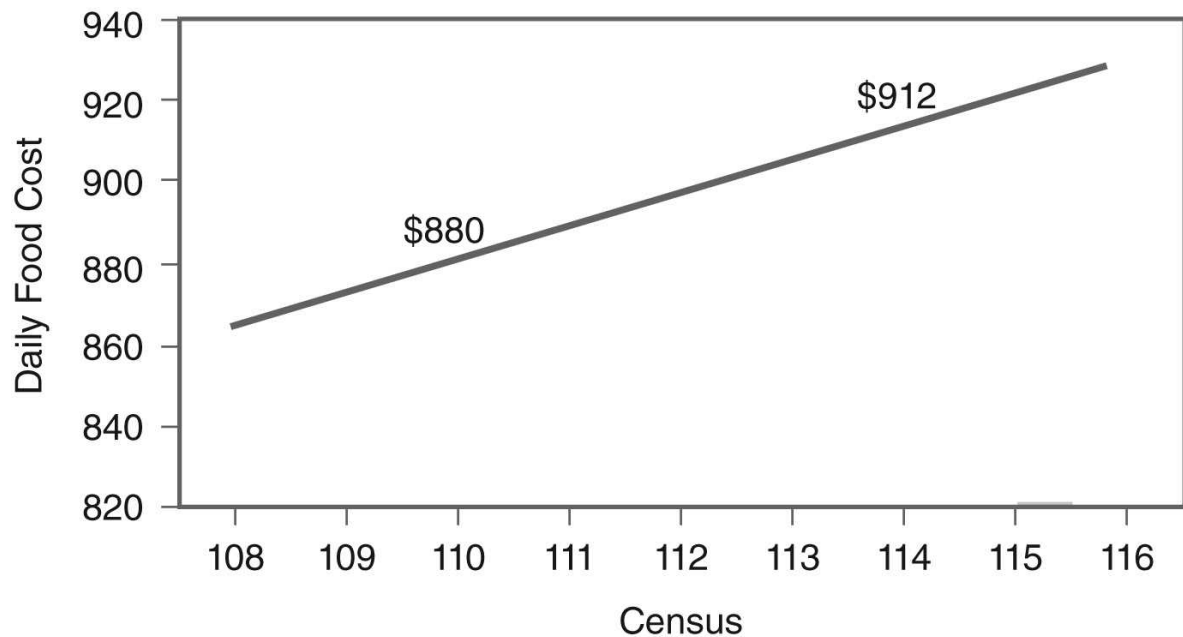


FIGURE 18-3 Food cost within a census range of 108 and 116

The third category consists of semifixed or step-variable costs. [Semifixed costs](#) remain fixed within parts of the census range; they rise or fall for another part of the census range. Semifixed costs are generally encountered in paraprofessional labor hours, such as certified nursing assistant (CNA) hours. The example illustrated in [Figure 18-4](#) assumes that CNAs are scheduled in 8-hour increments. In this example, 360 hours of CNA time is scheduled even though the census may vary between 108 and 110; 368 hours are scheduled when the census increases to 111; an additional 8 hours are scheduled only when the census reaches 114. Like variable costs, semifixed costs are also controllable, but not for minor fluctuations in census. Depending on management policy, some facilities may treat semifixed costs as variable costs. Semifixed labor costs can be treated as variable costs if a facility is able to employ adequate part-time associates who may be called in as needed. Some facilities that do not have this flexibility still treat these costs as variable; thus, a CNA is sent home without completing a full shift if the census drops by as little as one resident. Such a practice can be demoralizing for the associates and contribute to problems such as absenteeism and turnover. In the long run, relatively small upfront cost savings may actually end up costing the facility much more.

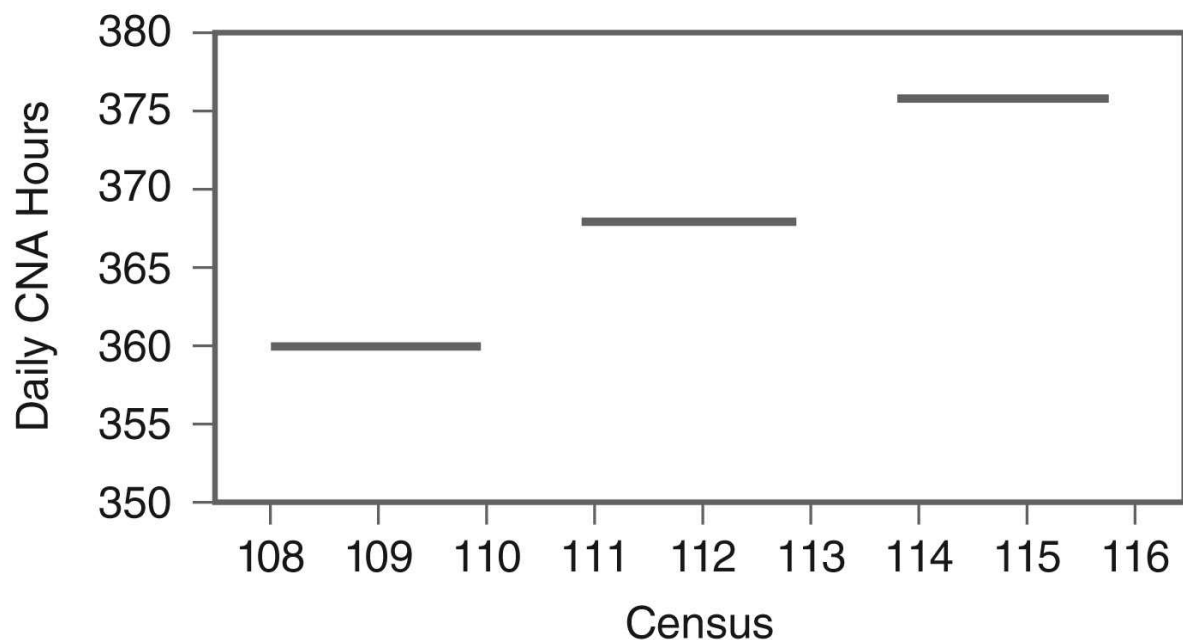


FIGURE 18-4 CNA hours within a census range of 108 and 116

Controlling Labor Costs

Labor costs have two components: hours of labor and dollars spent on labor. Labor dollars are affected by hours of labor—both regular and overtime—and average wages paid to the associates. Wages are governed by a facility's wage policies. Competitive pressures may also influence how much a facility may have to pay to hire and retain qualified associates. Hence, the NHA may have more control over the hours of labor than over total dollars spent on wages and salaries.

Labor costs and other expenditures are controlled using the technique of variance analysis mentioned earlier. **Exhibit 18–4** presents a labor hour report for a particular nursing unit within a facility. Similar reports would be prepared, generally every pay period, for other nursing units and departments such as food service, housekeeping, and laundry, and also for the entire facility. This report shows budgeted hours, adjusted budget hours, actual hours, and the variance between the adjusted budget and the actual hours. The budgeted hours in this example were based on 532 resident days for the pay period. However, the facility's actual resident days were 504. Therefore, for determining the variances, the budgeted hours must be adjusted for the lower actual census.

Exhibit 18–4

Labor Hour Report
Pay Period: October 11, 2020–October 24, 2020
Department: Nursing (Unit B)

Resident days

Budget	Actual
532	504

	Budgeted Hours				Adjusted Budget Hours				Actual Hours				Variance			
	Regular Hours	Overtime Hours	Total Hours	PRD Hours	Regular Hours	Overtime Hours	Total Hours	PRD Hours	Regular Hours	Overtime Hours	Total Hours	PRD Hours	Regular Hours	Overtime Hours	Total Hours	PRD Hours
RN	168	0	168	0.32	159	0	159	0.32	168	4	172	0.34	–9	–4	–13	–0.03
LPN	388	4	392	0.74	368	4	371	0.74	388	0	388	0.77	–20	4	–17	–0.03
CNA	1,762	30	1,792	3.37	1,669	28	1,698	3.37	1,668	28	1,696	3.37	1	0	2	0.00
Total	2,318	34	2,352	4.42	2,196	32	2,228	4.42	2,224	32	2,256	4.48	–28	0	–28	–0.06

In an adjusted budget, also called a **flexible budget**, the budgeted figures are raised or lowered to reflect the actual census. There are two methods for adjusting the budgeted figures:

$$(1) \text{ Flexible budget} = \text{Budgeted PRD hours} \\ (\text{or costs}) \times \text{Actual resident days} \\ \text{or}$$

$$(2) \text{ Flexible budget} = \frac{\text{Budgeted hours}}{\text{Budgeted resident days}} \\ \times \text{Actual resident days}$$

In **Exhibit 18–4**, formula (2) is used to obtain adjusted figures separately for regular and overtime hours. Most accounting and finance software programs treat labor hours as variable costs rather than fixed or semivariable costs. Nevertheless, computer-generated labor hour reports are useful in pointing out the variances. In **Exhibit 18–4**, CNA hours are consistent with the adjusted budget, but the negative variance of 9 hours for RNs and 20 hours for licensed practical nurses (LPNs) indicates overstaffing. However, if licensed nursing hours are treated as fixed costs to staff the nursing unit regardless of census, the variance can be ignored because actual hours match budgeted hours. On the other hand, RNs have incurred 4 hours of overtime that was not budgeted, and this overage calls for follow-up to determine whether this overtime was avoidable. It can be seen that 4 hours of overtime budgeted for LPNs was not used. There was likely a trade-off between LPN and RN overtime. The NHA should decide whether circumstances warranted swapping overtime hours.

In **Exhibit 18–5**, the labor hours shown in **Exhibit 18–4** have been converted to dollar costs based on hourly wage rates. Variances show improved hourly rates for RNs and CNAs compared to the budget, which likely reflect turnover, which caused filling the positions at lower rates of pay. Rates of pay for LPNs likely reflect higher salary increases than what was anticipated in the budget, hence a negative variance. Total cost variances are negative for RNs and LPNs mainly because these costs are fixed for a lower census than what was anticipated in the budget. However, because of lower CNA wages, the total costs for the nursing unit are

better by \$1,105. Even though the variance is positive, the NHA must keep in mind that staff turnover has costs, such as those associated with recruitment and training, that are not reflected in the variance analysis. Staff turnover also disrupts consistent delivery of resident care.

Exhibit 18–5

Labor Cost Report

Pay Period: October 11, 2020–October 24, 2020

Department: Nursing (Unit B)

	Hourly Rates	Budget			Adjusted Budget			Actual Costs				Variance			
		Regular Costs	Overtime Costs	Total Costs	Regular Costs	Overtime Costs	Total Costs	Regular Costs	Overtime Costs	Total Costs	Hourly Rates	Regular Costs	Overtime Costs	Total Costs	Hourly Rates
RN	\$ 35.31	\$ 5,932	\$ 0	\$ 5,932	\$ 5,620	\$ 0	\$ 5,620	\$ 5,816	\$ 208	\$ 6,024	\$ 34.62	\$ -196	\$ -208	\$ -404	\$ 0.69
LPN	\$ 29.65	\$ 11,504	\$ 178	\$ 11,682	\$ 10,899	\$ 169	\$ 11,067	\$ 11,578	\$ 0	\$ 11,578	\$ 29.84	\$ -679	\$ 169	\$ -511	\$ -0.19
CNA	\$ 19.05	\$ 33,566	\$ 857	\$ 34,423	\$ 31,799	\$ 812	\$ 32,612	\$ 29,841	\$ 751	\$ 30,592	\$ 17.89	\$ 1,959	\$ 61	\$ 2,020	\$ 1.16
Total		\$ 51,002	\$ 1,035	\$ 52,038	\$ 48,318	\$ 981	\$ 49,299	\$ 47,235	\$ 959	\$ 48,194		\$ 1,083	\$ 22	\$ 1,105	

Controlling Nonlabor Expenses

A facility's basic approach to controlling expenses—such as food, supplies, and linens—is also based on variance analysis. However, other types of monitoring and control methods are also used, and these methods are discussed in this section. The variance analysis for expenses is very similar to what was discussed earlier.

Exhibit 18–6 presents the expense summary for the food service department. This summary contains variances for the month of October and for the year-to-date totals for 10 months of the year. Although the flexible budget is not shown, the variances are derived from a comparison of the actual expenditures against a flexible budget, which is calculated by multiplying the budgeted PRD costs by the actual resident days. Labor costs for supervisory personnel are considered fixed costs, so a negative variance is produced when the actual resident days are below budget. Similarly, the negative variances for labor cost for operational staff may be ignored if these costs are considered fixed. In **Exhibit 18–6** the variance for the year-to-date raw food cost is small and can be ignored, but the variance for the month of October should be investigated. Expenditures for chemicals and small equipment are better than budget; food service supplies, however, require further investigation.

Exhibit 18–6 Expense Summary—Food Service Department Month of October, 2020

Resident Days										
Month		Year to Date								
Budget	Actual	Budget	Actual							
3,472	3,286	34,564	33,423							
	Month				Year to Date				Variance	
	Budget	PRD	Actual	PRD	Budget	PRD	Actual	PRD	Month	Year to Date
Labor										
Supervisors	\$4,794	\$1.38	\$4,794	\$1.46	\$47,940	\$1.39	\$47,940	\$1.43	–\$257	–\$1,583
Operational staff	17,112	4.93	16,709	5.08	171,120	4.95	168,718	5.05	–514	–3,247
Raw food	24,998	7.20	24,021	7.31	246,367	7.13	238,352	7.13	–362	–118
Chemicals	1,457	0.42	1,314	0.40	14,375	0.42	13,085	0.39	65	815
Food service supplies	1,701	0.49	1,774	0.54	16,785	0.49	17,486	0.52	–164	–1,255
Small equipment	415	0.12	360	0.11	4,150	0.12	3,782	0.11	33	231
Total cost	\$50,477	\$14.54	\$48,972	\$14.90	\$500,737	\$14.50	\$489,363	\$14.63	–\$1,199	–\$5,156

Accounts Payable Report

Expenses should also be monitored by looking at an accounts payable report. This report is generally produced weekly, and it lists all the **accounts payable**—money owed to vendors from whom goods, supplies, and services have been purchased on credit—processed by the facility's bookkeeper. The report shows the date when an invoice was processed, the name of the vendor, and the amount paid. Reviewing this report each week may bring to attention anything that may appear out of place.

Inventory Management

Inventory management is an important tool for controlling expenses. As an example, a linen inventory control system is presented in **Exhibit 18–7**. Such a system serves two main purposes: (1) It ensures that the facility always has adequate linens available to serve residents and (2) it provides a mechanism for linen cost control.

Exhibit 18–7 Linen Inventory on October 31, 2020

	Par Levels	On Hand	Purchases	Discards	Closing Inventory	Physical Count	Over / (Short)	To Replenish	Replenishment Cost	
		October 1			October 31	October 31			Unit Cost	Total Cost
Bath towels	384	412	0	17	395	406	11		\$4.40	
Hand towels	636	507	120	0	627	611	-16	25	\$3.16	\$79.00
Wash cloths	1,260	966	300	0	1,266	1,009	-257	251	\$0.85	\$213.35
Bed sheets	504	478	36	14	500	500	0	4	\$10.80	\$43.20
Pillow cases	252	276	0	6	270	268	-2		\$2.85	
Blankets	252	162	0	11	151	154	3	98	\$17.15	\$1680.70
Bedspreads	192	178	0	4	174	174	0	18	\$21.50	\$387.00
Mattress pads	192	230	0	2	228	224	-4		\$13.60	
										Total Replenishment Cost \$2,403.25

The first of these objectives is achieved by establishing adequate par levels. The second objective is achieved by instituting inventory control systems. In the perpetual inventory system for linens, the closing inventory at the end of a month is calculated as follows:

$$\text{Closing inventory at the end of a month} = \text{Beginning inventory} + \text{Purchases} - \text{Discards}$$

The system requires that the person in charge of linens maintain a record of items discarded because of thinning, fading, and tearing. Periodically, a physical inventory should be taken by counting each linen item. Because linens are constantly in circulation, the facility should develop a procedure for counting all linens throughout the facility. A suitable time for taking a physical inventory is when resident care activities have slowed down, generally in late afternoon or during the night. At a given time, the nursing staff should count all linen items in resident rooms, bathrooms, linen carts, and storage closets on nursing units. At the same time, all soiled linens should be removed to the laundry for washing. These soiled items are counted as they come out of the laundry processing area for folding and storage. Before this count, all items that were processed in the laundry and linens in the main storage room should have been counted. Following this method should produce a fairly accurate count, although there will always be some minor discrepancies. The "over/(short)" column in [Exhibit 18-7](#) shows such discrepancies. For example, the overage of 11 bath towels and shortage of 16 hand towels may be attributed to a miscount. On the other hand, a shortage of washcloths is more significant if the counting was accurate. Such variances in a given month should not cause any alarm, but shortages occurring month after month indicate pilferage or other misuse. The column "to replenish" is the difference between "physical count" and "par levels," and shows the number of additional linens the facility must purchase to bring the counts up to par levels. According to [Exhibit 18-7](#), the greatest need is to purchase additional blankets and washcloths. The last column in [Exhibit 18-7](#) provides the total cost of bringing current inventory to par levels.

Managing Receivables

Accounts receivable are amounts due from residents and from third-party payers for services that the facility has already provided. Receivables are revenues that have yet to be collected. The income statement, discussed earlier, records all revenues regardless of whether the facility has actually received payment for the services it has performed. A facility that may be profitable on paper may experience serious financial difficulty if the booked revenues remain uncollected. Collecting receivables is critical for maintaining adequate cash flow. Therefore, managing accounts receivable is one of the critical elements of cash management, which is vitally important for the long-term survival of the facility.

Accounts receivable management has three objectives (Cleverley & Cameron, 2002):

- Minimize lost charges and reimbursement
- Minimize write-offs for uncollectible accounts
- Minimize the accounts receivable collection cycle

Minimizing Lost Charges and Reimbursement

The term **charge** means a fee that is established by the nursing facility for a particular service or product. The key phrase in this definition is “established by the facility.” In contrast, *reimbursement* is the fee established by a third-party payer, such as Medicaid, Medicare, or a managed care organization.

To minimize lost charges and lost reimbursement, the nursing facility must have a census tallying system to accurately account for all residents in the facility at midnight each day. The **midnight census report** is prepared by the night charge nurse and forwarded to the facility’s business office, where this report is used for calculating daily revenues for all residents by their respective payer types. Such daily revenue accounting forms the basis for producing monthly bills for each payer. Without adequate controls over daily census accounting, some revenues could be lost.

Charges other than room and board include ancillaries, such as medical supplies. Most third-party reimbursement rates are now all inclusive. An **all-inclusive rate** is a bundled fee that includes, in a single rate, all services and supplies furnished to a resident. For private-pay residents, however, ancillary items are billed in addition to the basic room-and-board fee. To capture ancillary charges for private-pay residents, the facility must maintain adequate procedures to record all ancillary services and supplies used by each resident. For example, each time a supply item such as a catheter is used, a voucher should be filled out.

Minimizing Write-Offs

The accounting term for write-offs is “bad debts.” For various reasons the facility is not able to collect all the monies it is owed. After several attempts to collect them, the outstanding accounts are declared uncollectible and are called bad debts. So, a **bad debt** is an amount that is legitimately owed to the facility but is deemed uncollectible.

To maximize payment from third parties, the facility’s personnel must thoroughly understand the rules established by each third-party payer. The facility must maintain updated Medicare and Medicaid manuals for reference purposes, and all new personnel must be adequately trained to comply with all rules that pertain to payment. Compliance with rules and regulations and maintenance of appropriate documentation in the medical records are critical to billing and collections.

Although third-party payments constitute the largest component of accounts receivable, deductibles and coinsurance are to be paid privately by the resident. Most residents have a **responsible party** handling the resident’s private financial affairs. Complete information on each resident’s designated responsible party, such as a spouse or relative, must be obtained at the time of admission. The responsible party is also asked to sign a statement that he or she assumes the responsibility to pay all amounts that the resident must pay privately.

Timely billing and follow-up are critical for collecting private monies. The facility must institute collection policy and procedures to be followed by its administrative personnel. The collection policy should outline at what point a collection call should be made, at what point a letter should be sent to demand payment, and at what point an account should be turned over to a collection agency. The policy should also outline at what point and under what circumstances the organization writes off accounts as bad debts (Nowicki, 2001). The decision to write off uncollectible amounts is made jointly by the administrator and corporate officers (for facilities affiliated with hospitals or multifacility chains) after evaluating each account that falls within the policy criteria for a bad debt. As a rule of thumb, after various collection efforts have been made and an account still remains uncollected for a year, it should be written off as a bad debt.

Minimizing the Collection Cycle

An essential tool for monitoring receivables and evaluating performance is called an “aging schedule,” also known as an “aging report.” An [aging schedule](#) provides a breakdown of each resident’s account by showing the length of time that various amounts within the account have been outstanding. **Exhibit 18–8** provides an illustration of an aging schedule. Notice that this exhibit shows for each resident the amounts due from each payer type and the age of each amount due. This exhibit also provides totals for the entire facility, and it shows the percentage of the total receivables that have been outstanding in each age category.

Exhibit 18–8 Aging Schedule on October 31, 2020

Resident’s Name		0–30 Days	31–90 Days	91–120 Days	Over 120 Days	Total Outstanding	
Adam, B	Private	920	103		1,354	\$2,377	
	Medicare	3,395	972			\$4,367	
	Medicaid		2,049		374	\$2,423	
	Other				127	\$127	\$9,294
Blake, C	Private	858	143			\$1,001	
	Medicare					\$0	
	Medicaid					\$0	
	Other	3,579				\$3,579	\$4,580
Cooper, D	Private			684		\$684	
	Medicare					\$0	
	Medicaid	2,894	320			\$3,214	
	Other					\$0	\$3,898
							
							
Total receivables		\$708,865	\$218,612	\$41,125	\$112,553	\$1,082,237	
		65.5%	20.2%	3.8%	10.4%		
Collection period						63.4 days	

The collection cycle for accounts receivable is measured in terms of the [collection period](#), which is also called “days’ revenue outstanding” or “days in accounts receivable.” This measure indicates the number of days’ worth of revenue that is in accounts receivable, which also indicates the average number of days it takes to collect receivables. Hence, the collection period evaluates how quickly a facility is able to bill and collect its revenues. This measure should be calculated at the end of each month using year-to-date data. The calculation is as follows:

$$\text{Collection period} = \frac{\text{Total accounts receivable}}{\text{Revenue/Days in period}}$$

Exhibit 18–8 shows that the receivables constitute 63.4 days’ worth of patient revenues. This result is derived by plugging the year-to-date patient revenue of \$5,205,696 (not shown) and the 305 days in the period from January through October into the preceding formula. The NHA and governing board should decide whether 63.4 days is an acceptable collection period or whether a shorter period ought to be the standard.

Budgeting

An operating budget specifies how revenues will be generated and what resources will be used during a specified period (Gapenski, 2002). It combines forecasts for revenues and expenses. Its format is like that of an income statement (see [Exhibit 18–1](#)). The operating budget is generally prepared for an entire fiscal year, and the planning process for this budget often begins 3 to 4 months before the current fiscal year ends. The fiscal year generally coincides with the calendar year.

Projections for the next fiscal year are made on the basis of some reasonable assumptions. Throughout the budgeting process, this question must be asked: “What can we reasonably expect to achieve?” Answers to this question should incorporate all known variables, such as any foreseeable changes in market competition; trends in the local economy; anticipated Medicare and Medicaid reimbursement rates based on economic and political factors; local labor market conditions for nursing and other personnel; general inflation for consumer products; and results expected from implementing any new strategies, such as a refocused marketing strategy. Using such assumptions, the NHA must first forecast anticipated census by pay type. Next, projections are made for private-pay charges and reimbursement rates from third parties. Finally, expenses are projected.

The assumptions just mentioned are applied to some base of reference. A reasonable base to use is what the facility has accomplished in the current fiscal year so far. Current data are often compared with the previous year’s performance data. Using all this information, managerial judgments are made regarding reasonable projections for the next fiscal year. The budgeting process is greatly facilitated by developing budget worksheets. The worksheets include all major pieces of information on which the budget projections are based.

Budgeting Revenues

Sample of a worksheet for census forecast is presented in [Exhibit 18–9](#). The first two sections of this exhibit contain historical and current data for 2018 and 2019. Note that at the time the budget projections for 2020 were made, the census data for 2019 were available only for the period until and including the month of October. The assumptions made for the 2020 projections have been noted on the worksheet. A similar worksheet (not shown) is used for projecting per diem rates, and revenues are calculated using the formula, $R = Q \times P$, where R is revenue, Q is quantity (resident days), and P is price (charge or reimbursement rate). Budgeting software programs calculate the resident days and revenues automatically as the census and per diem rates are entered into the computer. Finally, estimates for ancillary revenue and other revenues, such as income from investments or rental fees, should be added to the budget to arrive at the total revenue figure.

Exhibit 18–9 Census Projection Worksheet for 2020 Budget for a 126-bed facility.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year
2018 average daily census													
Private pay	27.8	28.1	29.1	28.5	27.7	28.0	28.0	27.0	26.6	24.7	23.4	24.0	26.9
Private insurance	2.2	2.2	2.4	2.4	2.5	2.3	2.1	3.0	2.0	3.0	4.0	4.0	2.7
Medicaid	59.6	59.2	59.9	62.9	61.8	63.4	63.9	63.1	64.8	65.2	65.7	63.2	62.7
Medicare	13.4	13.6	15.6	14.9	16.1	16.3	16.6	16.0	16.8	16.2	14.7	13.8	15.3
Veterans contract	4.0	5.0	5.5	5.5	4.5	3.5	3.5	3.0	2.0	2.0	1.0	0.0	3.3
Total	107.0	108.1	112.5	114.2	112.6	113.5	114.1	112.1	112.2	111.1	108.8	105.0	110.9
Occupancy rate	84.9%	85.8%	89.3%	90.6%	89.4%	90.1%	90.6%	89.0%	89.0%	88.2%	86.3%	83.3%	88.0%
2019 average daily census													
Private pay	22.4	23.1	24.1	23.5	23.7	24.2	26.0	27.0	26.6	27.5			24.8
Private insurance	2.2	2.2	2.4	3.4	4.5	2.3	2.1	3.0	2.0	2.4			2.6
Medicaid	62.6	61.2	59.9	62.9	61.8	65.4	63.9	63.1	64.8	60.8			62.6
Medicare	13.4	13.6	14.6	13.9	16.1	15.2	16.6	16.0	16.8	17.0			15.3
Veterans contract	2.0	2.0	1.0	1.0	0.0	0.0	3.5	3.0	2.0	4.3			1.9
Total	102.6	102.1	102.0	104.7	106.1	107.1	112.1	112.1	112.2	112.0			107.3
Occupancy rate	81.4%	81.0%	81.0%	83.1%	84.2%	85.0%	89.0%	89.0%	89.0%	88.9%			85.2%
2020 average daily census projections													
Private pay	26.0	26.0	28.0	29.0	30.0	30.0	31.0	31.0	31.0	31.0	30.0	30.0	29.4
Private insurance	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
Medicaid	58.0	58.0	60.0	60.0	62.0	62.0	62.0	62.0	62.0	61.0	59.0	59.0	60.4
Medicare	17.0	18.0	18.0	19.0	19.0	19.0	20.0	20.0	20.0	20.0	20.0	20.0	19.2
Veterans contract	2.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Total	105.6	106.6	108.6	110.6	113.6	113.6	115.6	115.6	115.6	114.6	111.6	111.6	111.9
Occupancy rate	83.8%	84.6%	86.2%	87.8%	90.2%	90.2%	91.7%	91.7%	91.7%	91.0%	88.6%	88.6%	88.8%
Assumptions:													
1. The previous administrator resigned in November 2018. The facility was without a permanent administrator for 2 months. It is assumed that a temporary drop in census occurred in early 2019 due to this change.													
2. A new marketing strategy aimed at private-pay clients was implemented in September 2019. It is assumed that private-pay census will be slightly higher in 2020.													
3. The VA contract will not be renewed once the existing VA patients are discharged.													
4. Contract with a new rehab company is expected to increase Medicare census.													

Budgeting Expenses

Expenses are budgeted for each department separately and then consolidated into a single budget for the entire facility. Separate departmental budgets allow the departmental managers to give their inputs into the budgets that they would be responsible for controlling. Projecting nursing labor costs is the most challenging aspect of the expense budget. This task can be simplified if the facility already has preestablished labor hour standards for different census ranges as illustrated in [Figures 18–2](#) and [18–4](#). Labor hours for maintenance, business office, social services, and activity departments are generally fixed. Housekeeping, laundry, and dietary department hours are also fixed for the most part. They may be adjusted if the census varies substantially. To facilitate labor-hour projections, budget worksheets should be developed to record historical data and assumptions used in forecasting.

The NHA and corporate officers should also determine budgetary allowances for overtime, training, and orientation, all of which are legitimate costs incurred in operating a facility. Overtime and orientation costs are partly a function of employee turnover and absenteeism. The budget should incorporate any funds required for implementing programs that may effectively reduce turnover and absenteeism. However, when funds are committed, the budget should also anticipate future cost savings.

Once labor hours have been determined, the next step is to project average hourly wages for each category of employees. The starting point for hourly rate projections is the actual hourly rates that appear in the current labor cost reports (see [Exhibit 18–5](#) for an example of these rates). Projections for the next year will be based on the facility's wage increase policies and the labor market conditions in the local area. Once projections for hours and wage rates have been made, labor cost can be determined by $C = H \times W$, where C is the labor cost, H is hours of labor, and W is average hourly wage rate. As in the case of revenue, budget software programs calculate labor costs automatically as the hours and wage rates are entered.

Finally, all other anticipated expenses should be included in the budget. Fixed costs such as telephone, postage, information technology, and insurance are generally entered as a constant amount for each month.

Costs such as utilities would vary according to hot and cold months and should be spread out accordingly. Variable expenses are generally projected on the basis of PRD costs. For example, if the projected cost for housekeeping chemicals for the 2020 budget is \$0.95 PRD, according to the census projected in [Exhibit 18–9](#), the budgeted expense would be \$3,110 for January (average daily census of 105.6 × 31 days in the month × 0.95 PRD expense) and \$2,937 for February (29 days in 2020).

The administrator should also budget for any activities associated with marketing and public relations. In the example presented in [Exhibit 18–9](#), one of the assumptions made for an increased private-pay census is the effect of a new marketing strategy. Any expenses associated with implementing this strategy should be budgeted, but an increase in census should also be anticipated.

Budgeted Margin

Once all revenues and expenses have been budgeted, the operating income (profit or loss before taxes) is calculated as

$$\text{Operating income} = \text{Total revenue} - \text{Total expenses}$$

[Operating margin](#)—total profit (or loss) as a percent of total revenue—indicates the organization's profit goal:

$$\text{Operating margin} = \frac{\text{Operating income}}{\text{Total revenue}} \times 100$$

Suppose the 2020 budget projected total revenues of \$8,337,650 and total expenses of \$7,304,000. These projections result in an operating margin of 12.4%. The NHA and the governing board must decide whether this projection is reasonable. Suppose the expectation is 13%. The budget would then require some further tweaking, perhaps both on the revenue and expense sides. In most instances, reasonable modifications are necessary before the budget is finalized and approved by the governing board.

Terminology for Review

accounts payable
accounts receivable
accrual-basis accounting
aging schedule
all-inclusive rate
assets
average daily census
bad debt
balance sheet
budget
budgeting
cash flow statement
census
census range
charge
collection period
days of care
equity
financial accounting
fixed costs
flexible budget
income statement
liabilities
management accounting
midnight census report
net assets
operating margin
resident days
payer mix
responsible party
semifixed costs
variable costs
variance
variance analysis

For Further Thought

Refer to Exhibit 18–3. Suppose the facility loses its Veterans contract. To make up for the lost revenue, the NHA undertakes a marketing campaign to promote the facility's rehabilitation services with the objective of building its Medicare census. How many Medicare resident days will be needed to make up for the lost revenue?

CASE

Get in Line with the Budget

Contributed by Juliet A. Davis, PhD, MHA, University of Alabama, and Paul W. Davis, vice president of operations, Nutrition Management Services.

Greater Metropolitan Health Systems (GMHS) owns two skilled care nursing homes, one assisted living facility, and a freestanding adult day care center. GMHS is relatively new and the chief executive officer, Jordan Shelby, is seeking ways to expand the company's health care outreach. An inpatient drug rehab facility, Turning Leaf Drug Treatment Hospital, has come up for sale. Turning Leaf specializes in treating substance abuse issues in adults over the age of 60. According to a report from the Substance Abuse and Mental Health Services Administration, substance abuse issues among older adults are steadily increasing. Hence, in the future, the number of elders seeking treatment options will also continue to rise. Shelby believes that the acquisition of Turning Leaf will be an additional source of revenue for GMHS and a source of referrals for long-term care services within the system.

An analysis of Turning Leaf's financial operations shows some problems. Annual expenses are running \$50,000 over budget; the entire negative variance is in food service. Revenues also show an annual shortfall of \$170,000, mainly because of cuts in reimbursement from the state. Shelby thinks that if the facility can deal with cuts in expenses, it can overcome the revenue shortfall by expanding GMHS's marketing strategies to increase the number of resident days. If this can be achieved, Turning Leaf will become profitable.

In a management meeting to discuss the acquisition of Turning Leaf, the following key points were made:

- To keep client satisfaction level high, no cost reductions should be made in the regular food cost.
- Snacks are a separate expense item for food service. Clients recovering from various types of addictions often experience cravings for sugar, caffeine, and junk food. However, simply eliminating snacks is not an option because, in some cases, cravings are attributed to the pharmaceuticals some clients must use.
- Clients are given all day access to snacks and coffee. In the past, clients paid for their own snacks, but management at Turning Leaf stopped charging for snacks shortly after the state cut personal allowance funds by 7% for those on public assistance.

Shelby's ears perked up when his chief financial officer (CFO) remarked, "Their financial control systems are ridiculous. We must not only get in line with the budget, but also charge the residents \$0.50 per person per day for the snacks to offset the costs. My calculations show that we can reduce the snack expense by close to \$80,000."

Expenses for Snacks at Turning Leaf Drug Treatment Hospital

Budgeted resident days (annual)	29,450
Actual resident days (annual)	25,540
Budgeted cost of snacks	\$122,410
Actual cost of snacks and coffee	\$172,584
Breakdown of monthly cost of snacks	
Snack bags available to clients	\$5,067
Floor stocks	\$2,852
Snack bags for new admissions	\$1,113
Special diet bags	\$2,913
Specialized snacks	\$2,437
Monthly Total	\$14,382

Questions

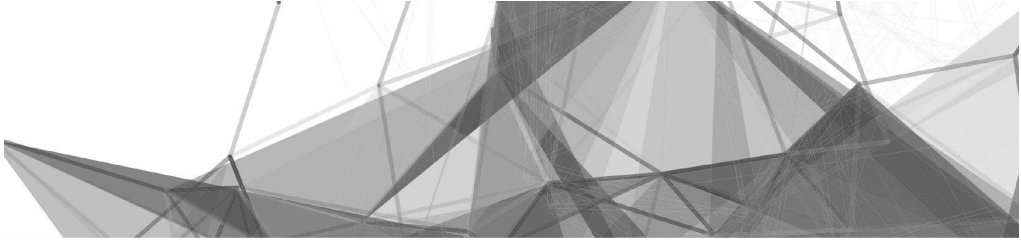
1. Do you agree with the CFO's statement? Run your own numbers to prove your point.
2. What is the advantage or disadvantage of charging clients \$0.50 per day?
3. Generally, special diet and specialized snacks are more expensive than regular snacks. If GMHS can negotiate a discount of 4% on special diet and specialized snacks and 10% on regular snacks from the vendors, by how much will the profitability improve, including what you found in question 1?
4. Suppose the facility gets paid \$134 PRD in reimbursement from the state. All other things being the same, how many additional resident days would be needed to cover the budget deficit remaining after questions 1 and 3? Note: Ignore the additional costs associated with the increased resident days.

For Further Learning

Beyond the basics presented in this chapter, the reader can pursue additional analytical techniques that use financial ratios: http://educ.jmu.edu/~drakepp/principles/module2/fin_rat.pdf

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CHAPTER 19

Effective Quality and Productivity Management

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WHAT YOU WILL LEARN

- Plant and environmental services include maintenance, housekeeping, laundry, security, waste management, and environmental safety.
- Maintenance operations must plan for urgent service calls, routine repairs, preventive maintenance, and different types of contract work.
- Housekeeping practices require daily routine cleaning, weekly heavy-duty attention, and periodic reconditioning. Certain sanitizing and infection control practices specifically apply to housekeeping.
- Laundry operations require microbicidal washing, standard precautions, and prevention of cross-contamination. To ensure an adequate linen supply, the administrator should institute a multi-par system and inventory control.
- A security audit should be part of the physical security operation. The administrator should be able to do simple cost-benefit analyses to make decisions about investing in surveillance equipment.
- All associates must be trained in fire protection steps represented by the acronym RACE. The facility must have designated areas of refuge during a fire or disaster emergency. Plans must include partial and total evacuation.
- Waste disposal practices must include removal of general waste and hazardous waste.
- Various environmental safety procedures and monitoring of hot water are necessary to prevent accidents.

Introduction

Efficiency, productivity, and quality improvement are often regarded as isolated and even contradictory concepts. Some people instinctively equate “efficiency” and “productivity” with “doing more with less.” Nursing home personnel have a tendency to presume that improved efficiency means working harder, doing more in less time, and constantly rushing to meet residents’ needs. It is also assumed that quality suffers when greater efficiency is required and that an organization may achieve either higher quality or greater efficiency but not both. Years of research and experience in various industries, however, have demonstrated that such ideas are flawed.

Modern methods of improving quality and productivity were developed in manufacturing industries. Service-oriented organizations, including health care organizations, had generally lagged behind the manufacturing sector in implementing these methods. Increasingly, however, health care managers have realized that quality and productivity can indeed be managed and that effectively managing these areas can provide a competitive edge to an organization.

Productivity and Quality

For all practical purposes, *productivity* and *efficiency* are synonymous. Measuring productivity and efficiency means taking into account the cost of inputs used in the production of certain outputs. Delivery of health care is particularly labor intensive, which means that people have to provide hands-on services. In an aging society, however, improvements in productivity become even more critical because of decline in the supply of qualified workers. Although improving productivity has been challenging in the health care sector, technological innovation that can complement human-patient interface will continue to gain prominence.

Productivity is often viewed as physical outputs produced in exchange for certain quantified inputs. A sole focus on physical outputs, however, can actually be counterproductive. The notion of outputs must incorporate the quality of the outputs produced, not merely their quantity. Productivity and its enhancement are understood as follows:

$$\text{Productivity} = \frac{\text{Outputs}}{\text{Inputs}}$$
$$\text{Productivity enhancement} = \frac{\text{Desired quality}}{\text{Minimization of resource inputs}} \quad (1)$$

or

$$\frac{\text{Maximized quality}}{\text{Unit of resource inputs}} \quad (2)$$

For simplicity, outputs in a nursing facility are collectively called resident care. These outputs are the result of the various resident care delivery processes: social services; medical care, nursing, and rehabilitation; recreation and activities; dietary services; plant and environmental services; and administrative and information systems. Productivity is enhanced when the most desirable outputs are produced at the least cost for these services (minimization of resource inputs).

Productivity and quality are interrelated. According to current management thought, improved quality can lead to improved efficiency and vice versa. From this perspective, **productivity** is defined as maximization of quality for each unit of resources used in delivering health care. Accordingly, productivity can be expressed as “desired quality at the lowest possible cost” ([equation 1](#)) or as “highest possible quality for a given cost” ([equation 2](#)) (Palmer, 1991, p. 12). Measuring productivity therefore requires assessing how effectively a nursing facility’s resources are used in delivering resident care services that meet certain standards of quality. **Inefficiency**, on the other hand, reduces the opportunity for quality at a given level of resources (Griffith & White, 2002). In other words, when resources are deployed without enhancing quality, the use of such resources becomes inefficient.

Cost and Quality Relationship

Studies have shown that nursing homes that produce high-quality services are able to lower their costs for delivering resident care because quality improvement often improves processes of care as well as productivity. A state-wide study of nursing homes concluded that good quality care actually costs less than poor quality care (Rantz, 2003). Even when higher costs are incurred by increasing hours for registered nurses (RNs) in relation to other staff, positive outcomes of care are achieved that have an inverse effect on overall costs (Weech-Maldonado et al., 2003). Through a higher skill mix, care-related problems can be addressed more promptly, better direction can be given to paraprofessionals, and regulatory and legal sanctions can be avoided through improved care.

The implication is clear: Focusing on providing high-quality services is a cost-effective strategy for nursing facilities (Rantz, 2003). By lowering the cost of inputs, improved quality also increases productivity. The cost of poor quality can indeed be very high. Just think of the many costs associated with low quality. Direct costs can include fines and penalties imposed by regulatory agencies, legal costs incurred in defending against lawsuits, and payment of legal settlements. Indirect costs are incurred when trust in the community erodes, followed by declining reputation, loss of managed care contracts, and a drop in resident census. Certain hidden costs may

include increased staff turnover and absenteeism. Costs associated with investigation of complaints are also hidden costs of poor quality.

What Is Quality?

Quality in a nursing facility can be defined as the consistent delivery of services that maximizes the physical, mental, social, and spiritual well-being of all residents, produces desirable clinical outcomes, and minimizes the likelihood of undesirable consequences. Note that delivery of high-quality care in the nursing home has four essential components: consistency, holistic well-being, desirable clinical outcomes, and prevention of undesirable consequences. Hence, quality is a multifaceted concept.

Consistency

The word *consistency* signifies four characteristics that apply to nursing home services:

- Continuity
- Regularity
- Uniformity
- Reliability

Continuity means that delivery of high-quality services must be sustained over time. Variations from one day to another must be kept to a minimum. In practical terms, continuity means that the facility should, among other things, be just as clean on the weekend as it is on a weekday and that the food served should taste just as good at supper as it does at lunch.

Regularity means timeliness. Regularity emphasizes timely attention to resident needs. Examples of regularity in a facility include regular bed checks for incontinent residents, prompt response to call signals from residents who need staff attention, and timely attention to situations that require the intervention of social services.

Uniformity is sustained delivery of quality not only over time but also across the resident population within the facility. Uniformity means delivering the same caliber of services to all residents regardless of their pay status, race, or any other characteristics.

Reliability is the acid test of consistent quality. Reliability is achieved when a facility's associates can deliver uncompromised quality when no one is watching, because management and family members cannot be in the facility all the time to monitor quality. Trust and dependability are built when family members can be free from undue worry about the total well-being of their loved ones.

Holistic Well-Being

Holistic care is one of the key characteristics of long-term care. The holistic approach emphasizes delivery of services that meet each resident's physical, mental, social, and spiritual needs in the context of the whole person. Hence, quality includes much more than clinical care. It must also emphasize all aspects of quality of life.

Desirable Clinical Outcomes

An **outcome** is an actual result obtained from medical, nursing, and other clinical interventions. An increase in positive outcomes indicates that quality has improved. For example, quality is improved when there is notable progress with the healing of pressure ulcers that were present when residents were admitted, when residents are weaned off urinary catheters, and when infections are reduced. On the flip side, incidence of new pressure ulcers acquired in the facility, prevalence of falls or injuries, frequency of infections, and occurrence of health-threatening weight loss or dehydration are indicators of negative quality outcomes.

Prevention of Undesirable Consequences

An important aspect of quality is the system a nursing facility implements to prevent negative outcomes—and how effectively that system is actually used and monitored. Such negative outcomes as accidental deaths and injury from negligence can have catastrophic consequences. Waiting for negative outcomes to occur is obviously not the desirable approach. Clinical errors, lapses in safety, unsanitary practices, and poorly maintained equipment have the potential to cause harm that can be prevented.

Technical and Consumer-Defined Quality

An understanding of total quality must incorporate both technical and consumer perspectives. The outcomes of care delivery are just as important as client satisfaction.

Technical Quality

The preceding description of quality, related to care delivery, refers to *technical quality*. The level of a facility's technical quality depends on its clinical structures, its processes and practices, and the technical competence of its staff. Increasingly, in health care delivery, evidence-based practices—also referred to as clinical practice guidelines and **best practices**—are being used as a means of reducing inappropriate care and improving patient outcomes (Berlowitz et al., 2001). Hence, the use of evidence-based practices is an essential characteristic of long-term care. Best practice guidelines are available for a number of clinical situations, such as management of urinary incontinence, prevention of pressure ulcers, treatment of pressure ulcers, prevention of urinary tract infection, diabetes management, post-stroke rehabilitation, and pain management for cancer patients, etc. The American Geriatric Society, the Agency for Healthcare Research and Quality, and the Society for Post-Acute and Long-Term Care Medicine (formerly, the American Medical Directors Association—AMDA) have been at the forefront of developing best practice guidelines for the care of elderly patients. The AMDA has also developed training tools on how to implement the guidelines. The underlying premise of evidence-based protocols is that standardizing work processes decreases variability in care delivery and improves outcomes (Finch-Guthrie, 2000). However, implementation of standardized guidelines has been challenging in nursing homes because care delivery requires interdisciplinary decision making, and as much as 70% of the care is provided by paraprofessionals who have little formal training. Hence, training of associates is critical to improving quality.

Consumer-Defined Quality

Consumers' impressions about quality can be called *consumer-defined quality*. Even though residents and family members are not equipped to evaluate technical quality, they form impressions about quality on the basis of their personal observations and experiences, what they may hear from other family members, stories they may encounter in the news media, and how the facility's staff interact and communicate with them. Consumers are also better able to assess quality-of-life factors than technical quality. Their impressions are influenced by the aesthetics of the physical premises, cleanliness and comfort, food, activities, staff attitudes, interactions with management, and the facility's accommodation of individual needs and preferences.

It is possible for consumer-defined quality to actually be at odds with a facility's technical level of quality. In general, consumers seek more than technically correct health care. They seek humanistic qualities as well as technical competence (Palmer, 1991). For this reason, staff members must be trained in communicating with the resident and family, listening for signs of distress, responsiveness, respect, empathy, honesty, and sensitivity.

Framework of Quality

The framework of quality described here has been credited to the work of Avedis Donabedian (1919–2000). The management of quality requires an understanding of this framework to guide quality improvement. Donabedian proposed three domains in which health care quality should be examined: structures, processes, and outcomes. All three domains are equally important in driving quality improvement, and they are closely linked in a hierarchical manner (see **Figure 19–1**); structures influence processes, and both structures and processes together influence outcomes. Structures and processes in long-term care are shaped by regulations as well as by other changes in the external environment such as new technology, culture change, ecological forces (new infections, antibiotic-resistant strains of bacteria, natural events, etc.), and management philosophies and practices.

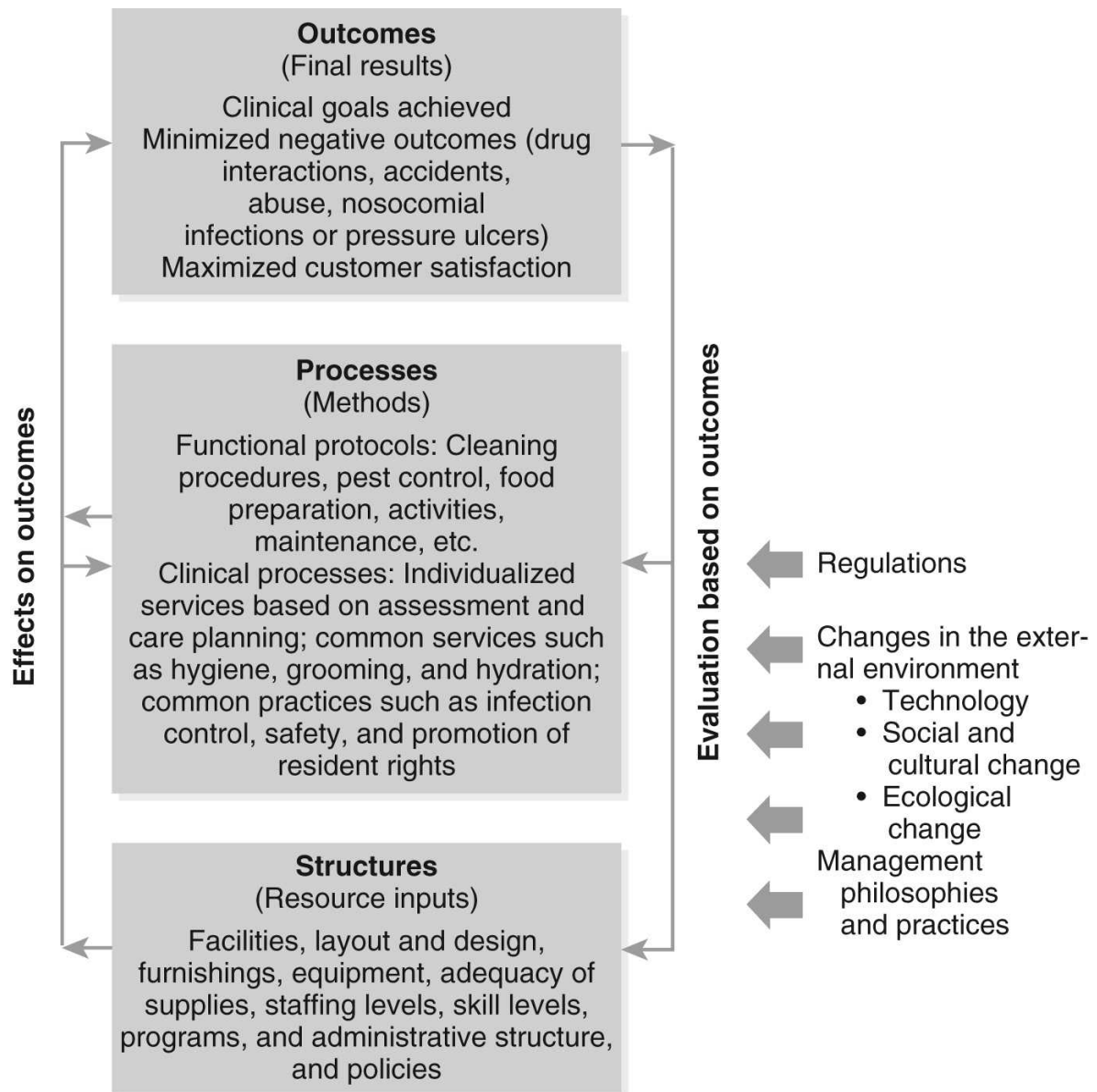


FIGURE 19-1 Framework of quality

Structures

Structure provides the necessary foundation without which high-quality care cannot be delivered. In that sense, structure is where quality begins because inadequate structural quality would negatively affect processes and outcomes. Structural criteria refer to the availability of resources, such as facilities, equipment, staffing levels, staff qualifications, programs, and the administrative structure (McElroy & Herbelin, 1989). Space, building layout, furnishings, technology, adequate supplies, trained associates, staffing levels and skill

mix, minimum absenteeism and turnover, and facility policies constitute structural elements of quality. The structural elements determine a nursing home's capabilities to deliver an adequate level of care.

Processes

Processes are methods designed for producing desired outcomes and the application of those methods to actually produce desired outcomes. Processes entail staff functions, timeliness, accuracy, following established protocols, monitoring and observation, and taking appropriate action to counter negative observations. Each department of the nursing facility must establish functional protocols to aid in the achievement of the process elements of quality. Examples of such protocols include clinical practice guidelines; quality improvement program; cleaning and sanitizing procedures; pest control; food purchasing, storage, production, and service; building and equipment maintenance procedures; and activities and recreational programming.

The quality of nursing home processes is governed by achieving excellence in the delivery of services that can be classified into three categories: individualized services, common services, and routine practices.

Individualized Services

Resident assessment is the cornerstone on which clinical processes (such as plan of care and the delivery of services) are based to meet individual needs. Individualized care plans establish clinical expectations that guide the delivery of individual care such as administration of medications, nursing treatments, rehabilitation therapies, social interventions, recreational support, special diets, and assisting the resident with activities of daily living (ADLs).

Common Services

Common services refer to practices that apply to all residents unless contraindicated in the care plan. Examples include daily hygiene and grooming, scheduled shower or bath, hydration, bedding change, and clean towels. Other types of common services include accurate billing, timely and complete medical records, communication with family about the resident's status, and notification to physicians.

Routine Practices

Routine practices refer to protocols to ensure that certain practices are consistently followed to improve both the quality of care and quality of life for the entire resident population in the nursing facility. Examples include infection control, quality improvement systems, environmental cleanliness and comfort, safety and security, respect and dignity, privacy, and active promotion of resident rights.

Outcomes

Outcomes are the final results produced by the structures and processes. Primarily, clinical outcomes are evaluated against individualized care plans to determine whether preestablished treatment and intervention goals have been met. Other outcomes include elements outside the plan of care and focus mainly on preventing negative incidents such as drug interactions, accidents, resident abuse, infections, and facility-acquired (nosocomial) pressure ulcers. In almost all cases, outcome issues can be addressed only by retrospectively evaluating structures and processes and by taking appropriate corrective action.

Regulatory Standards and Quality

Historically, quality in nursing facilities has been defined by the standards established for participation in the Medicare and Medicaid programs, known as Requirements of Participation. Compliance with these standards has been widely used as a proxy for quality.

Over the years, quality of care in nursing homes has improved, mainly in response to the enforcement of regulatory standards. The survey process, however, has had three major limitations:

1. Regulations establish only minimum standards of quality.
2. Nursing facilities cannot be monitored on a continuous basis by regulatory agencies.
3. Survey results vary widely despite the government's efforts to standardize the process and train its surveyors.

The QAPI Program

Manadated by the Affordable Care Act, the Quality Assurance/Performance Improvement (QAPI) program is now part of the Requirements of Participation for all certified facilities. The main regulatory requirements pertaining to QAPI are summarized in **Exhibit 19–1**. The regulations define quality assurance (QA) and performance improvement (PI) as follows (CMS, 2016):

- QA is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards. QA is ongoing and both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.
- PI (also called quality improvement—QI) is the continuous study and improvement of processes with the intent to improve services or outcomes and prevent or decrease the likelihood of problems by identifying opportunities for improvement and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve facility processes involved in care delivery and resident quality of life.

Exhibit 19–1 Regulations for Quality Assurance and Improvement (Summarized)

F- Regulatory Requirements

Tag

F865 Each long-term care facility must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The QAPI program must be ongoing and must address the full range of care and services provided by the facility.

A QAPI plan is the written plan to guide the nursing home's efforts in assuring that care and services are maintained at acceptable levels of performance and continually improved.

F866 The facility must establish and implement written policies and procedures for feedback from staff, residents, and family members; data collection systems; performance indicators; and monitoring that includes tracking of medical errors and adverse events.

F867 The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

F868 The facility must maintain a quality assessment and assurance (QAA) committee which must include the director of nursing; the medical director (or his/her designee); the infection preventionist; the administrator, owner, or board member; and at least two other members of the facility's staff.

The QAA committee is responsible for identifying and responding to quality deficiencies throughout the facility, oversight of the QAPI program, corrective action, and monitoring to ensure performance targets are achieved.

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP: Guidance to Surveyors for Long-Term Care Facilities.
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>.

The Centers for Medicare and Medicaid Services (CMS, 2016) has proposed five elements considered essential for success of the QAPI program (summarized here):

1. Design and scope: QAPI is an ongoing program that must encompass all services, departments, systems of care, management practices, quality of life, and resident choice. It should utilize the best available evidence to define and measure goals.

2. Governance and leadership: The governing body should assure adequate resources for QAPI, designate one or more individuals to be accountable for QAPI, and assure leadership development and facility-wide training on QAPI. The governing body should create an atmosphere in which staff is comfortable identifying and reporting quality problems as well as opportunities for improvement.
3. Feedback, data systems, and monitoring: Systems should be established to monitor care and services by drawing data from multiple sources. Feedback systems should actively incorporate input from staff, residents, families, and others as appropriate. Performance indicators should be established to review findings against benchmarks and/or targets. Adverse events must be investigated every time they occur and action plans implemented to prevent recurrences.
4. Performance improvement projects (PIPs): A PIP is a concentrated effort on a particular problem in one area of the facility. It is used to examine and improve care or services in areas that the facility identifies as needing attention.
5. Systematic analysis and systemic action: When determined necessary, a systematic approach should be used to undertake an in-depth analysis to fully understand a problem, its causes, and implications of a change. Systemic actions look comprehensively across all involved systems to prevent undesirable events and promote sustained improvement.

Measurement and Evaluation of Quality

Quality cannot be improved without measuring it. **Measurement** refers to collection of meaningful data, analysis of the data, and comparison of the data to objective benchmarks of quality. Measurement and evaluation of quality are geared to pinpoint deficiencies so that corrective actions can be taken to improve quality.

Focus on Outcomes

Although structure, process, and outcome data all have a place in measurement of quality, the focus of measurement must be on outcomes. Structural measures only serve to ensure that staff, facilities, equipment, and organizational features meet the necessary conditions for delivering good care (Palmer, 1991). Process measures evaluate methods and practices intended to maintain or improve quality. Outcomes, however, define whether quality goals are being met. When anticipated outcomes are not achieved, structures and processes must be examined to determine where the breakdown occurred and what actions should be undertaken to prevent future failures.

Quality measurement can be illustrated by using the simple example of a meal tray delivered to a resident who requested to have the noon meal in her room. Placing the meal tray before the resident is the main outcome, without which the output would be zero, a total failure of quality. But assuming that a meal tray is delivered, other attributes of this output—such as timeliness of delivery, conformance with the resident's diet, compliance with the resident's likes and dislikes regarding choice of food items, portion size, temperatures of the hot and cold items, the amount of food actually consumed by the resident, and the resident's level of satisfaction with the meal—must be evaluated. Each of these attributes is measurable, so a composite score can be used to quantify the level of quality.

Measuring Customer Satisfaction

Customer satisfaction is best assessed through a satisfaction survey—called a *survey instrument*—completed by residents and their surrogates. It is critical, however, that the reliability and validity of the survey instrument be established in order to get meaningful information about customer satisfaction. **Reliability** is the extent to which the same results occur from repeated applications of a measure under identical conditions. Reliability deals with the precision of measurement. Unless a survey instrument delivers reliable results, the results obtained by surveying customers at repeated intervals, such as every year, cannot be compared. For example, if in the first year of using the survey a facility scored a 7 on a scale of 1 to 10, and in the second year the same facility scored a 7.5, improvement in customer satisfaction can be inferred only if the instrument used to assess satisfaction had a high degree of reliability. The **validity** of a survey instrument denotes the extent to which the instrument actually measures what it purports to measure. Reliability in itself does not ensure that a measure is valid. An instrument can have very high reliability, but if it has poor validity, the results become useless. For example, if a survey instrument measures customer satisfaction with factors other than those associated with the facility's services, such as satisfaction with location, geographic access, and opinions of friends, such an instrument will be useless in helping the facility improve satisfaction by improving the facility's services. Reliable and valid measurement instruments can be designed by health care researchers.

Individually rated responses from consumer surveys are consolidated to determine an overall score of customer satisfaction. Such aggregated scores derived from all the responses to a survey provide an estimate of the average perceived quality (Lawton, 2001). When necessary, survey results can be supplemented with other approaches, such as focus groups, particularly when further clarification or additional information is needed. Research has demonstrated a high degree of correlation between subjective assessments of satisfaction and key outcomes.

Several private firms specialize in developing and conducting client satisfaction surveys for health care organizations. Many of the instruments have undergone extensive development and testing. Separate survey instruments should be used for nursing home residents and their family members. For nursing home residents, a survey administered by an interviewer is likely to produce more objective results than one that the resident fills out independently.

Evaluation and Interpretation

Once outcomes have been measured, the results must be interpreted (or evaluated). For instance, a numerical score is meaningless unless its relevance is clearly established. The goal of evaluation is to transform numerical scores into meaningful information that would be useful for improving quality. Evaluation is always done in relation to some benchmark. A benchmark can be anything that management considers acceptable. For example, staff turnover is an inverse and indirect measure of quality; a high score indicates low quality of human resource and leadership practices and vice versa. Suppose a given nursing home has an annual turnover rate of 30% for licensed nurses. This measure is not very helpful unless it can be interpreted in

relation to some benchmark, such as nurse turnover rates in the nursing home industry or within a multifacility corporation or a target established by the administrator and the governing board.

Measuring Quality of Life

For nursing home residents, quality of care and quality of life (QoL) are closely intertwined. However, measuring QoL has been challenging even though various scales have been developed. One main barrier is the ability of all residents to complete the surveys because of various degrees of cognitive impairment. Although it is possible to interview care personnel or family members to obtain proxies of a resident's QoL, research shows that staff and family answer questions differently than residents do (Kane et al., 2004). Only in high cognition groups can 80% to 90% of the residents answer QoL-related questions. Hence, the level of cognitive impairment has a substantial influence on the validity of QoL measures (Gerritsen et al., 2007).

Continuous Quality Improvement

The current focus in health care is on [continuous quality improvement \(CQI\)](#), which is an ongoing undertaking to improve quality throughout the nursing facility. Quality improvement in long-term care embodies six basic principles (adapted from Evans & Lindsay, [1993](#)) that form the framework for CQI. The principles outlined here can also enable a facility to successfully carry out the QAPI program:

1. A facility can be successful only by understanding and fulfilling the needs of its customers.
2. Leadership in improving quality is the responsibility of the nursing home administrator, with full support from the governing body. Leaders must demonstrate ongoing commitment to quality.
3. Statistical evaluation using factual data is the basis for CQI.
4. All departments within the facility must implement CQI.
5. Problem solving and process improvement are best performed by interdisciplinary (or multidisciplinary) work teams.
6. Continuous learning, training, and education are the responsibility of everyone in the organization, but these activities require support from top management.

Meeting Customer Needs

In a broad sense, the term [customer](#) refers to any entity that receives the product of a transaction. Residents and their families are the primary customers. There are other customers, however, who may not receive the end product but have a vested interest in the quality of the products. Griffith and White ([2002](#)) referred to them as *customer partners*. External customers include payers (Medicaid, Medicare, managed care organizations, and other insurers), regulatory agencies (state departments of health, agencies on aging, local health and fire departments, and the Joint Commission), and referral agencies (hospitals, physicians, and others). A nursing facility also has internal customers that include all personnel who receive information, services, or other professional support from fellow employees. To deliver what external customers expect, these internal customers have to depend on each others' outputs (Bradley & Thompson, [2000](#)). Attending physicians, for example, rely on information and support from the facility's nursing staff. Certified nursing assistants (CNAs) need the support of professional nurses, and nurses in turn often rely on the CNAs to report problems or changes in a resident's condition. Fulfilling the needs of internal customers affects the way the needs of external customers are addressed.

Leadership Commitment

Empirical evidence demonstrates that success in CQI implementation is strongly associated with the commitment and culture of top management. In organizations characterized by top management commitment, turnover at key top-level positions is low, the associates view top management as strong advocates of CQI, leaders are open minded and communicative, leadership styles are participatory and team oriented, and top managers demonstrate a clear understanding of CQI principles (Parker et al., [1999](#)).

Top managers must first understand the concepts of CQI and then become knowledgeable about the tools, processes, and methods necessary for quality improvement (Baird et al., [1993](#)). Commitment to CQI includes allocation of necessary resources. Top managers should then set goals and plans for implementing principles and practices for quality improvement. Top managers must be committed to involving all associates by providing proper training and a reward system for accomplishing quality goals (Evans & Lindsay, [1993](#)).

One of the key barriers to change is the conscious or unconscious retention of old beliefs and actions that discourage innovation, creativity, empowerment, or other components of CQI (Gaucher & Coffey, [1993](#)). Once a CQI program is implemented, both managers and workers should be prepared to accept failures along the way. However, patience and perseverance are necessary. Fear of failure only stifles innovation.

Relatively short tenures of nursing home administrators and other key personnel disrupt the continuity and commitment that are so essential for CQI. Job-hopping administrators never get to understand the facilities they manage for short durations. Such administrators do a great disservice to the residents and to their profession because follow-through over time is necessary for building quality and productivity.

Statistical Evaluation

Quality improvement is anchored in a quantitative approach in which data and measurements are used to evaluate the current state of quality, improve processes, and track progress. Sources of data may be the facility's own internal records and information systems, special surveys, logs, check sheets, or observational studies. The data can be charted to show trends and deviations from benchmarks.

Encompassing All Departments

CQI must focus on all departmental functions in the facility. At any given time, each department in the nursing facility can have some area of concern to improve upon. CQI also requires scrutiny of interdepartmental communications, process interlinkages, and horizontal coordination among the various organizational units, all in the context of meeting the expectations of internal and external customers.

Interdisciplinary Work Teams

A team approach to quality improvement is likely to make the process unbiased, systematic, and thorough. Under the leadership of the administrator or a consultant, the composition of the QAA committee should change as new quality issues are addressed. As different associates get the opportunity to be on the team, the team becomes a mechanism for building a culture of quality in the organization, in training associates, and in building a sense of ownership in quality improvement. Once the CQI is well established, more than one team can work on different quality improvement projects.

Hiring a consultant may be necessary for CQI, especially when a facility initiates a CQI program. The consultant can evaluate the cultural aspects of the organization that could pose barriers to the success of a CQI program. When substantial barriers are foreseen, the administrator is in a better position to develop a strategy for gradual change. The consultant can also be instrumental in training associates at all levels as well as senior management. Such organization-wide training is how CQI programs are almost always formally begun. Training is necessary to reach a common understanding about CQI, clarify goals, and establish reasonable expectations.

Continuous Learning

A well-developed CQI program involves the participation of associates at all levels of the organization. Continuous learning then becomes institutionalized alongside continuous improvement of quality as associates discover improved methods and play a role in implementing them. In an interdisciplinary environment, associates get to better understand how their actions affect the work of others and how their actions, in turn, affect the expectations and satisfaction of both internal and external customers.

Deming's Process Improvement Cycle

The Deming cycle, named after W. Edwards Deming (1900–1993), is used to focus on improving processes that would result in improved outcomes. It involves four steps: plan, do, study, and act (PDSA). The PDSA cycle is a continuous improvement cycle (**Figure 19-2**) that can be applied to any process.

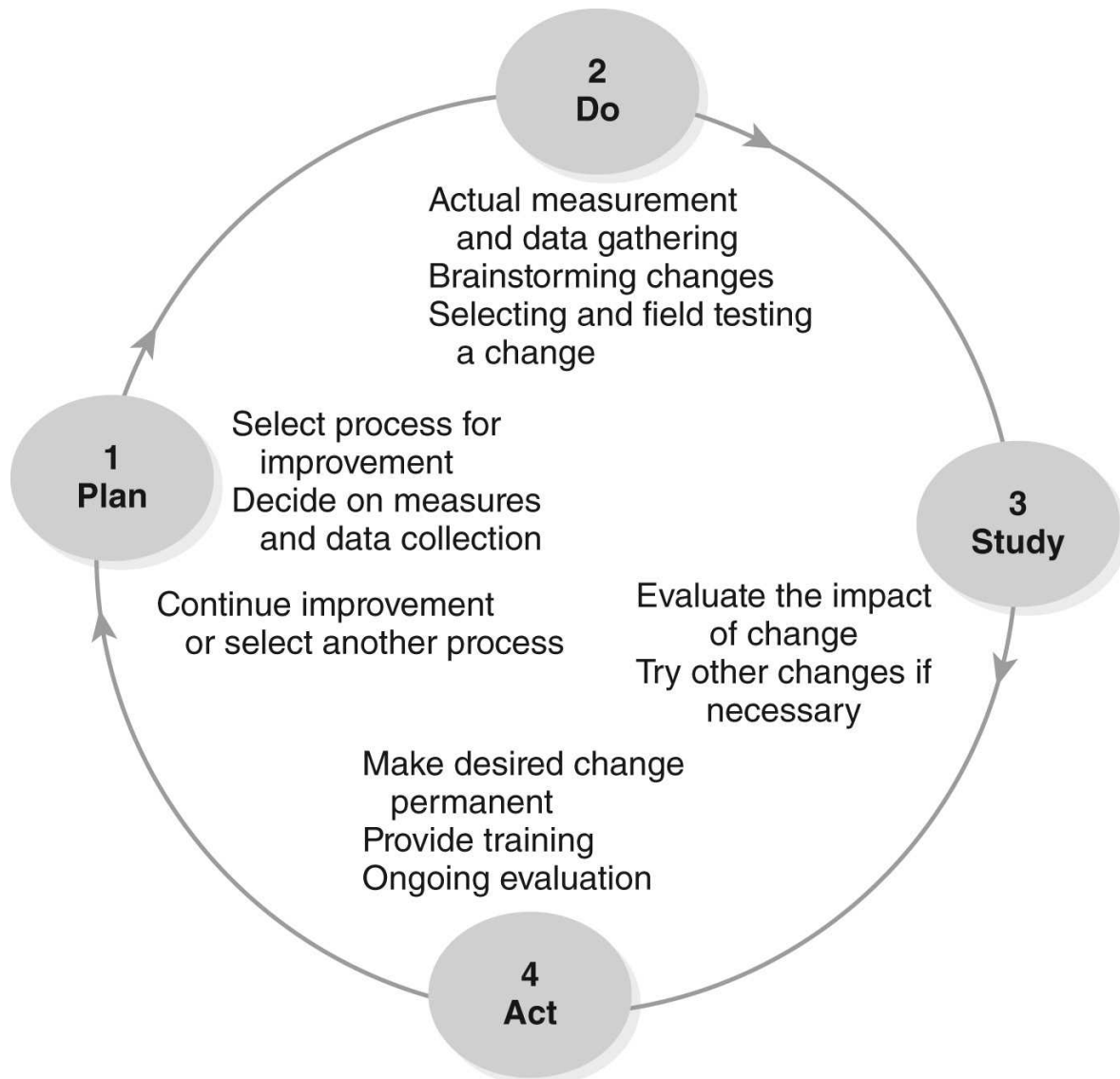


FIGURE 19-2 The PDSA cycle

Plan

The plan stage focuses on uncovering quality problems. It involves selecting a specific area for improvement, studying the current situation, deciding on which measures would be appropriate and how data would be collected, and discussing plans for improvement. Initially, it may be best to address small-scale problems that would facilitate learning the PDSA process and build the confidence of associates in applying this process. If benchmarks or standards are available, variations are measured to determine how much current outcomes deviate from the standards. In the absence of benchmarks, data should be collected to establish a baseline against which future progress can be measured.

Once the PDSA system is learned, the selection of topics should be driven by priorities in addressing areas where outcomes are less than acceptable. Improvement in resident care should outweigh all other goals of a quality improvement program. Answering certain questions can help focus on the most important topics (Vitale & Vengroski, 1993): Does the problem interfere with the delivery of high-quality care? Is it a high-risk concern? Will the benefit of improved outcomes outweigh the cost of monitoring and correcting the problem? Is the

problem common enough to warrant the effort and cost to solve it? Can the problem be solved with available financial and human resources?

Do

The do stage involves actual measurement and data gathering. Certain types of flowcharts or diagrams can provide a clear understanding of the various steps and interfaces involved in a given process to help pinpoint critical stages in a process that can be improved. For example, the flow of centralized food service from the main kitchen involves starting the food service by a certain time, maintaining the right temperatures at the service line, checking plated foods against diet cards, picking up trays by CNAs, serving the food to the residents, pouring beverages, etc.

Once the point at which a breakdown occurs has been identified, changes are then discussed and implemented on a small-scale trial basis, referred to as *field testing*. Field testing is particularly useful when best practice protocols are not available. In the previous example, tray accuracy studies can be a useful diagnostic tool for evaluating the quantity and seriousness of diet errors (Dowling & Cotner, 1988). Field testing an intervention in the meal delivery system may involve, for example, assigning a food checker at the end of the tray line to check all items on the meal trays against diet cards for individual residents.

Study

The study stage requires an evaluation of the changes that have been made in a selected process and the effect of those changes on quality improvement. This stage requires ongoing data collection to determine the effectiveness of implemented changes and the extent of improvement. If the changes do not produce the desired improvement, other interventions should be discussed, tried, and field tested. In the meal tray example, ongoing data collection will tell whether the change results in reducing diet errors and whether the change should be made permanent.

Act

The act stage deals with implementing a change after the value of that change has been confirmed. New practices are institutionalized by training all associates who are affected by the changes and by communicating, updating policies and procedures, and monitoring to ensure that the improved methods become routine.

The PDSA process is repeated to further improve the same process, if outcomes show the need for additional improvement, or to address a different area of concern. Ongoing use of the PDSA cycle produces continuous improvement in quality.

Building a Quality Culture

A culture of quality is built over time with staff stability and consistency. Culture requires empowering leadership that is open to the ideas of others. Managers share organizational power by giving autonomy and discretion over tasks to the associates; they build teams by coaching and mentoring; they use rewards and recognition to change behaviors that would otherwise stifle quality improvement (Gaucher & Coffey, 1993).

An organization-wide culture of excellence institutionalizes quality. In such an environment, all associates receive social and psychological gratification by knowing that because they have chosen to put excellence first and foremost, others are better off. Management recognizes the contribution of the associates by expressing appreciation in various forms, including financial rewards. The reward system is designed so that it promotes cooperation and team effort, not envy and competitiveness. As such, the reward system does not exclude any member of the organization. Finally, such a nursing facility gains a community-wide reputation for excellence. But even at this stage, facility management continues to seek ways to improve structures, processes, and outcomes. Management ensures the satisfaction of customers through a firm commitment to never-ending improvement in quality.

In studying the ongoing pursuit of quality, some thoughts from Deming are noteworthy. Deming is counted among the greatest pioneers of the quality improvement movement. Many books on CQI have reproduced, in one form or another, his 14 principles of quality improvement. These principles are directed at management attitudes and actions because Deming believed that quality breakdowns were attributable to management, not workers. Much of the earlier discussion in this chapter incorporates these principles. The following thoughts summarize the remaining pertinent requirements that are necessary for building a culture of quality in nursing facilities:

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

- A facility must create value to remain ahead of the competition. Cost reduction efforts that reduce quality are likely to decrease value. On the other hand, improving quality may increase cost somewhat, but improved quality should enhance value to a greater extent than cost increases (Lighter & Fair, 2000). Hence, CQI efforts should aim to increase both quality and productivity (efficiency).
- Cease dependence on inspections to improve quality. Eliminate the need for inspections on a mass basis by building quality into the product (service) in the first place. Inspection should be used as an information-gathering tool for improvement, not as the principal tool for quality control (Evans & Lindsay, 1993).
- Drive out fear so that everyone may work effectively for the organization. Fear may promote short-term gains, but longer term accomplishments are less likely. Empowerment rather than threats should be used to motivate employees (Lighter & Fair, 2000). CQI should be used to find process problems, not to assign blame to workers. Otherwise, they would spend their time covering up problems for fear of being blamed for problems.
- Break down barriers between departments. Promote cooperation, not competitiveness.
- Eliminate slogans and exhortations. Posters and slogans assume that all quality problems are attributable to people. They overlook the fact that most quality problems are systemic and cannot be improved through posters, slogans, or the wearing of happy-face buttons. Attacking problems rather than workers, understanding the causes of problems, and using statistical thinking and training to improve processes are necessary for achieving higher quality.
- Eliminate quotas. Standards and quotas that workers are often held to are generally used punitively. A quota, such as requiring each CNA to take sole responsibility for a predefined number of residents, promotes shortcuts in quality in order to reach a numerical goal. Once numerical goals are achieved, there is no incentive to continue production or to improve quality. When these standards are not achieved workers become frustrated and resentful (Evans & Lindsay, 1993).
- Remove barriers to pride in workmanship. Hourly workers such as CNAs, housekeepers, dishwashers, and laundry workers are often treated by management as commodities. Pride in workmanship can be achieved through teamwork and continuous improvement strategies when workers are treated as valuable resources, not as commodities. According to Deming, employees fall into one of three categories: most work within the system, some are outside the system on the superior side, and others are outside the

system on the inferior side. Superior performers should receive special compensation; inferior performers need extra training or they should be replaced (Evans & Lindsay, 1993).

Terminology for Review

best practices

continuous quality improvement (CQI)

customer

inefficiency

measurement

outcome

productivity

quality

reliability

validity

For Further Thought

Refer to federal regulation F868 in Exhibit 19-1, Critically evaluate the composition of the QAA committee as mandated by this regulation. What suggestions do you have to improve upon this regulation?

CASE

Eliminating Pressure Ulcers at Lakeview

Frustrated with ongoing complaints from family members, Reba Sanders, the administrator of the 100-bed Lakeview Skilled Care and Rehabilitation Facility, replaced the director of nursing (DON) after she had been on the job for less than 2 years. At the exit conference with Reba, the DON had remarked, "I don't think pressure ulcers have been a problem in this facility the way it is made out to be by some families. Some residents develop the ulcers at the hospital before they come here; we try our best to take care of them, and I have explained to the families what we are doing. I think firing me is unfair, but it is your decision." Before the new DON, James Osterwal, was hired for the job, Reba had mentioned to him that looking into the pressure ulcer problem would be his first priority. Reba arranged for James to attend meetings of the local chapter of a national quality improvement organization for nursing homes. Based on some of the information presented at the meetings, James quickly settled on making pressure ulcer elimination as his primary goal. James was quite familiar with the PDSA quality improvement cycle. He discussed it with the charge nurses, decided how data would be collected, and started a campaign asking all nursing staff to adopt the motto: "We will eliminate pressure ulcers at Lakeview." The associates liked the motto because it gave them a specific goal to work toward. At James' request, Reba approved hiring an RN nurse coordinator to float among the three shifts. The charge nurses asked their nursing assistants to report to them right away all cases of skin breakdown. James trained the nurses in best practice protocols to treat pressure ulcers. After 4 months, data showed little to no improvement in the prevalence (total number of cases) of pressure ulcers at Lakeview. Both Reba and James could not understand why.

Questions

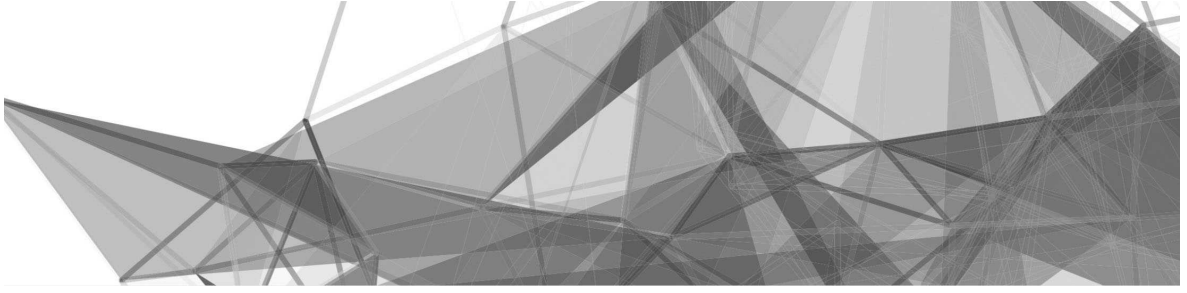
1. Based on what you have learned in this chapter, evaluate the quality improvement program as it pertains to pressure ulcers at Lakeview. Provide a specific outline of weaknesses in the overall approach.
2. Employ the PDSA cycle to address the issue of pressure ulcers. Be specific. For example, how should data be collected? How would you go about identifying root causes of the problem? What interventions would you implement? What roles should the various personnel and the administrator have?

For Further Learning

The Quality Assurance/Performance Improvement program proposed by the Centers for Medicare and Medicaid Services.
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html>

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PART V

Case Studies

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This section contains 12 cases that represent a variety of situations and challenges that nursing home administrators are likely to encounter in their careers. All cases in this section were either contributed by or were developed with the assistance of experts in the field of long-term care. Generally, these cases are more challenging than the ones furnished at the end of various chapters; they may span topics covered in more than one chapter. Each case narrative is followed by questions that require application of the materials learned and even provoke further thought to make the student reason beyond what may be discovered in a textbook. Following is an overview of the cases:

- *Case 1: A Central American Immigrant Couple*. An elderly immigrant couple has been living with their son's family for a number of years. Changes in their circumstances require the family to make arrangements for the parents' long-term care (LTC) needs. Is a nursing home appropriate?
- *Case 2: A Legal and Ethical Dilemma*. A woman who lived independently until she was 87 years old now has to live in a nursing home. She suffers from depression and dementia. The woman's son, an attorney, has threatened the facility with a lawsuit for failure to comply with his mother's alleged request to withhold food so she can die a quick death. The matter is before the ethics committee for deliberation. What are the resident's rights?
- *Case 3: Abusive Spouse*. The wife of a 72-year-old nursing home resident has been accused of patient abuse. Is this really abuse?
- *Case 4: Advance Directives*. A young head trauma patient has been transferred back and forth between the nursing facility and the hospital. The court-appointed legal guardian is uninvolved. How can advance directives be obtained?
- *Case 5: A Love Triangle*. Students often do not think that such situations can arise in a nursing facility. A 66-year-old male resident has a relationship and then a falling out with a 70-year-old woman who is also a resident in the same facility. He then falls in love with a younger resident who is HIV positive and makes her pregnant. How should the administrator handle issues surrounding resident rights, the drama and commotion created in the facility, and the pregnancy?
- *Case 6: Wound Care at Mountainview Nursing Center*. An 83-year-old resident has various chronic comorbid conditions, and his daughter has power of attorney. She does not go along with medical advice to amputate the patient's gangrenous leg. One day maggots are discovered in the wound. What are the legal implications of the nursing care the resident had received?
- *Case 7: Implementing Culture Change in Food Service*. The governing board of a four-story, 32-year-old nursing home has authorized funds to construct household-style kitchen and dining facilities on each floor. Current plans call for closing the existing kitchen, yet the facility must continue to serve meals to the residents. How can this be accomplished?
- *Case 8: Evacuation of Angel Care Center*. Hurricane Rita was approaching. Some residents were relocated, but about half had to be evacuated. Evacuation of nursing homes was not on the local government's evacuation plan. A day before the mandatory evacuation, the administrator learned that contracted transportation would not be available for taking the residents to a retreat center located 120 miles away. Last-minute pleas for help came through, but numerous problems were encountered. What lessons can be learned?
- *Case 9: Tug-of-War with the Director of Nursing*. A rookie administrator ends up creating tensions with the director of nursing. How can such conflicts be managed?
- *Case 10: Corporate Compliance at Mid-Atlantic Care Centers*. Five minority employees of a chain-affiliated nursing facility file a lawsuit over compensation issues triggered by the involvement of the vice president of operations. Which conditions of corporate compliance were broken, and what should be the appropriate role of governance?
- *Case 11: Chapel Square Health Care Center: Workforce Diversity*. An inner-city unionized nursing home has a history of staff-related issues. The changing inner-city social environment and a workforce that has become culturally diverse pose serious challenges for a new administrator. The problems appear to be insurmountable. Is there a way out?
- *Case 12: Start-Up of Blissful Gardens*. A new LTC center that will have a small number of independent living apartments and a small skilled nursing facility is under construction. The executive director needs to define the mission, develop a plan to hire management personnel, prepare a marketing plan, and think about future profitability. Can this operation be profitable by the end of its second year?

Note: Several of the cases reflect actual situations. All identifying information has been disguised, except for any acknowledgements used by consent of the contributors.

CASE 1

A Central American Immigrant Couple

Rosa and Jaime Sanchez immigrated to the United States from a Central American country 18 years ago when they were in their early 60s. A son and a daughter were already living and working in the United States when they arrived. Rosa and Jaime lived with their son, Jorge, his wife, Maria, and two small children in a two-bedroom apartment. To make ends meet, Rosa found work in the laundry of a nearby motel, and Jaime took the night janitor's position at the local boys' club. Rosa had hypertension, which she controlled with medications obtained at a nearby community health center. Jaime was an insulin-dependent diabetic and had to pay for most of his medical expenses.

Two years after the arrival of her in-laws, Maria gave birth to another child. During the next 6 years or so, Rosa and Jaime learned barely enough English to become U.S. citizens. During this time, Jorge and Maria purchased a modest three-bedroom home, and the parents occupied one of the bedrooms. Rosa and Jaime had to stop working because of old age and declining health. Without a source of income, they qualified for Supplemental Security Income (SSI) and Medicaid. Most of the SSI income was handed over to the son for their room-and-board expenses. Medicaid covered their medical expenses.

Starting at age 71, Jaime suffered several ministrokes. His blood sugar had not been well controlled. He also developed glaucoma in one eye and was barely able to see with that eye. The son and his wife both had full-time jobs. Before, Rosa was able to spend a lot of time taking care of her grandchildren, but now her husband required more attention. He needed assistance with bathing. He also needed insulin injections and blood sugar monitoring three times a day. Their daughter, who lived with her family about 15 miles away, came over and provided help periodically.

Jaime is now 77 years old. Two years ago, he fell and injured one of his ears. He has lost 75% of his hearing in that ear. Fortunately, he did not sustain any fractures. He wears a hearing aid in the other ear. Recently, he complained of declining eyesight in the good eye. An eye exam showed signs of macular degeneration. Rosa does not have the level of strength she once had to take care of Jaime. Both Jaime and Rosa use canes for walking because of some limitations in mobility.

Jaime and Rosa's grandchildren are growing up. They need more space in their home and time to devote to their school work. Jorge and Maria show some level of frustration because they are unable to devote the necessary time to take care of Jorge's elderly parents. The parents don't have the money to go to an assisted living facility, but perhaps they can qualify for care in a nursing home. Jorge, Maria, and Jorge's sister have come to realize that the parents need to move out, but they don't know where to turn.

Jorge calls a nursing home located 6 miles from his home and makes an appointment to see the administrator.

Assignment

1. On the basis of the information given in the case, assess Jaime and Rosa's current long-term care needs.
 2. What type of living and care arrangement would you recommend?
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CASE 2

A Legal and Ethical Dilemma

Contributed by Alan S. Whiteman, PhD, FACMPE, and Lisa E. Sliney, MS, LNHA, Barry University

Background

Mary Evelyn Greene, who has memory impairment, lives in a private room at Shady Brook Skilled Nursing Facility located in a beautiful suburb of a major metropolitan city. She has resided at Shady Brook for the past 18 months. Before moving into Shady Brook, Mrs. Greene lived independently in her own home with assistance from a private-duty nursing assistant and a housekeeper. She and her husband had resided together in this home for more than 50 years. Mrs. Greene is 89 years old and suffers from several health problems associated with aging.

Mrs. Greene has one son, David Greene. David has the power of attorney to handle his mother's health care and other personal affairs. David works as a trial attorney in one of the city's largest and most prestigious law firms. He owns a large home in an upscale neighborhood and works hard to put two of his children through college and another one through medical school. His home is about an hour's drive from his workplace and about 20 minutes from Shady Brook. David's wife Barbara has never been close to her mother-in-law and has not shown much interest in her care. Hence, looking after the care for his mother has become a major responsibility for David, and he is having a difficult time dealing with her declining health and the onset of mild dementia. It is becoming increasingly more difficult for David to leave his law practice or the court room to deal with issues related to his mother.

Mrs. Greene's husband was a very successful land developer who left her with a substantial estate, which meets all of her financial needs. After her husband passed away, Mrs. Greene decided to remain in her home. She was able to maintain her independence until she was 87 years old, when she began to show signs of dementia. Shortly thereafter, David moved her to Shady Brook. David also hired a part-time "sitter" to keep her mother company because she was too weak to go out of her room on her own. Mrs. Greene seems to enjoy the sitter's company and likes the attention she gets.

Upon entering Shady Brook, Mrs. Greene became depressed over losing her independence and her home and felt a growing frustration with forgetfulness. She gradually lost her appetite, and her desire to eat continued to decline. On the other hand, Mrs. Greene seems to enjoy the smell of certain foods. The nursing home associates monitor and document her food intake and her facial expressions when she is offered different foods. Mrs. Greene is particularly fond of Susan Brown, a certified nursing assistant (CNA), who sits with her and helps Mrs. Greene with whatever little she can eat. When this occurs, her appetite shows some improvement. Mrs. Greene also responds well to volunteers who carry out activities at the facility.

Frustrated Family Member

Mrs. Greene has become too weak to eat on her own. When no one is feeding her, she leaves most of her food on the tray. Recently, she has sustained a weight loss of more than 5 pounds per week. Her plan of care needs to be reevaluated, and her situation needs immediate attention.

David has been visiting his mother quite regularly. Recently, however, his visits have become less frequent, generally two to three times per week. The associates who work on Mrs. Greene's nursing unit have reported some changes in David's attitude. At one time he became angry with his mother, raised his voice, and spoke to her as if she were a bad child. Although no one was present in Mrs. Greene's room at the time, the associates working at the nursing station heard David's loud voice. When the charge nurse went into Mrs. Greene's room to find out why David was angry, David told her that it was none of her business. On David's subsequent visits, the associates observed that Mrs. Greene would become agitated during David's visits. These issues were brought to the charge nurse's attention, and they were documented in the resident's medical record.

The Dilemma

One day David approached the charge nurse and exclaimed that his mother had expressed that she wished to die. On his next two visits, David also told the CNAs that his mother's desire was not to eat anything so she could just die a quick death. This was the first time the CNAs had heard that Mrs. Greene had expressed a desire to die. The associates also believed that Mrs. Greene appeared to be happier when David was not there.

Before the week was over, David came into the facility early in the morning on his way to work. He handed a sealed envelope to the incoming charge nurse on the day shift. The envelope was addressed to

Betty Wright, Shady Brook's administrator. David said to the charge nurse, "I have been telling you people that my mother wishes a speedy death. Tell your administrator that I will be filing a lawsuit if my mother's wishes are not carried out." David left without visiting his mother.

Betty Wright decided to place the issue on the ethics committee's agenda for that same afternoon. As a safeguard, Betty also notified the facility's liability insurance carrier of the potential legal action.

Meeting of the Ethics Committee

That afternoon, Betty met with members of the ethics committee: chaplain, medical director, director of nursing, charge nurse, social worker, two CNAs, and the local ombudsman. Betty began the meeting with these remarks: "The man's mother has been declining rapidly and eats very little. He wants his mother to die rather than prolong her suffering. I have learned that the son is the heir to his mother's estate, and my overall concern is my trust in his decision or his motives. I think he needs the money to pay for the college expenses for his three children. Although it is not uncommon for some residents to be ignored by family after they are admitted, it is rare that they express the wish to enable the death of a relatively healthy person." The ethics committee is faced with the issue of what is legally and ethically appropriate. The committee deliberates on whether or not to comply with David's request to withhold food as well as the threat of a lawsuit.

Assignment

1. In a sentence or two, identify the main issue.
 2. Outline the facts pertaining to this issue.
 3. Identify alternative solutions that the ethics committee might consider.
 4. What may be the consequences of the alternatives you have proposed? Discuss the consequences from the perspectives of (a) Mrs. Greene and (b) Shady Brook.
 5. Discuss the alternatives from the standpoint of the resident's rights.
 6. What will be your recommendation to the ethics committee?
 7. In their deliberations, should the committee members take into consideration Betty's comment that David needs the money to educate his children?
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CASE 3

Abusive Spouse

The assistance of Anthony Ughetti, NHA, in developing this case is gratefully acknowledged.

Sid Hollister, a 72-year-old male patient with Parkinson's disease and dementia, was admitted to Golden Gate Nursing Center. The attending physician ordered a pureed diet, and the resident had a G-tube for enteral feeding. Mr. Hollister occupied a private room, located right across from the nursing station.

Mrs. Hollister, the resident's spouse, made it a point to visit the facility every day, particularly at meal times. As time progressed, she seemed to spend more and more time in the facility. Although the posted visiting hours were from 6:30 a.m. to 8:30 p.m., Mrs. Hollister often stayed in the facility until late at night. The associates observed behaviors that led them to think that Mrs. Hollister carried a lot of frustration and dissatisfaction, but she never expressed any complaints. From time to time, she would make comments such as, "I can't leave him alone here; something will happen to him." "There is never any help around here." She constantly felt that she needed to be involved with Mr. Hollister's care. She would assist him with eating. She kept a washcloth to wipe off the drooling saliva from the resident's face. She even started directing his care regarding bathing and toileting.

One January day during the lunch meal, Mrs. Hollinger was in the room feeding the resident. A nurse observed that Mrs. Hollinger was forcing the resident's mouth open. Her hand was lifted up, and she allegedly slapped the resident on the left cheek. The staff immediately removed the spouse from the resident's room. The director of nursing and the police were notified. A police report on domestic violence was registered. The facility also completed its internal incident report, and another incident report was sent to the state's Department of Health.

From this point on, Mrs. Hollinger was barred from the facility. After she complained about her right to be in the facility, the social worker notified her that she could be in the facility as long as she was supervised. A meeting was held in the facility that included the local ombudsman, a representative from adult protective services, and the corporation's risk management representative. An understanding was reached that the facility would monitor Mrs. Hollinger's conduct during her visits to the facility.

There were no further incidents. In April, John Shull was appointed as the administrator. At 7:30 a.m. when John came to work one day in July, a CNA approached him and informed him that she saw Mrs. Hollinger hit her husband on the face. The alleged incident had occurred during breakfast in the resident's room. The wife admitted and said, "I was giving him a glass of water, and he clamped his teeth down on it. I had to smack his face a bit to make him let go. This is not abuse." Upon examination by a nurse, it was found that no injuries were sustained by the resident.

Assignment

1. Should the latest incident in July be regarded as physical abuse or not? See **Exhibit CS3-1**.
2. How would you go about investigating and documenting the incident?
3. Suppose this is physical abuse. What further action would you take?

Exhibit CS3-1

Nursing Home Regulations (Excerpts)

F540 – Definitions

Abuse is the willful infliction of injury; unreasonable confinement; intimidation; or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

F600 – Freedom from Abuse and Neglect

Sections §§1819 and 1919 of the Social Security Act provide that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility must provide a safe resident environment and protect residents from abuse.

Some situations of abuse do not result in an observable physical injury or the psychosocial effects of abuse may not be immediately apparent. In addition, the alleged victim may not report abuse due to shame, fear, or retaliation. Other residents may not be able to speak due to a medical condition and/or

cognitive impairment (e.g., stroke, coma, Alzheimer's disease), cannot recall what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. Neither physical marks on the body nor the ability to respond and/or verbalize is needed to conclude that abuse has occurred.

Physical Abuse

Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking.

Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object.

It has been reported that some facilities have identified that they are in compliance with F600—Free from Abuse and Neglect because that they could not foresee that abuse would occur and they have “done everything to prevent abuse,” such as conducted screening of potential employees, assessed residents for behavioral symptoms, monitored visitors, provided training on abuse prevention, suspended or terminated employment of the perpetrator, developed and implemented policies and procedures to prohibit abuse, and met reporting requirements. However, this interpretation would not be consistent with the regulation, which states that “the resident has the right to be free from verbal, sexual, physical, and mental abuse....”

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP: Guidance to Surveyors for Long-Term Care Facilities. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>.

CASE 4

Advance Directives

The assistance of Patrick Claudius, MD, in developing this case is gratefully acknowledged.

An 18-year-old male patient was admitted to Greenfields Nursing Home, South Carolina, from another skilled nursing facility located in North Carolina. The patient was moved to South Carolina because he qualified for Medicaid in that state. The resident stayed at Greenfields for 12 years until his death at the age of 30.

The resident had sustained a serious head injury in an auto accident at the age of 15. As a result of this injury, he became comatose. He remained in a persistent vegetative state and had a G-tube for enteral feeding. However, the resident's overall condition was stable. He received maintenance rehabilitation for severe contractures in hands, arms, and feet. The resident also received regular sensory stimulation.

The resident had fevers off and on in the range of 100°F (37.8°C) to 102°F (38.9°C). His fevers were most likely to be secondary in nature because most other causes, such as infections, were ruled out. The nursing staff were able to control the fevers using ice packs and alternate administration of Tylenol and Motrin. At times, however, the resident would have episodes of urinary tract infection. He was also hospitalized with recurrent aspiration pneumonia. He began running fevers as high as 106°F (41°C). Sputum and urine cultures showed the presence of methicillin-resistant *Staphylococcus aureus* (MRSA) infection. At times, severe infection required hospitalization in the intensive care unit. Intermittently, the patient had to be placed on a ventilator.

Shortly after the auto accident, the resident's mother had abandoned him. The mother is the one who was responsible for the accident that resulted in his severe head trauma; she was driving the vehicle in a state of intoxication. The resident had no family contact whatsoever. The court appointed the Department of Social Services as the resident's legal guardian. The Department of Social Services, however, was uninvolved in his care and did not give any directives regarding continuity of treatment. The resident eventually died of natural causes.

Assignment

1. Should the resident have been referred to hospice care?
 2. The resident went into coma at the age of 15 and had no advance directives. What role would advance directives have played in this case?
 3. How might Greenfields Nursing Home be able to obtain advance directives in a similar situation?
 4. What role(s) would be appropriate for the facility's social worker in the life of this resident?
 5. What role should the activity department play in the life of this resident?
-

CASE 5

A Love Triangle

Contributed by Elizabeth A. Berzas, PhD, MHA, FACHE, and Jacqueline Shellington, LCSW

Located in Opelousas, Louisiana (population 15,000), Maison de Fontenot is a 100-bed nursing home, the only such facility in the greater Evangeline Parish area. The facility's large activity center is sometimes made available to local civic organizations for meetings. On these occasions, members of the community also take the time to interact with the residents; several visit with family or friends living in the facility. Some of them also volunteer at the facility.

Joseph Vidrine

Joseph is a 66-year-old resident of the facility. He was admitted to Fontenot a little over a year ago after he had suffered several minor strokes. He requires close monitoring and some assistance with dressing and bathing but is able to get around independently. Joseph is from Mamou, a rural community that has limited long-term care services. Hence, his sister decided that Fontenot would be the best place to meet his needs. Joseph never married but had a few long-term relationships over the course of his life. He participates in several activities and helps out with minor chores at the facility. He also enjoys transporting residents in wheelchairs to and from the dining room. Joseph is personable, outgoing, and friendly.

Phyllis Landry

Phyllis was born and raised in Opelousas and has never lived anywhere else. She is an attractive and vivacious 70-year-old woman who has been living in the nursing home for the past 5 years, ever since she was widowed. Her husband died of complications in the aftermath of an automobile accident. Phyllis is a severe diabetic and has some cardiac issues resulting from her diabetes that had remained uncontrolled before she was admitted to Fontenot. Otherwise, she is alert, oriented, and mobile. She needs assistance with her insulin injections, monitoring of her heart condition, and treatment of occasional minor bruises. After the loss of her husband, she had no source of income and had to go on Medicaid. She is alone, with no children or relatives living nearby. Phyllis is an outgoing individual. Many of the male residents find her attractive, but she has not expressed an interest in other men since her husband's death. She does miss having a man to take care of her, though. Before moving into Fontenot, Phyllis was an active member of the community. Now she enjoys helping out at birthday parties and other social activities held at the nursing home.

Joseph and Phyllis became friendly during BINGO games when Joseph would pay more attention to her game than his own and make her win. Gradually, they found themselves physically and emotionally attracted to each other. Joseph feels that Phyllis needs him because she had once stated that she liked men who take charge, which reminded her of her late husband. Joseph and Phyllis have started spending more and more time together. Now they commonly refer to each other as boyfriend and girlfriend. From time to time they get into arguments when Phyllis feels he is ignoring her or when Joseph believes she is not following his advice.

Nancy Leblanc

Nancy, a 36-year-old female, was admitted to Fontenot about 4 months ago after being in and out of the hospital a few times because of complications from her AIDS diagnosis. She was assigned to share the room with Phyllis. Nancy has four children between the ages of 3 and 15 who live with Nancy's mother in another state.

Jealousy and Tensions

Joseph has been frequently visiting Phyllis and Nancy in their room. Phyllis, however, feels that he pays more attention to Nancy, which then leads to arguments between Phyllis and Joseph and creates tensions between all three. During the arguments, Joseph innocently points out that he is only helping a new resident better adjust to the nursing home environment. At times, Joseph has been found sitting outside on the swing with Nancy or helping her mark off her cards at the BINGO games. More recently, Joseph has been inviting her to join him during snack time. Nancy too likes Joseph's company and enjoys her walks with him on Fontenot's grounds where flowers are in full bloom.

Joseph has told some of the staff that Phyllis is too controlling and that they have broken off their relationship. Phyllis, however, still refers to him as her boyfriend and accompanies him to some of the activities and social events. Joseph and Nancy, on the other hand, have said to the staff that they are just friends and like to hang out together.

Just Friends?

The other day, a certified nursing assistant on her lunch break saw Nancy sitting in the garden with her legs crossed over Joseph's lap, but she did not think much of it. Another resident told the social worker that she "caught them" sitting in a "lovers' position" and they were startled. Two members of the Kiwanis Club also saw "something" and were a little taken aback and mentioned it to the administrator. One resident told the activity director that he thought Joseph and Nancy "go a little too far" in their public displays of affection. Another resident was amused when he recounted, "Just the other day Joe was grabbing at her as they walked down the hall."

Spillover and Commotion

Phyllis accosts the administrator in the hallway and asks, "What kind of a place is this? Isn't it against nursing home rules?" She has also commented to some other residents, "They both need to be thrown out of this place." When Phyllis confronts Nancy about her relationship with Joseph, Nancy adamantly denies there is anything romantic and states that they are just friends. When she confronts Joseph, however, he retorts, "You have been giving me a hard time, Phyllis, and I have news for you—Nancy and I are gonna have a baby, and we're gonna get married." Phyllis could not believe it. She seems devastated, and the social worker has to calm her down. But, when asked why she was so upset, she simply refused to talk.

At the next resident council meeting, Phyllis makes a bold appeal that both Joseph and Nancy are a disgrace and must be ousted from the facility. In response, Joseph barked at her, "Just shut up." The president of the resident council told the activity director that there were some real bad feelings between Joseph and Phyllis just because Joseph liked Nancy.

Later the same day, in a fit of rage, Phyllis throws Nancy's few belongings out into the hallway and curses incessantly for several minutes. Several staff members, a few residents, and two visiting volunteers gather at the scene to witness the commotion. The social worker, activity director, and administrator are called to the scene; they take the three residents apart to calm the situation. The social worker, activity director, and administrator together hold counseling sessions with the three residents who are threatened with eviction for disrupting the facility's living environment. The social worker is adamant that Nancy and Phyllis should no longer stay in the same room, but both residents have refused to separate.

Mother, I Am Pregnant

Approximately a month later, Nancy's children and mother, Colette, arrive at the nursing home to visit Nancy. With great enthusiasm Joseph announces to them his plans to marry Nancy. Taking Colette aside, Nancy quietly whispers, "Mother, I am pregnant." Nancy's mother and children are shocked and infuriated. Without saying a word, Colette heads straight to the administrator's office and demands answers. The administrator is equally shocked at the news, and the meeting does not go well. Colette wants to know why the facility has failed to fulfill its responsibility to protect its residents. She declares that she is ready to meet with a lawyer to sue the facility. Finally, in a burst of anger, she screams out, "Who will take care of this baby? You?" She stomps out of the administrator's office. Taking her grandchildren, she leaves the facility.

What to Do Now?

The administrator could hardly believe what she just heard. She calls an emergency meeting with the director of nursing, social worker, and activity director. For a moment, they all sit stunned after the administrator recounts what had just transpired.

Assignment

1. Should it be against the facility's rules for residents to pursue romantic relationships? How should a nursing home policy address resident conduct?
2. Based on the information on the romance between Joseph and Nancy, what, if anything, should the nursing home administrator have done? Did the facility have an obligation to inform Joseph that Nancy was HIV positive?

3. Did the facility have a right to move Nancy or Phyllis to a different room even though both had refused to move?
4. Does Nancy's mother have any rights in this situation? Does the threat of a lawsuit have merits? Is the nursing home liable for Nancy's pregnancy?
5. How should the administrator handle Nancy's pregnancy? What role would some of the department heads have?

Dr. Berzas is associate professor and program director, Our Lady of the Lake College, Baton Rouge, LA. Ms. Shellington is the director of St. Anthony's Home in Baton Rouge, LA, and an adjunct instructor at Our Lady of the Lake College.

CASE 6

Wound Care at Mountainview Nursing Center

The assistance of Patrick Claudius, MD, in developing this case is gratefully acknowledged.

Subsequent to his discharge from a local acute care hospital where he had received treatment for pneumonia, Jim Harris was admitted to Mountainview Nursing Center 5 years ago. Mr. Harris was 83 years old. According to the minimum data set (MDS) assessment, the resident had various chronic comorbid conditions. These conditions persisted over a period of 2 years while Mr. Harris was a resident at Mountainview. He was eventually discharged to an acute care hospital and never returned to Mountainview.

Mountainview is a 112-bed dually certified skilled nursing facility affiliated with a for-profit multifacility chain. The nursing home is located in a rural county with a population of 27,000. The median household income in the county is \$39,000. Approximately 64% of the adults over the age of 25 have completed a high school education; 10% of the adult population have finished a bachelor's degree or higher.

Mr. Harris's daughter, Nancy, had the power of attorney for the resident's medical treatment. Nancy visited the facility regularly and did not express any notable concerns with her father's care at Mountainview.

Medical and Nursing Evaluations and Treatments

Diagnoses at the Time of Admission

- Diabetic gangrene of the foot (heightens the risk for septicemia)
- Peripheral vascular disease (causes poor healing of wounds)
- Congestive heart failure (poses high surgical risk)
- Depression
- Short-term memory loss
- Dysphagia (increases the risk of nutritional deficiency)
- Unsteady gait; a walker was used for ambulation

Main Observations

The resident had a vascular (ischemic) ulcer.* Necrosis of the tissues had set in, the wound was infected, and purulent discharge was observed.

Treatments

The wound's dressing was to be changed once a day, and Accuzyme, a topical medicine, was to be applied with each dressing change. Protein supplements, zinc supplement, and multivitamins were ordered to promote healing of the wound. The resident needed insulin for diabetes.

In addition to daily dressing change, the wound was measured once a week. The resident was also referred to a specialized wound care center located 45 minutes away from Mountainview, where he received wound care once a month. At Mountainview, Mr. Harris also received intermittent physical therapy to promote circulation and speech therapy for dysphagia.

As a patient in the hospital, before his admission to Mountainview, a Doppler study was conducted to evaluate arterial circulation in the leg. The test showed a severe blockage in the leg. Consultation with a vascular surgeon was recommended. However, Nancy refused the consultation on grounds that surgery presented too great a risk given the patient's medical condition. Nancy also refused the insertion of a G-tube through which the patient could ingest specialized nutritional formulas.

A general surgeon had recommended amputation of the leg because of the gangrene. Nancy considered this to be too drastic a measure and did not opt for it. The surgeon as well as the patient's attending physician had discussed with Nancy the risks and benefits of leg amputation versus nonsurgical treatments. According to medical opinion, amputation presented the least risk. However, Nancy had anticipated that over time her father's wound would heal. As time progressed, Nancy showed growing frustration that the wound was not healing. Although some progress would be noted at times, it would be followed by deterioration. The ups and downs in the healing process persisted.

Incidents and Outcomes

In the final 30 days of the resident's stay at Mountainview, Mr. Harris sustained a fall from wheelchair to floor. He did not have a history of falls even though his gait was unsteady. A restraint was not recommended and was not used. When the resident was in a wheelchair, the nursing staff used a personal

alarm that would alert the staff to any forward movement or leaning from the wheelchair. However, by the time the staff came to see what had happened, the fall had already occurred. The nurses did not notice any injuries from the fall, but the resident was sent to the hospital for evaluation. Within 2 weeks of the fall, the resident developed pneumonia and was hospitalized, but he returned to Mountainview within 3 to 4 days.

One morning a nurse found that the dressing had slipped from the wound. At times the resident was agitated. Hence, the nurse believed that the resident may have kicked off his dressing while he was agitated. On closer examination, the nurse saw maggots in the wound. The wound was cleaned with saline solution, and the dressing was changed. In the afternoon, maggots were found again. In accordance with nursing protocols, Nancy was informed, and the medical director, who was also the attending physician for this resident, was notified. The resident was transferred to the hospital's emergency room.

Mr. Harris never returned to Mountainview. Three months later, the facility was informed that it had been named as the defendant in a lawsuit. Mountainview's corporate office settled the lawsuit out of court for an undisclosed amount.

Assignment

1. Evaluate the legal implications of the nursing care that Mr. Harris received while a resident at Mountainview Nursing Center.
2. Would a physical restraint be appropriate to prevent falls in this situation?
3. Discuss Mr. Harris' medical care from the standpoint of his rights.
4. In this situation, how would you ensure that the resident's own wishes are carried out?
5. Why do you think the nursing home corporation settled this case out of court? Would you have let the litigation proceed through the court system? Do you think the facility would be held liable?
6. It was assumed that the resident's agitation caused the dressing to dislocate. Could the facility have done anything to prevent that?
7. What actions would you take to assess and improve infection control practices in the nursing home following Mr. Harris's discharge?
8. In this case, Nancy refused the insertion of a G-tube. In a resident who has dysphagia, medical problems such as aspiration, pneumonia, and choking can occur. Can the facility take any proactive steps to protect itself against an allegation of negligence?

* An open wound that results from poor blood circulation.

CASE 7

Implementing Culture Change in Food Service

Contributed by Juliet A. Davis, PhD, and Paul W. Davis

City Nursing Home (CNH) is a nonprofit, independent, 200-bed facility located outside a major city in the western United States. The community has a population of nearly 150,000 with a high rate of poverty. CNH has a current occupancy rate of 97%, which is significantly higher than the state and national averages. CNH is ranked highly on Medicare’s 19 quality indicators (**Table CS7–1**), but the facility had eight deficiencies cited on its certification survey when it was inspected about a year ago (**Table CS7–2**). The four-story building was opened 32 years ago and has maintained an excellent reputation for delivering high-quality care. Staff stability in a community that offers relatively few jobs has been one of the main factors that has contributed to the quality of care. The facility trains its own certified nursing assistants (CNAs). With less turnover compared with the industry, and having a pool of trained CNAs to fill vacancies, the facility maintains above-average staffing levels. The facility also takes pride in having its own in-house rehabilitation therapy staff. Ms. Morehouse has been the administrator of CNH for the past 12 years.

TABLE CS7-1	Medicare Quality Measures for City Nursing Home

Measures	City Nursing Home (%)	State Average (%)	National Average Quality (%)
Long-stay residents given influenza vaccination during the flu season	100	92	90
Long-stay residents who were assessed and given pneumococcal vaccination	100	94	87
Long-stay residents whose need for help with daily activities has increased	19	12	15
Long-stay residents who have moderate to severe pain	0	2	4
High-risk long-stay residents who have pressure sores	15	14	12
Low-risk long-stay residents who have pressure sores	0	2	2
Long-stay residents who were physically restrained	0	3	4
Long-stay residents who are more depressed or anxious	8	10	14
Low-risk long-stay residents who lose control of their bowels or bladder	50	52	50
Long-stay residents who have/had a catheter inserted and left in their bladder	2	4	6
Long-stay residents who spend most of their time in bed or in a chair	0	2	4
Long-stay residents whose ability to move about in and around their room got worse	17	11	12
Long-stay residents with a urinary tract infection	3	7	9
Long-stay residents who lose too much weight	8	8	9
Short-stay residents given influenza vaccination during the flu season	100	84	80
Short-stay residents who were assessed and given pneumococcal vaccination	100	87	80
Short-stay residents with delirium	0	1	2
Short-stay residents who had moderate to severe pain	0	15	19
Short-stay residents with pressure sores	21	19	16

TABLE CS7-2 | Survey Deficiencies

	Survey Date		
	One Year Ago	Two Years Ago	Current Complaint
	Complaint Reporting Period:	Complaint Reporting Period:	Reporting Period: Deficiency Category
	July–September	July–June	July– June
Mistreatment	2	0	0
Quality care	2	3	1
Resident assessment	1	0	0
Resident rights	1	0	0
Nutrition and dietary	2*	1**	0
Pharmacy service	0	0	0
Environmental	0	3	2
Administration	0	2	1
Reported between inspections	0	0	0
Total number of health deficiencies for this nursing home	8	9	4
Average number of health deficiencies in the state	6	6	6
Average number of health deficiencies in the United States	9	9	9

* Inspectors determined that the nursing home failed to:

1. Provide food in a way that meets a resident's needs.
2. Store, cook, and give out food in a safe and clean way.

** Inspectors determined that the nursing home failed to:

1. Store, cook, and give out food in a safe and clean way.

For its current strategic plan, the governing board has approved adoption of culture change mainly through self-managed work teams in nursing services and the implementation of family-style dining. Implementation of this plan would require both structural and process changes. The existing kitchen is located in the basement of the building, and the main dining room is on the first floor. Using an elevator, food is transported in carts with hot and cold compartments. CNAs pick up the meal trays with preportioned food straight from the food carts, check the resident's name against the meal card on each tray, and place the tray in front of the resident. Although the service is efficient, its appeal is very institutional. However, residents and families have been generally satisfied with the meals.

One main issue in the past few years has been three leg injuries that the food service associates sustained while transporting the heavy carts. One of the injuries was serious enough to keep the associate away from work for 4 months. Shortly after returning to work, that associate resigned to take a job at the local McDonald's. One year, the kitchen sustained some flooding after heavy spring rains and had to be closed down for almost 2 weeks. Food services were temporarily contracted out.

Ms. Morehouse and the board worked together to engage the architectural firm of Caplin & Reese. The firm has had some experience with modern architectural designs for nursing homes. Considering the financial resources and other logistical issues, the facility would redesign its kitchen and dining areas in three to four phases. It is anticipated that over the next few years, each floor will have its own family-style kitchen and dining area. CNH is now in the early planning stage, having recently formed a Food Service Planning Committee.

The Planning Committee met 2 weeks ago, and Ms. Morehouse is reviewing the minutes from that meeting:

Minutes from the Planning Committee Meeting

Present: Ms. Morehouse, administrator; Mr. Hassan, finance and admissions coordinator; Mr. Washington, food services director; Ms. Laird, director of nursing; Ms. Smith, rehabilitation supervisor; Mr. Keith, construction representative; Mr. Morgan, designer; Mr. Welbourne, contractor; Ms. Reese, architect. The meeting started at 9 a.m.

Ms. Morehouse began with introductions of those present. She explained that culture change in the nursing home industry was going to gain momentum, and if traditional facilities did not adapt to changing consumer expectations, they would not be able to compete. Hence, the governing board had authorized

a long-range plan to implement certain structure and process changes. Modification of current dining arrangements was part of this long-range plan. Ms. Morehouse then opened the meeting for comments and questions from those present.

Mr. Washington, who has been employed at CNH for almost 20 years, explained the existing food service procedures. The kitchen is located below ground. He acknowledged that this layout was not uncommon when the facility was built, but the location is dark and damp according to current standards. The flooding about 6 years ago was like a nightmare. A large amount of food had to be discarded because of spoilage and the risk of contamination. An outside cleaning company had to be hired, and even then it required a lot of staff overtime to bring the kitchen into operation again. The residents were used to having home-cooked meals, and there was a lot of dissatisfaction with the food that was catered in. Mr. Washington fully supported the idea of moving the kitchen out of the basement, but he was not quite sure how the staffing for the four smaller kitchens would have to be planned. But, then, that was still a few years away!

Ms. Morehouse stated that the main purpose of today's meeting was to discuss the first phase of the project. This phase would be completed in two stages. In the first stage, the existing basement kitchen will be converted to a larger food storage and dishwashing area than what currently existed. A temporary kitchen would be built on the first floor. In the second stage, a household-style kitchen would be constructed by taking space from a portion of the current dining room on the first floor. She noted that during today's meeting, the designers would begin discussion of their plans for this phase of the project.

Mr. Hassan expressed some misgivings about this arrangement. He stated that he was not convinced that building a kitchen on every floor was the best use of financial and human resources. He noted that the first phase of the project alone would cost just over \$1,000,000. He also mentioned that other than the first floor, the other three floors simply did not have the space for a kitchen area.

Mr. Washington responded that the current arrangement was outdated and that elimination of food carts would be a big plus for the facility. But he agreed that availability of space on the remaining three floors was a problem and he was not sure what would be the best solution.

Ms. Laird stated that she was excited about the project. The aromas from meal preparation on the floors would create a homelike environment in the facility. Some of the residents could even help out and do minor chores in the kitchens if they so desired.

Ms. Morehouse suggested that they discuss Mr. Hassan's concerns at a later date since the board had already approved the construction budget for the first phase. She asked for an update from Mr. Morgan, Mr. Welbourne, and Ms. Reese.

Mr. Welbourne informed the group that his team was ready to begin both the remodeling of the basement to create food storage and dishwashing areas. At the same time, construction of a temporary kitchen on the first floor would begin. He said that it would take about 5 months to complete this project. Once the basement and the temporary kitchen renovations were completed, a portion of the dining room would be blocked off to begin construction of the new household-style kitchen. He estimated that this stage would take an additional 3 months.

Ms. Morehouse informed the group that therapy services would be moved and the temporary kitchen would be placed in that space.

Ms. Laird questioned how noise, dust, security, and other potential disruptions would be handled during the construction. Mr. Welbourne said these considerations have been included in his plans, and he furnished some details. He requested that Ms. Laird should provide him with a list of any resident-related concerns and he would address those concerns before the next meeting.

Ms. Smith said that she had become aware of some resident-related concerns. She stated that rehabilitation was using a large open area that has also been used as a multipurpose space for activities such as church services, meetings, games, parties, etc. She added that the activity director was upset that once the kitchen was moved to this location, the space would be too small to accommodate all of the residents. Mr. Welbourne suggested that perhaps activities could temporarily take place on the floors or in the residents' rooms. Ms. Smith expressed concern that the residents may be isolated in their rooms. Ms. Morehouse stated that a solution to this would need to be explored.

Ms. Reese and Mr. Morgan jointly presented the completed designs. Ms. Morehouse asked about the color scheme and overall kitchen aesthetics. Ms. Reese responded that her plan was to use colors consistent with the current facility color scheme given that the facility had been repainted less than a year ago. Ms. Morehouse said that the proposed color scheme would not be consistent with culture change. She offered to provide Ms. Reese with information on appropriate color schemes and other aesthetics consistent with culture change. Mr. Morgan explained that the kitchen would be equipped with commercial-style fixtures and appliances. He further stated that he was concerned that it sounded like the facility wanted something other than an institutional-type kitchen. Ms. Morehouse agreed that the kitchen fixtures and appliances needed to be chosen with the household model in mind. She asked if it would help if she provided him with some information detailing what type of fixtures and appliances would be appropriate for this style of kitchen. Mr. Morgan said he would welcome this information and attempt to make appropriate modifications with the understanding that all items must still meet NFPA and *Life Safety Code*® regulations.

Ms. Morehouse asked whether there were any other concerns from anyone. Mr. Washington wanted to know whether the temporary kitchen on the first floor would be sufficient to prepare meals for 200

residents. Mr. Welbourne replied that the temporary kitchen was not meant for cooking that many meals. He said that the main use of the temporary kitchen would be for heating and serving meals, but it would not be equipped to prepare meals on a large scale. Mr. Washington stated that because the facility is required to provide hot meals, he would have to research other options. He further stated that because the kitchen staff would not be cooking meals during the building stage, each member of the kitchen staff would need new task assignments, because their essential jobs would change. The cooks, for example, would need new assignments because they would not be involved in meal preparation. Ms. Morehouse requested a report from him on the new task assignments.

Ms. Smith stated that although she understood the reason the current therapy location was chosen for the temporary kitchen, her staff was not happy with the idea of moving. She further stated that the residents would need to be prepared for moving to a new location to receive therapy. Ms. Morehouse replied that she understood these challenges and would work with Ms. Smith to address staff and resident concerns.

The meeting adjourned at 11:30 a.m.

Following the meeting, Ms. Morehouse jotted down a list of things to do. As she pondered over it further, she was convinced that culture change was necessary, but wondered whether alternative plans should be explored.

Assignment

1. In a brief memo to the members of the Planning Committee, outline the main advantages of implementing household-style meal service.
2. In the context of this case, do a SWOT analysis* outlining the facility's strengths and weaknesses in relation to external opportunities and threats with the objective of informing members of the governing board on the value of their strategic decision.
3. Provide specific responses to the concerns expressed by the members of the Planning Committee.
4. What alternative plans should Ms. Morehouse consider?

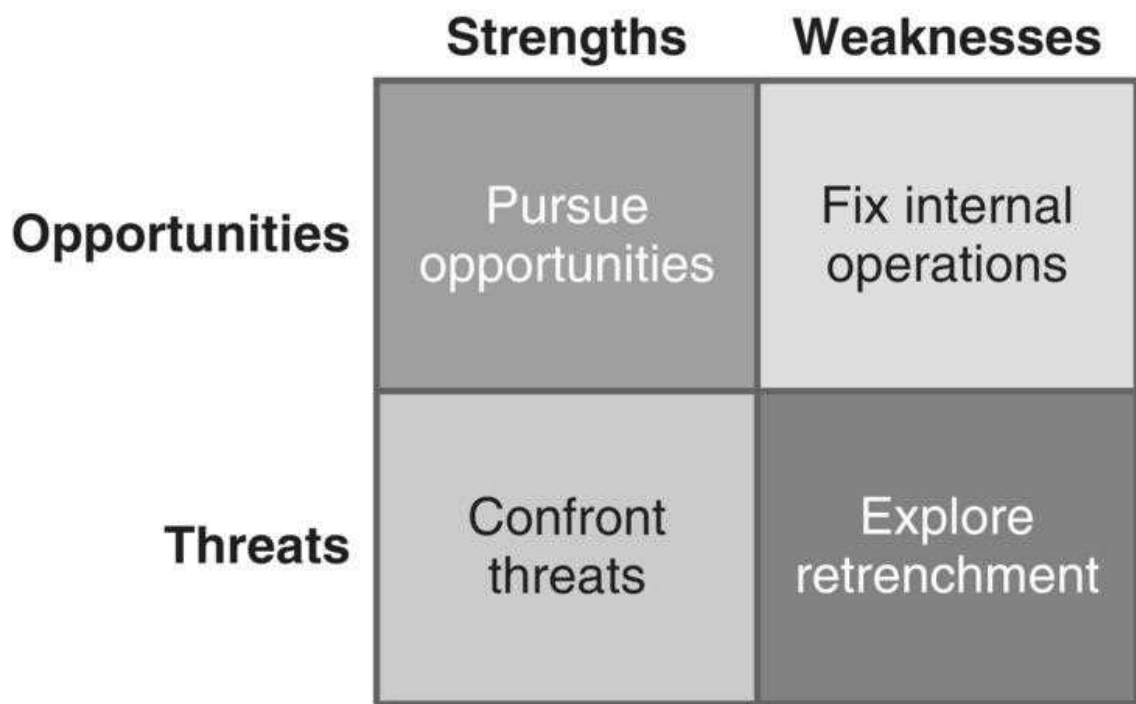


FIGURE CS7-1 The SWOT Matrix

Dr. Davis is associate professor of Health Care Management, Management and Marketing Department, University of Alabama. Mr. Davis is vice president of operations, Nutrition Management Services.

* Conceptually, strategic planning requires management to evaluate external opportunities and threats against the organization's internal strengths and weaknesses. The model commonly used to help such an analysis is referred to as the SWOT analysis (see **Figure CS7-1**).

CASE 8

Evacuation of Angel Care Center

Hurricane Rita made landfall on the morning of September 24, 2005, as a category 3 hurricane on the Saffir-Simpson scale. The storm caused significant damage in Texas and Louisiana. In the days preceding landfall, Rita's strength increased to a category 5 with winds of 175 mph, and landfall was projected at that time anywhere from Matagorda Bay to the Freeport/Galveston Bay in Texas. Eventually, however, Rita turned to the east. Although the bay areas were spared from the main wrath of the storm, strong winds damaged power lines, trees, many homes and businesses, and public utility facilities.

In 2005, Harris County's population was estimated to be 3.7 million, making it the most populous county in Texas and the third most populous county in the United States. The county is split into four geographical divisions called precincts. Each precinct elects a commissioner to sit as a representative of the precinct on the commissioner's court and also for the oversight of county functions in the precinct. The county's southern section is located in surge zone 1. As a result of Hurricane Rita, the county was formally declared a federal disaster area. It gave the county residents access to federal funds for cleanup and restoration.

The City Government

The state government has delegated to local governments at the county and city levels the responsibility for disaster planning and civil assistance. The city's standing plan requires safe shelter in place (no evacuation) in the event of a category 1 or category 2 hurricane. In the event of a more severe storm, the city government would decide whether or not evacuation would be mandated.

On the afternoon of Monday, September 19, city government officials, emergency management personnel, and police and fire chiefs began meeting to discuss preparations for the storm. The State Operating Center in Texas was briefing local governments on the status of the storm and the state's preparations. On the basis of these updates, the city government issued a media release warning that the storm was intensifying and that preparations should be under way to include possible evacuation if advised to do so. The local health department and the Emergency Management Services staff began contacting special needs facilities to advise them of the approaching storm and to ascertain whether the facilities had evacuation plans in place. Also on September 19, the Texas Department of Aging and Disability Services faxed a letter to all nursing homes in the state. In the letter, the department implored the facilities to review their disaster plans and to be prepared to implement the plans as necessary (**Exhibit CS8-1**).

Exhibit CS8-1 Texas Department of Aging and Disability Services (Letter)

Commissioner
James R. Hine

September 19, 2005
Dear Provider:

As you are aware, another tropical storm is expected to enter the Gulf of Mexico this week and strengthen, threatening the Texas Coast. In anticipation of this, we are asking that you ensure your preparations for a storm are in place.

State regulations require that all facilities have written emergency preparedness plans that provide specific procedures to respond to disasters such as severe weather. Please review your plans and ensure that you and your entire staff are prepared to implement such plans if necessary.

In the event an evacuation is ordered, critical items in your plan should include transportation arrangements to move residents and emergency health care back-ups, including dialysis treatments for patients who require this. You should contact the entity(ies) that will be providing the transportation and the locations to which residents are to be evacuated to ensure they are prepared to transport and receive your residents. Check to be sure those sites will have food and supplies for your residents, or be prepared to take some with you.

Other important considerations are your plans to assure necessary supplies and equipment are available should your facility be left without power, or delivery of supplies.

We will be contacting you for more detailed information as landfall is identified. If we can provide assistance to you, please contact one of our program managers:

Valerie Collins, Geriatric/Assisted Living Facilities	713-767-2305
Mark Kendall, Geriatric/Assisted Living Facilities	713-767-2363
Carolyn Kirkwood, Geriatric/Assisted Living Facilities	713-767-2303
Carol K. Wright, Geriatric/Assisted Living Facilities	713-767-2301
Larry Beauvais, Life Safety Code®	713-767-2293

Kay Smith, ICF/MR Facilities
Marline Boyd, HCSSA Agencies

713-767-2292
713-767-2067

Sincerely,
Brenda McCoy, Regional Director
Region 06, Houston
BMC:sam

Courtesy of Texas Department of Aging and Disability Services.

City government officials continued to meet on Tuesday, September 20. At this point, a local school district also joined the meetings to discuss the use of school buses in case an evacuation was ordered. One city government official met with officials in an adjoining county to learn about their emergency plans. Later during the day, city government officials met with industry representatives and hospital representatives. At 6:15 p.m., the local government issued a voluntary evacuation advisement for the general public. In addition, a mandatory evacuation order was given for residents with special needs such as those with physical and mental disabilities.

Angel Care Center

The Facility and Its Organization

Angel Care Center (ACC) is a 105-bed skilled nursing facility that is affiliated with a Christian denomination. All the beds are certified for Medicare, and 68 of the beds are dually certified. The facility was built in three stages. The original section was constructed during the 1960s and now has 51 rooms that offer private accommodations and 10 beds in 5 double rooms. A 26-bed wing was added sometime in the 1970s. Two more wings, one to accommodate services such as laundry, maintenance, and storage, and the other providing 18 beds, were built in 1987–1988.

The administrator, Marsha Gabel, who has the title of executive director, has been with ACC for 18 years. Marsha obtained her nursing home administrator license in 1980. She joined ACC in 1987 as the facility's assistant administrator and was named executive director in 1992. She has an undergraduate degree in behavioral sciences. Before Hurricane Rita, Marsha had no experience in the evacuation of nursing home residents.

Exhibit CS8–2 shows the facility's organizational chart. A risk manager's position is somewhat unique to ACC. **Exhibit CS8–3** summarizes the main responsibilities of this position. The risk manager, Frances Cummings, who is a registered nurse (RN), has been employed with ACC for 2 years. Frances had prior experience with evacuation of nursing home residents. Susan Andrews, the director of nursing (DON), has 10 years of experience and has been with ACC for 3 years.

Exhibit CS8–2 Organizational Chart

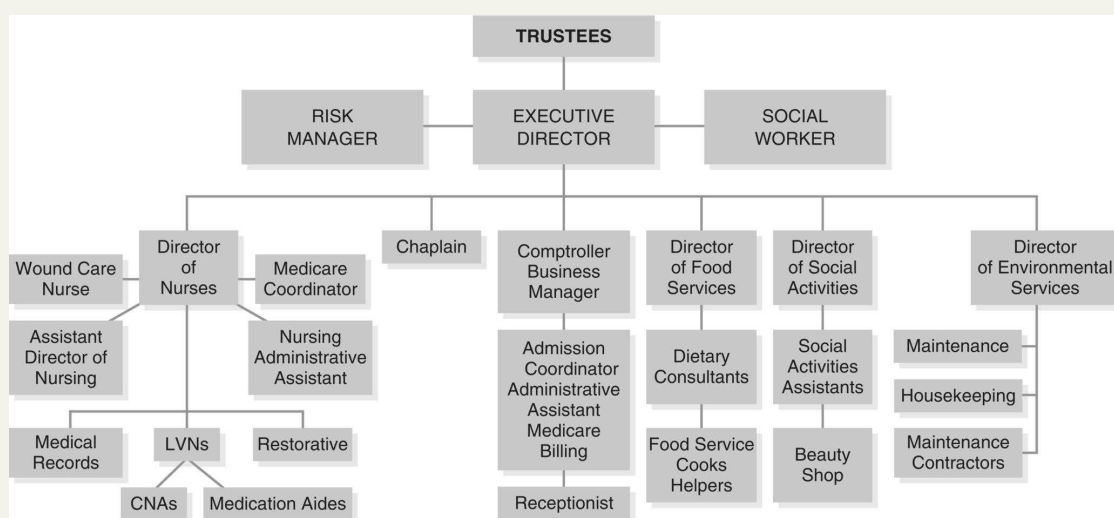


Exhibit CS8–3 Risk Manager: Frances Cummings, RN

The position reports to the executive director and has the following main responsibilities:

- Quality improvement. The individual heads the Quality Assurance Committee. A subcommittee meets weekly to evaluate and discuss resident care quality issues, such as pressure sores, weight variations, falls, medication use, infection control, hydration, family satisfaction surveys, and state inspection survey findings.
- Review all resident-related incident and accident reports. Perform investigations and follow ups.
- Follow up on complaints from family members.
- Make regular building rounds to identify potential hazards.
- Staff inservice and training.
- Prepare for state inspection surveys, with subsequent involvement during the survey process.
- Coordinate annual risk assessment. An external private company does annual site visits for risk assessment.

Mission Statement

Angel Care Center provides a retirement home for older adults where they will feel secure, receive high-quality care, and enjoy the company of others in a loving and Christian environment.

Angel Care Center is a not-for-profit organization that strives to operate efficiently and charges rates that reflect the full cost of care. In recognition of its charter to serve all, Angel Care Center has a program to provide some financial assistance to those who cannot pay the full cost of their care.

Disaster Planning

In fall 1998, the air-conditioning unit located above one of the resident care wings of the facility had burned out. At around 2:00 a.m., the staff noticed smoke odors in that wing and in two other adjoining wings. Although the fire alarm was not pulled, the local fire department was called. The charge nurse on duty, a licensed vocational nurse (LVN), decided that the affected wings had to be evacuated. Approximately 20 residents were evacuated outside the building in wheelchairs and geriatric chairs. The residents were brought back into the facility when the fire department declared an all-clear. ACC experienced no other incidents until Hurricane Rita.

The facility had a disaster plan (the section on evacuation has been reproduced in **Exhibit CS8–4**). On September 19, Marsha Gabel began planning for a possible evacuation of the 104 residents present in the facility. As early as July 2005, Marsha had entered into a transportation contract with Coach USA. The contract required Coach USA to provide two 55-passenger buses to transfer residents to a designated location during an emergency and to transport the residents back to the facility after the emergency was over. Services of Coach USA were subject to the availability of equipment and drivers (**Exhibit CS8–5**).

Exhibit CS8–4 Angel Care Center Disaster Plan (Section of Evacuation)

I. Fire Evacuation

A. There are two basic types of evacuations:

1. Safe-area evacuation: A safe-area evacuation will be done when the fire is located and affecting only one area while not endangering the nursing home as a whole. If this type of evacuation is ordered, personnel will evacuate residents to other areas within the facility.
2. General evacuation: A general evacuation will be done when the building is endangered by a major fire. If this type of evacuation is ordered, residents will be evacuated by following the fire plan or the bulletin board in your work area.

B. In the event of an evacuation, it is the responsibility of the Director of Nursing and/or Assistant Director of Nursing and Charge Nurses to ensure that all residents are evacuated in a proper and orderly manner with their medications.

Call the Civil Defense to provide transportation in moving the residents if the facility must be evacuated.

C. Residents are evacuated to their families, Jordan Care Nursing Center in Houston, or other facilities as deemed necessary.

D. There are three basic categories of residents to be evacuated:

1. Ambulatory: They and visitors should be led in groups in accordance with the type of evacuation ordered. Have them walk out the nearest exit. If residents are slow ambulating, use wheelchairs. They should go directly to the area specified by the Administrator. **DO NOT LEAVE RESIDENTS WITHOUT GUIDANCE FOR FEAR OR PANIC. DO NOT LET ANY RESIDENT RE-ENTER THE BUILDING TO GET ANYTHING. KEEP RESIDENTS WARM.**

[Note: The remaining two subsections are missing in the original plan]

E. Be alert to the following:

1. Note the possible sources of danger, such as crumbling walls, broken glass, and water mains.
2. Don't try to drag a person away from a live wire unless you have insulated material (thick rubber gloves). Make sure the material is dry. If you know where the circuit breaker is, TURN OFF FIRST.
3. Don't move a resident unless it is to remove her/him from immediate danger.
4. If testing for an electrical short, use the back of your hand; never use the palm of your hand.

II. Other Emergencies

- A. Storms: Nurses and aides should check all resident rooms when there is evidence of an approaching storm to secure all windows and to reassure the residents.
- B. Hurricane: HURRICANE WATCH (does not mean that hurricane conditions are imminent, but there is a real possibility that a hurricane will threaten the area within 24 hours). The administrator will call a meeting of Department Heads to begin checking the following:
- a. Transistor radios and flashlights with spare batteries.
 - b. Nonperishable foods, canned goods, and water containers.
 - c. Make arrangements for materials such as boards, lumber, and tape for boarding up windows and other glass openings.
 - d. Move or tie down movable objects, garbage cans, boards, signs, etc.
 - e. Check the supply of special items such as emergency medicines, drinking water, etc.
 - f. Monitor progress of the storm by radio or television.
- C. HURRICANE WARNING (means that hurricane conditions are expected within 24 hours). TAKE THE FOLLOWING ACTIONS IMMEDIATELY:
Department Heads will meet to finalize plans and take the following steps:
- a. Board up large windows. Tape may help against shattering.
 - b. Move all loose objects from outside.
 - c. Fill containers with water.
 - d. Warn residents to stay indoors on downwind side of the house away from windows and glass doors. The strongest winds will come from somewhere between north and southeast directions.
 - e. Beware of the eye of the hurricane. Do not be fooled by a lull in the wind because high winds may return from the opposite direction.
 - f. Administration or a designated representative will attend meetings of the city's Emergency Management Center to obtain information and updates, and coordinate evacuation plans if deemed necessary.
 - g. If the hurricane is a category 3 or 4, the roster of residents will be evaluated to determine those who can be cared for by their families for the duration of the hurricane and until all clean-up etc. has been completed. Nursing staff will prepare medications and/or other supplies if necessary. Housekeeping will pack belongings for approximately 1 week. If the hurricane is a category 5 or greater and total evacuation is deemed necessary, arrangements will be made by the Administrative Staff for the removal of heavy-care residents (Schroeder Ambulance Service has a stretcher ambulance that can carry at least two residents).

III. Evacuation

The city's Emergency Management Center (EMC) has advised: In case of a hurricane, the residents of Angel Care Center will NOT be evacuated unless deemed necessary by the EMC. If evacuation becomes necessary, the facility will make arrangements for lodging and transportation. Staff will be requested to accompany the residents. Compensation will be provided to those assisting.

- A. Tornado: If complete evacuation is not deemed advisable, remove all residents in their beds and simply roll beds out of the rooms to corridor areas. Keep some windows partially open on the opposite side from the direction of tornado to avoid creating a vacuum in the building.
- B. Explosion: In the event of an explosion in one of the nearby petrochemical plants that causes damage to the facility and/or injury to the residents, ALL OFF-DUTY PERSONNEL are to report to the facility as soon as possible.

IV. Responsibilities of Personnel Not Assigned to a Station

In the event of a fire or disaster, the following units shall first secure their own work areas and then report to the location of the fire or disaster to aid in the removal of residents from that area:

Office personnel
Dietary personnel
Social and activity personnel
Beauty shop personnel
Restorative nursing personnel
Laundry personnel

V. Transferring of Medical Records

In the event of an evacuation of Angel Care Center, the Director of Environmental Services, aided by the Secretary, shall be responsible for transferring medical records to the designated location.

Exhibit CS8–5 Contract with Coach USA

July 14, 2005

Re: Angel Care Center
1800 Sherman Avenue

This letter is to confirm our telephone conversation on July 14, 2005. It is agreed that Coach USA will provide emergency transportation for the above facility. The service would involve two 55-passenger buses transferring residents to and from designated location. Service will be supplied on an as-needed basis and is subject to availability of equipment and drivers. It is understood that the above facility would pay Coach USA based on established hourly commercial rates or mileage charge, whichever is greater.

Thank you for choosing Coach USA.

Signed (Jim Jacobs)

Sales Representative

Mon–Thu	\$425.00 (5-hour minimum)

Fri–Sun	\$500.00 (5-hour minimum)

Price Rates

Day Rates Mon–Thu	\$880

Day Rates Fri–Sun	\$950

\$85.00 for each additional hour

\$3.00 per mile live miles

\$1.85 per dead head mile

Susan Andrews and Frances Cummings began planning how residents would be evacuated. Marsha and the department managers shared the responsibility of calling all families to find out which families would take their loved ones with them. During the phone calls, comments such as “It’s your responsibility,” “I can’t handle my daddy,” and “There is no way I can take care of my mother” were frequently heard. But others wanted to take their loved ones with them. Marsha also tried to find empty beds in nursing homes around the area.

Before ACC had to evacuate, 54 residents went with their family members, leaving 50 in the facility. Only the medications and directions for medication administration accompanied the 54 residents who went home. Another 8 residents were transported to a skilled nursing facility located 120 miles away. These residents were designated as “special care residents” and were evacuated by private ambulances. **Exhibit CS8–6** provides information on the medical conditions of these residents. Medications and medical records accompanied these residents. ACC became responsible for evacuating the remaining 42 residents. In preparation for the evacuation, ACC procured extra medications, drinking water, and skin and wound care products.

Exhibit CS8–6 Special Care Residents

Resident A

Chronic pulmonary disease; end-stage renal disease; diabetes; congestive heart failure; oxygen dependent.

Resident B

Atherosclerotic cardiovascular disease; atrial fibrillation; congestive heart failure; dependent for all ADLs; oxygen dependent.

Resident C

Severe chronic obstructive pulmonary disease; morbid obesity; history of respiratory failure; oxygen dependent; steroid dependent.

Resident D

Cerebral vascular accident; chronic obstructive pulmonary disease; congestive heart failure; morbid obesity; dependent for all ADLs; intermittent oxygen use; at risk of decompensation.

Resident E

Renal insufficiency; congestive heart failure; morbid obesity; dependent for all ADLs; needs to be positioned at a 30-degree angle for proper breathing.

Resident F

End-stage renal disease; atherosclerotic cardiovascular disease; congestive heart failure; dementia; uses Foley catheter; dependent for all ADLs.

Resident G

Cerebral vascular accident; dementia; diabetes mellitus; gastrointestinal tube feeding.

Resident H

Atherosclerotic cardiovascular disease; chronic obstructive pulmonary disease; cerebral vascular accident; dementia; gastrointestinal tube feeding.

On learning about the city's orders for a mandatory evacuation, Marsha contacted Coach USA to obtain the services of two buses. She did not get a firm commitment from the bus company. Coach USA told her that the company had no drivers available at that time. Marsha hoped that Coach USA would have the buses and drivers available on Wednesday, September 21, when the facility must evacuate. The local government was unable to furnish transportation. Other nursing homes in the area were in a similar bind.

Marsha recalled that she knew Mr. Spicer who was the executive director of a large retirement/nursing home complex located about 200 miles away. On the 20th, as a backup plan in case Coach USA would not come through with their services, Marsha called Mr. Spicer with a desperate plea for help.

The Evacuation

On September 21, Coach USA was unable to provide the much-needed buses. Fortunately, Mr. Spicer was ready, along with three of his staff, to make the 200-mile trip to ACC. Mr. Spicer and his team brought with them a 21-passenger van, a 16-passenger van equipped with a wheelchair lift, and a pick-up truck. They reached ACC at 7 p.m., after spending more than 6 hours on the road, a trip that normally should take about 3½ hours. A nursing facility in Houston, which did not have to evacuate, was also able to provide a bus and a van. Evacuated residents would be transported 120 miles away to a furnished two-story retreat center. The center had motel-like accommodations that included kitchen, dining, and laundry facilities.

On the Move

At around noon on September 21, the bus obtained from the Houston facility left ACC with 8 residents and 5 staff members. Medical records, medical equipment, nursing supplies, and some of the personal belongings of these residents were also dispatched at the same time. The trip to the retreat center took about 2 hours. Frances Cummings arrived at the center to do some basic preparations for resident care.

By 8 p.m. on September 21, the remaining 34 residents were evacuated and loaded on the two vehicles furnished by Mr. Spicer. One van was filled with 34 wheelchairs. Medical records, medications, supplies, oxygen cylinders, and one bag of personal belongings for each resident were also loaded. A cooler with ice, nutritional drinks, and drinking water were carried. The dietary department packed sandwiches for the trip that was anticipated to take about 3 to 4 hours. A convoy of nine vehicles that included six personal vehicles belonging to the staff set out for the retreat center shortly after 8 p.m.

By this time, the main highways had become clogged with traffic. Vehicles on all evacuation routes were moving at a crawling pace, at times standing still for long periods of time. Only emergency vehicles were permitted to use the highway lanes going in the opposite direction. The outside temperature was 100°F (about 38°C), but all vehicles were equipped with air conditioning. People in different vehicles communicated with each other using walkie-talkies.

The Transportation Ordeal

One of the drivers heard someone say, "She's vomiting on me, she's vomiting on me; make her stop." A certified nursing assistant (CNA) on board did the best she could using the wipes and water available on the van. The same thing was heard again. There were no empty seats to move anyone, nor a good way to clean the residents. Residents would slide forward in their seats as brakes were applied, and the staff would assist them back into their normal sitting positions. Around midnight, this van developed transmission trouble. A message was relayed on the walkie-talkies to pull off the highway at the next exit. Pulling into a commercial parking lot, the driver shut off the engine, got out, and noticed that transmission fluid was pouring out underneath the vehicle. The 17 residents on this van had to be moved, in most cases physically lifted using bed sheets, to the remaining vehicles. To make room for the passengers, some of the equipment had to be jettisoned. The convoy of eight vehicles had to get back on the highway, but the Department of Public Safety was not available to help.

The convoy managed to get back into traffic despite numerous disabled cars that blocked the highway shoulders. By this time, the traffic was moving even slower. Earlier it took 16 minutes to cover a half mile; now it was taking 26 minutes. The concern for the residents' well-being was on the rise because the residents had been in the vehicles for at least 8 hours.

It was around 4 a.m. on September 22 when the engine of the second passenger van stopped. The alternator was not running fast enough to keep the battery charged. After the vehicle was given a jump start

in blocked-up traffic, the driver had to get off at the next exit. This vehicle also started spewing transmission fluid and could go no further. To remain stranded was not an option.

To add to the ordeal, the van carrying resident care supplies got separated from the ones carrying the passengers. Another main challenge encountered was how to keep the residents cleaned and changed on the vehicles. Even if this could be done, privacy would be an issue.

At the Retreat Center

The trip to the retreat center took more than 18 hours. Residents were exhausted and dehydrated. Fortunately, no lives were lost. Susan Andrews took charge of accommodating the residents and ensuring continuity of care.

Before leaving ACC, things had to be packed in a hurry. The cardboard boxes were not sturdy enough to hold the weight of the medical records. Some records did not stay together. Wheelchair footrests and other accessories that were taken apart to save space also got mixed up. Some of the residents' articles of personal clothing were misplaced. There was a shortage of skin care products and other supplies.

Some supplies were purchased at a local Walmart store. A triage system was instituted to address resident care needs. During the trip, eight residents had developed stage I and II pressure sores. Skin care, care for urinary incontinence, hydration, and assistance with feeding were high priorities. One resident had a tendency to wander outside. Others showed signs of general confusion and anxiety. Television programming was mostly about the hurricane and the damage it was causing.

Most staff employed at ACC could not go to the retreat center; many had their own families to attend to. Associates who went to the retreat center included 2 RNs (Susan Andrews and Frances Cummings), 2 LVNs, 16 CNAs (including 1 certified medication aide), and 7 others. To some extent, staffing pressures were relieved because the retreat center had cooks available to handle the cooking and meal services. The retreat center had a supply of linens, but it was not adequate to meet the needs of nursing home residents. Frequent washing of linens became necessary.

At first, the staff members were overwhelmed. They were themselves tired and stressed out. Resident care was chaotic until things could be better organized. However, overall staff morale was high. Susan Andrews organized the staff to work in pairs. Once basic routines were set up, shifts were assigned so staff could rotate and get some relief.

The Aftermath

The hurricane caused severe destruction in southern Texas. However, before landfall, the storm had veered to the east, and ACC was spared any damage. On September 26, families started bringing residents back, and the facility began resuming normal operations.

In retrospect, lack of good transportation and shortage of staff were the two most critical problems experienced. Yet, one staff member remarked, "If I have to do this again even without any extra pay, I would do it." Marsha Gabel thought that the local government should do better disaster planning.

However, in the aftermath of Hurricane Rita, neither city nor county officials had contacted ACC with plans for any future eventualities.

Assignment

1. Review Angel Care Center's contract with Coach USA ([Exhibit CS8-5](#)). What recommendations can you make to improve this contract?
 2. When the second van carrying passengers became disabled, to remain stranded was not an option. What options would there be to complete the trip to the retreat center?
 3. On a trip that lasted more than 18 hours, at least some residents would require cleaning and changing. How could such care be provided while on the move?
 4. What would you do to relieve fear and anxiety among the residents after they have been moved to a temporary shelter, such as the retreat center in the case?
 5. What human resource policies would you recommend to improve staffing under the type of circumstances described in the case?
 6. Review Angel Care Center's evacuation plan ([Exhibit CS8-4](#)). What recommendations can you make?
 7. What actions can the facility's administrator take to work more closely with the city and county governments to prepare for any future eventualities?
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CASE 9

Tug-of-War with the Director of Nursing

The assistance of Anthony Ughetti, NHA, in developing this case is gratefully acknowledged.

Tim Wagner worked as a physical therapy assistant (PTA) for 17 years and for a year tried the position of director of sales and marketing at a 120-bed skilled nursing facility (SNF). While holding a full-time PTA position, Tim also enrolled at a local university and completed a bachelor's degree in health services management. Upon graduation, Tim accepted the position of clinical liaison for special projects with Lippert Healthcare Inc., a privately owned multifacility chain that operated 10 SNFs. Tim's main responsibilities included assisting the 10 nursing homes with recruitment of therapy staff; development of therapy staff; optimizing utilization of therapy services to maximize revenues, clinical outcomes, and staff productivity; and assisting in the development of programs such as fall prevention, restorative care, and wound care. The nursing home corporation also used Tim as interim rehab manager whenever a need arose in one of the chain's facilities. Tim used his clinical background to his advantage and applied what he learned in his health services management program. He performed exceptionally well in this position. However, his main ambition after graduating with a bachelor's degree was to become a nursing home administrator (NHA). His goal was realized when Lippert Healthcare appointed Tim to be the administrator of Cloverleaf Nursing Center, a 90-bed SNF located in a small town of approximately 33,000. Lippert's corporate officers told Tim, "Because you want to be an administrator, we will put you at Cloverleaf. The management staff here is stable. It will be a place where you can learn and grow."

Previous Administrators

Joe Atkins

At Cloverleaf, Tim replaced Joe Atkins, who had managed the facility for approximately a year and a half. The vacancy at Cloverleaf was created when Joe was transferred within the chain to manage another nursing home that needed an experienced administrator. During the interim period of 2 months after Joe was moved to another city and Tim came to Cloverleaf, the director of nursing (DON), Claudia Moore, functioned as the interim administrator. Claudia had been employed at Cloverleaf for 9 years. She had been the DON for a year and a half and was a charge nurse for more than 7 years before that. She had no desire to become a licensed NHA.

Joe was in his mid-40s. He had a master of science degree in community health nursing, had been a DON, and had 5 years of experience as NHA. Although Joe was regarded as a people-oriented person, he would become confrontational if he disagreed with a subordinate and would assign personal blame when something did not go well. From time to time, he would have mood swings. As one department manager described it, "One day he would be all happy and everything would go well; the next day he would be chewing people out." At times, he would burst out, "I say you do this, and you will do it now." Apart from periodic episodes like these, Joe had given a free rein to most of his department managers, but he also favored some managers over others. He had formed an "inner circle" of his favorite managers that included the DON, the dietary manager, the human resource director (who worked 3 days a week), and the maintenance man. Not part of this inner circle were the business office manager, the social worker, the activity director, and the rehabilitation manager (who worked part-time). People in the inner circle generally assembled for lunch in the DON's office, would go out to eat together, or go for a drink or two after work; on some occasions, they would be invited to Joe's home for some partying.

Margaret Bond

Before Joe, Cloverleaf's administrator was an older female, Margaret Bond. She had managed this facility for a number of years. Ms. Bond had a passive personality. She spent most of the time in her office and was not seen much out on the floors.

Before coming to Cloverleaf, Ms. Bond was the administrator of a 35-bed facility, where she had fostered a family-like working environment with her staff. This facility closed down, and she was hired as the administrator at Cloverleaf. She brought with her the business office manager, the DON, and the facilities manager who was in charge of all plant and environmental services. Those who had worked with Ms. Bond described her as "motherly" and "cliquish." The assistant director of nursing (ADON) sometimes felt that the DON received preferential treatment from Ms. Bond for things such as requests for time off. The facilities manager would spend an inordinate amount of time in Ms. Bond's office while the work often did not get done. Ms. Bond had a pet name for the facilities manager, but other staff sometimes felt demeaned by her.

One day Ms. Bond sustained a broken hip in the nursing home. She took a long leave of absence and subsequently went on permanent disability leave. During her absence, Lippert's corporate officers visited the facility after a negative annual inspection by the state's Department of Health, and they terminated the

DON and the facilities manager for unsatisfactory performance. This is when Joe Atkins was brought in as the administrator.

The Upset DON

Thirty-one-year-old Tim obtained his NHA license and was so glad to have gotten a foot in the door at this 90-bed facility. But shortly after settling into his new position, Tim felt as if there was a tug-of-war between him and Claudia Moore, the DON. Tim thought that this situation was prompted by some recent incidents.

Ruffie Jacob

A resident, Ruffie Jacob, was admitted from the local hospital at around 6 p.m. on a Thursday. The hospital's policy did not allow them to send medications with a discharged patient. Intravenous (IV) Vancomycin (prescribed for severe infections) to be administered twice daily was one medication the patient was on. Cloverleaf had a contract with a local pharmacy, but the pharmacy did not have IV Vancomycin in stock. Consequently, the resident had to miss a dose Thursday night. Tim learned about it the next morning and found that even at that time the medication had not arrived. Tim became concerned and went to check with Claudia, who responded, "I have got it under control; don't worry about it. I am dealing with the pharmacy." That afternoon Tim felt that he had to transfer the resident back to the hospital, but Claudia overruled his decision. The medication came in at around 5 p.m. on Friday. On Sunday, the resident expired. Tim was very uncomfortable that it could become a potential legal issue. He informed the corporate officers, including the legal officer, who advised Tim to contact the medical director and explain the circumstances. On Monday morning, the medical director asked Claudia about the incident. After her meeting with the medical director, Claudia approached Tim and said, "Why did you make such a big deal of it? I had it under control." Tim explained that he had to inform the corporate officers about the potential liability, and the corporate officers had asked him to contact the medical director.

The Supply Clerk

Nancy was both the central supply clerk and the van driver for Cloverleaf. She filled out a request for a day off and presented it to Tim in person. Tim granted her the time off. The day Nancy was off, Claudia approached Tim and asked, "Where is Nancy?" Tim explained that since Nancy reported to him, he had granted her request for a day off. Claudia was not pleased, and asked, "Why are you doing this to me? Nancy is my employee."

The Night Rounds

Tim realized that it was important for him to make rounds of the facility unannounced on some weekends and nights. Once he dropped in at 2:00 a.m. for a surprise visit. Claudia told Tim the following day that a CNA, whom she did not name, felt that people were not being trusted, and that the CNA was going to turn in her resignation. "Why don't you trust us? Why do you have to check up on us?" Claudia demanded. Tim replied, "It is not a question of trust. I just need to get to know the operations and the night people." The next time Tim came in during the night shift, he told the staff, "I am not here to check up on you. I am just here to check the building."

The Prospective Payment System Meeting

Responsibilities in the nursing department were shared by three managerial personnel: the DON, the ADON, and the resident assessment coordinator. Corporate policy required the facility to have a daily PPS (prospective payment system) meeting in the morning. The meeting was meant to serve several purposes: review the clinical condition of residents; discuss factors that may affect reimbursement; and share information on clinical progress, therapies, and discharge planning. During this period, the facility was in the process of filling the resident assessment coordinator's position. In the interim, Claudia was handling the minimum data set (MDS). She had a lot of catching up to do. Tim was concerned about the annual survey, which could take place any day. He was not sure whether Claudia had a firm grip on keeping the assessments and care plans current. In the PPS meetings, Tim noticed that information was often missing. Tim thought that Claudia was perhaps overwhelmed with the increased workload. Tim had also observed that certain clinical systems were getting neglected. So, one day Tim decided to take over the PPS meetings. He thought he could help relieve some of the pressures Claudia was experiencing. Claudia, however, was not pleased. She approached Tim and asked him, "Am I not doing my job here? Am I not meeting your expectations?"

Assignment

1. Using the leadership models described in the textbook, Describe the leadership styles of Joe Atkins, Margaret Bond, and Tim Wagner.
2. Was it appropriate for Tim Wagner to intervene in the situation concerning Ruffie Jacob? Explain why or why not.

3. Did the DON have Mr. Jacob's situation under control? What should have been done?
 4. Was it appropriate for Tim to grant Nancy the day off? Explain why or why not.
 5. Should a nursing home administrator visit the facility on weekends and nights? How should such visits be approached?
 6. Was it appropriate for Tim to take over the PPS meetings? Explain why or why not.
 7. Why do you think the tug-of-war existed? How should Tim manage the conflict he has with the DON?
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CASE 10

Corporate Compliance at Mid-Atlantic Care Centers

Contributed by Paul R. Willging, PhD

Dave Short had been vice president of operations for 22 years . . . and a good one, he thought, at Mid-Atlantic Care Centers, a midsize nursing home chain headquartered in Baltimore. Although he had a genial personality, Dave worked “by the book,” despite his willingness to accommodate the particular needs and preferences of staff throughout the company’s seven facilities. With the corporation’s director of human resources, who reported to him, he had established personnel policies that he thought were among the most enlightened in the profession. He recognized that associates were best served within an environment that emphasized corporate culture as much as its bottom line, and he went out of his way to make sure that Mid-Atlantic’s corporate culture was conducive to staff satisfaction and retention. In short, Dave felt that he was an enlightened as well as a sensitive manager who didn’t let bureaucratic considerations interfere with employee morale.

Dave was taken by surprise when he received word that five minority employees in one of the company’s facilities had initiated a multimillion-dollar lawsuit against Mid-Atlantic for racial discrimination. Dave’s reaction to the litigation alternated between anger and disappointment. Dave knew each of the plaintiffs. In his opinion, all five associates were marginal at best and had been given every opportunity to succeed. He felt that they had been treated with the utmost respect, and he personally had been more than accommodating to what he felt were serious inadequacies in their work output. And now his sense of fair play was being rewarded with litigation! As Dave looked at the events leading up to this state of affairs, his anger only grew.

The Issues

Compensation Policies

In working “by the book,” Dave had tried to make sure the policies were state of the art. Salaries and benefits were clearly laid out in policies developed by one of the nation’s preeminent human resource consultants. Each job in the corporation was analyzed and compared with similar positions across the country, adjusted for local peculiarities, and ultimately tied to a salary range. The range was a product of management and budgetary considerations with an emphasis on keeping Mid-Atlantic competitive in a very difficult job market.

Staff Buy-In

At least once a year, Mid-Atlantic’s staff compensation policies were explained at department head and staff meetings in each of its facilities. Although the salary ranges for all jobs were established on the basis of the company’s desire to be competitive in the nursing home market, they were flexible enough to allow considerable discretion within each range to reward associates according to their performance. When questioned by some associates, explanations were given about the need to have upper limits to any job’s compensation just as there had to be lower limits, and there had to be penalties when job performance was not deemed sufficient to warrant even the lowest level of compensation. As Dave explained at each staff meeting, failure to meet even minimal job expectations was a question of retention, not compensation.

Communication

Dave liked to think that he had an open-door policy. Anyone with a problem was welcome to come in and discuss it with him, assuming it had first been discussed with a department head and/or facility administrator. The five litigants had been afforded more than one such opportunity. In fact, those five had been targeted for termination by their respective department heads long before they initiated the lawsuit. But when the facility sought approval from Dave to dismiss them, he put the adverse action on hold. In discussions with the facility’s administrator, Dave suggested that their respective supervisors “work both with and around them” to help them improve their performance. In the meantime, their compensation would be put on hold until satisfactory performance was achieved. It was the hold on their compensation that had earlier prompted these five associates to request a meeting with Dave.

The meeting did not go particularly well. What the five associates viewed as inconsistent application of compensation policy, Dave saw as an example of his willingness to be flexible in dealing with associates. None of the five were deemed to be performing at a level consistent with even the lowest levels of their given salary ranges. Yet, rather than taking action to terminate them as the policy suggested (and both department heads and the facility administrator had recommended employment termination), Dave had chosen to take a more sensitive approach, one designed to display his willingness to accommodate employee needs. Dave’s actions reflected his strong inclination to make “personnel” decisions “personal,” as he liked to put it.

At one point, the discussion became so heated that the five associates suggested that an outside, unbiased party be brought in to provide an independent assessment of the equitable application of staff compensation policy. The call for an independent audit, the five argued, was buttressed by their contention that only minority employees in the facility were paid beneath their salary ranges. The suggestion of racial overtones only hardened positions on both sides of the discussion.

Problem Verification

Given his own willingness to discuss any issue with staff, Dave saw little need to waste his and his associates' time by further reviewing an issue with which he was intimately familiar. In his own heart, Dave knew that although no one was perfect, there was not even a hint of racism reflected in corporate policies and their application. Although the minority status of the five litigants was coincidental, it was only that—coincidental. Dave also knew that his decisions had been in the best interest of the employees themselves. Dave thought that had he not been kind-hearted, these employees would be unemployed and unlikely to find jobs that would pay what they were getting at Mid-Atlantic.

Consequently, it seemed a waste of time to have an external party review what were already well-documented actions within the company. After all, the process that had led to the recommendation to discharge these employees had been appropriately documented in accordance with the company's personnel procedures. The employees had been made aware of their failure to perform. They had been provided specific standards of acceptable performance and given more than sufficient opportunity to improve. Dave's explanation of company policy had made it clear to them that the alternative option open to him was dismissal. Surely this was little more than a scam on the part of these employees and their attorney and really shouldn't be offered the luxury of yet another review. Dave saw an independent audit as just that—a luxury that Mid-Atlantic could ill afford. Dave viewed the reliance on any outside resources as a flagrant misappropriation of scarce company resources. Nor were there any obvious solutions that might stem from an external audit. The aggrieved associates might be brought up to their established salary ranges, but that would simply be rewarding poor performance. They could be discharged, but at this stage in the game such action would appear retaliatory. Best to leave well enough alone and let the courts do their own independent audit.

The Final Outcome

Dave's disinclination to spend dollars on outside resources was overturned by Mid-Atlantic's president and chief executive officer (CEO) when it became clear that the five employees were not interested in further discussions with Dave. In the face of the impending lawsuit, the CEO engaged external labor counsel. The counsel wasted little time before advising the CEO that this particular case was a "loser." And this was not just because a jury reflecting Baltimore's racial complexion would not be sympathetic to Mid-Atlantic's defense. "Coincidental" or not, it would be tough to explain why the company's compensation policies appeared to disproportionately affect minority employees, at least in this one facility. As it turned out, the case never went to trial because the company settled out of court.

Of much greater significance, however, was the fact that Dave's actions violated several of the principles of effective corporate compliance. Had the case gone to trial, the most effective defense would have been the argument that Mid-Atlantic had done nothing more than consistently apply its own long-standing, well-documented, and generally accepted company policies.

Assignment

1. Explain which of the six conditions of corporate compliance (discussed in Chapter 15) were violated by Dave Short.
2. How might he have circumvented the problems he faced?
3. How could he best balance his desire to accommodate particular associate needs with his responsibility to the corporation as a whole?
4. What should be the appropriate role of governance in this case?

The late Dr. Willing was associate director, Division of Geriatric Medicine, Johns Hopkins University School of Medicine. He was president of the American Health Care Association from 1983 to 1999 and president of the Assisted Living Federation of America from 2002 to 2003.

CASE 11

Chapel Square Health Care Center: Workforce Diversity

Contributed by Jeffrey A. Kramer, PhD

Historical Background

Chapel Square Health Care Center, a skilled nursing facility, is one of a decreasing number of inner-city nursing homes still operating in New Haven, Connecticut. Once a thriving New England city, New Haven has been hard hit by intense poverty, rising crime rates, and an exodus of the middle class to the suburbs. Chapel Square was built in an era when elderly people requiring institutional long-term care (LTC) intentionally sought out nursing homes in New Haven. Chapel Square was built in 1977 by John Stearns, an LTC facilities developer who foresaw a need for LTC beds in the heart of urban areas. In the 1970s, he invested heavily in nursing home ventures throughout northeastern United States. Chapel Square was one of nine facilities he built during this period and one of the first to become unionized.

Chapel Square originally had 180 beds, providing both skilled and intermediate care. From the late 1970s to the mid-1980s, occupancy was typically close to full capacity. As competition grew, Chapel Square expanded its resident base beyond geriatric care to ensure high occupancy rates. The facility began admitting mentally retarded/developmentally disabled (MR/DD) [now referred to as intellectually/developmentally disabled (IDD)] residents who were being moved from out of state facilities. Hence, the facility's primary mission of caring for the elderly was gradually compromised for the sake of guaranteed reimbursement and filled beds. This strategy provided short-term profitability—but had long-term repercussions.

During the 1990s, Chapel Square experienced a significant decline in demand. The mixed-resident population alienated geriatric residents' interest in the facility. Neighborhood decline had become noticeably worse, with crime and drugs becoming more prevalent. In addition, a dwindling pool of private-pay residents intensified competition from other facilities that also struggled to keep their beds filled and attract private-pay residents. Many started specialized services such as subacute care and rehabilitation programs, obtained accreditation from the Joint Commission, or followed other strategies to differentiate themselves from their competitors. Further, the physical plant of Chapel Square had deteriorated to the point where it affected the ability to attract residents and also jeopardized compliance with state and federal regulations.

Renovations and Expansion

The problems associated with a deteriorating physical plant, declining census, diversified resident mix, and cuts in reimbursement became more pronounced during the 1990s. Desperately trying to stay afloat, Chapel Square launched an ambitious construction program. The project included extensive renovation of the existing structure and major expansion that added 60 skilled nursing beds. The rationale was that additional beds in a new wing would enhance Chapel Square's declining reputation, attract more private-pay residents, and introduce economies of scale. The original intermediate beds were also converted to skilled beds. Although the financial risks associated with the project were considerable, it was viewed as a last resort plan for long-term survival of the facility. Renovations and construction of the new wing were completed in 1996. During this time, Chapel Square was also successful in relocating all of its MR/DD population to community-based providers. An aggressive marketing campaign was launched to highlight Chapel Square's new focus on geriatric services and its modern facilities.

Management Challenges

During this period, facility ownership and management changed several times. The facility remained proprietary, although several owners had experimented with various management approaches. Throughout its history, Chapel Square had been led by several well-intentioned—but minimally effective—administrators, contracted management services, and management teams. Shortly after construction of the new addition was completed in 2001, a new administrator, Ketty Hansen, was hired to "turn things around."

Hansen was not discouraged by the problems Chapel Square presented. She had worked in a number of inner-city facilities and was accustomed to the challenges of managing problem-plagued facilities. She was pleased by the physical plant improvements. Almost immediately she identified three major, interrelated problems that needed prompt attention if Chapel Square was to survive and prosper: an exceptionally low private-pay census, a poor reputation for quality, and an ethnically diverse and unionized workforce.

By this time, declining private-pay census had become a national trend. Despite its aggressive marketing campaign, Chapel Square could not fully shake its prior reputation for the mix of residents it served. On the other hand, the facility did have some success in attracting geriatric residents.

At the beginning of the 21st century, the facility housed a diverse resident population in terms of ethnic distribution, with a mix of approximately 30% Caucasian, 30% African American, 30% Hispanic, and 10% from other ethnic backgrounds. The facility also remained heavily dependent on Medicaid reimbursement. Its payer mix was 1% private pay, 5% Medicare, and 94% Medicaid. The overall occupancy rate was 70%, which was insufficient for the facility to remain profitable. The low occupancy rate and heavy dependence on Medicaid were pressing problems that required Hansen's immediate attention.

Chapel Square's reputation for low quality also required immediate attention. Its inner-city location did not help the situation, and the many survey deficiencies the facility had received over the years only made a bad situation worse. On several occasions, regulators had to threaten the facility's management with decertification, that is, expulsion from the Medicare and Medicaid programs. Although candidly admitting to herself and her department managers that the facility deserved its current reputation, Hansen recognized that measures were needed to reverse these impressions.

When Hansen was first offered the administrator's position, she knew that Chapel Square was unionized and had a diverse workforce. Having worked in unionized facilities before and having established a good rapport with union leaders, she had earned a reputation over the years for managing human resources successfully, even under exceptionally adverse conditions. However, she quickly discovered an unprecedented level of dysfunctional behavior among the Chapel Square staff. Recognizing its overall negative impact on what she was trying to achieve, she immediately set to work to address these problems.

Operational Issues

Hansen had observed a number of shortcomings that she felt contributed to the poor quality care. Basic supplies were lacking to the point where care was compromised. The facility was critically short on bed linens. The staff's prevailing attitude about supplies was, "We're not going to get them, so why bother even asking."

There was a desperate need to change ingrained staff behaviors that had become the hallmark of this facility's operational philosophies. Historically, employees had felt abused by management, and over time, a sense of complacency had resulted. Simply put, Chapel Square had become a facility "without a spirit." Staff's complacency about quality of care only made matters worse. Staff's apathy would be quickly picked up by newly hired staff. It seemed that the facility was stuck in a rut. Hansen was appalled that the facility lacked cleanliness and that the nursing staff was poorly trained and not capable of meeting residents' nursing care needs. Verbal abuse of residents by staff was a regular occurrence. The dietary department used only two menus, alternating them weekly.

Unionized positions at Chapel Square were typically paid \$3 to \$4 more per hour than at other facilities, helping to ensure a steady flow of job applicants. In past negotiations, management had agreed to union demands to avert lengthy and damaging strikes. High wages raised costs but did not improve performance. Paltry increases in Medicaid rates had made union wages unsustainable for the longer term.

Workforce Diversity

Chapel Square's staff reflected the "melting pot of America." It was dominated by three major immigrant groups: West Indians from some of the Caribbean nations, Hispanics, and East Indians from southern Asia. West Indians were the largest group, representing 50% of the licensed nursing staff, the majority of nursing management, 50% of the housekeeping department, 60% of certified nursing assistants (CNAs), and the entire dietary department. They were primarily from Jamaica and Haiti. Members of the Hispanic group came mainly from Cuba, Puerto Rico, and Costa Rica. They, too, represented a significant proportion of the overall staff, with 30% of the licensed nurses, 24% of CNAs, 40% of housekeeping staff, and the entire maintenance staff. The third largest group, East Indian, was spread throughout the facility without large representation in any given department. Other ethnic and national groups adding to the diverse workforce consisted of Africans, Caucasians, African Americans, and Chinese.

Hansen's assessment of her facility's workforce took on great importance as she sought to initiate improvements. She viewed the staff as a "dysfunctional family," with multiple communication barriers resulting from ethnic and cultural differences. New staff often came from the ethnic networks of current Chapel Square staff. Many workers were members of large extended families that had immigrated to the United States in recent years. Although this made for easy recruitment, it also tended to divide staff along ethnic lines. Intrastaff communication was essentially nonexistent.

During her first few months at Chapel Square, Hansen observed pronounced differences in behaviors and characteristics that existed among the groups, including levels of education, cultural values, participation in facility management, and communication styles. The large ethnic groups tended to have hierarchical structures reinforcing differences among the nationalities. For example, among the West Indians, a class system seemed to exist that placed Jamaicans above Haitians and other West Indians. The Hispanic hierarchy tended to value Cuban workers over Costa Ricans and Puerto Ricans. East Indians lacked a hierarchical structure, a characteristic that Hansen found surprising given the rigid caste system in their home country. East Indians, however, were often the most distant group, rarely interacting with other nationalities in the work setting.

Varying levels of education also seemed to strain relationships. Jamaicans and Africans were typically the most highly educated. It was not unusual for the CNAs from these nations to hold master's degrees,

because recent immigrants were often unable to secure other jobs. Hispanics usually had less formal education, and this often adversely affected relationships with other staff. Caucasians and Indians were usually well educated, although this too varied considerably.

Hansen recognized that cultural, religious, educational, language, and economic differences among the various nationalities were affecting resident care and facility operations. Communication problems were widespread, and little was being done to resolve the confusion they created. For example, Jamaican CNAs would talk to Jamaican nurses but not to Hispanic nurses. Most West Indians, Hispanics, and East Indians would not communicate with African nurses. In general, the staff did not seem to communicate well with either their superiors or their subordinates. Communication linkages were further strained by each group's preference to communicate in their native language, even if they had fluency in English.

The management staff at Chapel Square was mostly Caucasian. Ketty Hansen and her assistant administrator, Bob Manning, were Caucasian as were all the department heads. Of the 13 charge nurses, there were 6 West Indians, 1 African, and 2 African Americans.

To bring about change, Hansen started by replacing a couple of the existing department heads in an effort to replicate the ethnic mix of the facility's staff. She also identified informal leaders among the staff, representing various ethnic groups, to help work on the communication problems. These leaders served as interpreters during meetings and tried to help overcome cultural barriers. They understood the need for change and played an important role in facilitating the process. Although this approach was marginally effective, the unevenness of the leaders' dedication to the proposed changes limited its impact.

Other approaches were also tried to improve communication within the facility. Small-group training programs were developed to promote attitudinal changes. Outside consultants were brought in with packaged training programs to improve staff communication, but the results were disappointing. Hansen also began to emphasize a more informal management style that took into account the unique characteristics of the facility. She spoke frequently of a team orientation and spent considerable time with her management staff reinforcing concepts of team building and group consensus.

Management's Dilemma

Despite management efforts, there was little progress in improving attitudes. Hansen and her management staff became increasingly convinced that the communication problems were more a result of cultural differences than anything else. Hansen noticed that not all groups were equally receptive to the changes being implemented. East Indians accepted the changes without much resistance. Hispanics and Haitians, who had the least proficiency in English, were not as responsive and posed a more difficult challenge.

After several frustrating months of trying to improve internal communications, Hansen formed a Cultural Awareness Committee. The committee comprised representatives from all major groups in the facility. Special attention was given to selecting members who were both respected by their fellow workers and had demonstrated a willingness to improve the quality of resident care and overall performance. Hansen asked the committee to develop activities for the staff that could help overcome cultural barriers.

Hansen had hoped that her actions would lead to positive results. Occupancy had remained relatively stable at 70%, and the facility seemed unable to shed its "poor-quality" reputation. But Hansen feared that unless this image could be changed, the facility would lose market share. The corporate officers, although supportive of the management staff, were also losing patience. Without improvements in the financial performance, the possibility of selling the facility, declaring bankruptcy, or even closing it could not be ruled out.

Hansen worked with the Cultural Awareness Committee during the next few weeks to help participants develop their agenda. She reinforced the notion that the committee should plan activities whereby "each group could be proud of its own culture, but understand and appreciate other cultures." The first idea that surfaced was for a mini-exhibition that would include exhibits from each cultural group. This idea was rejected, however, because some committee members felt it would lead to further isolation rather than facilitate understanding. After much deliberation, the committee finally endorsed the idea of a Cultural Day to include special attire and foods from the many ethnic and cultural groups. Although not significantly different from the first idea, the committee was enthusiastic. And, although she remained somewhat skeptical, Hansen supported the idea.

As Cultural Day approached, Hansen continued to work on several different fronts. She met regularly with the Cultural Awareness Committee and made sure they had ongoing input and support from the management staff. She visited each nursing care unit almost daily, getting to better know and understand the staff, residents, and families. She also informally met with many members of the staff to solicit their opinions about how to improve the facility and its image.

On a separate track, Bob Manning was assigned to monitor Chapel Square's adherence to certification regulations. He responded with a "certification watch," which simulated the inspection process. Finally, realizing that additional steps were needed, Hansen called together her management staff. She asked them to begin work on a long-term strategic plan to improve communication among the facility's ethnic and cultural groups. It was hoped that this would lead to improvements in resident care and ultimately improve the facility's reputation in the community. A draft document outlining their ideas was to be submitted to her

for initial review. They began to work on this arduous task the following day, aware of the many obstacles facing them.

Assignment

1. Identify the underlying issues in this case.
2. What do you believe would be the most effective strategies for resolving these issues?
3. Was it a good decision by Hansen to replace a couple of department heads in an effort to replicate the staff's ethnic mix?
4. Do you support Hansen's efforts to date? Should the facility's owners instead appoint an administrator from an underrepresented group? Would this make a difference? What other initiatives do you think Hansen should undertake to bridge the cultural differences among the staff?
5. What early indicators might suggest that progress was being made, supposing that some of your recommendations in question 4 were successful? What metrics and measures would you use?

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CASE 12

Start-Up of Blissful Gardens

Contributed by Cindy K. Manjounes, MHA, EdD

Blissful Gardens is a new long-term care (LTC) and independent living facility set to open its doors to the first residents in approximately a year. The facility is located in the outskirts of St. Louis, Missouri, a major metropolitan area. In the state of Missouri, an LTC facility could not be licensed without certificate of need (CON) approval. Necessary permissions have been obtained, and construction has begun.

Building and Facility Plans

Blissful Gardens will have two separate buildings that will be joined by a central atrium and a section that will house administrative offices, a dining room, a piano lounge adjoining the dining room, and an arts and crafts room. One of the buildings will have three stories with 12 one-bedroom apartments for independent living. Each apartment will have its own private bathroom and a kitchenette. The building will be constructed as a "green facility," making use of many recycled materials for construction and also many energy conservation and efficiency devices. At least some of the trash will be recycled. Each apartment will have security features, including pull cords to summon help when needed. At an additional fee, the residents will have the choice of having two or three daily meals in the main dining room. Residents will need to furnish the apartments with their own furniture, linens, and other furnishings. High-speed internet connections and TV cable will be available for an additional fee in the individual apartments. There will also be a lounge area with a big-screen TV with full cable access and comfortable seating for group TV viewings. A separate common room will have four computers with printers provided by the facility for the residents' use. Once-a-week housekeeping services will be included in the monthly rent. Laundry service will be available for an added fee, or the residents will have the option to do their own washing and drying in a household laundry.

Blissful Gardens will have a 20-seat bus to provide shuttle service once a week to the grocery store, department stores, the movie theatre, and some local restaurants. Other local entertainment outings at various local attractions will also be scheduled. Residents will reserve their seats for these outings in advance.

The second building will be single-story with the capability to house 24 residents who require substantial assistance with activities of daily living and clinical interventions. The facility has a nested single-room design with four "neighborhoods." Two of these neighborhoods will be used for dementia care. In the dementia unit, the decorations will be brightly colored and cheery. The rooms will all be painted a light tan with white ceilings and baseboards. The curtains will be either bright blue or green, and the tiled floor will be tan and blue. The residents and their families will be encouraged to hang pictures on the walls and bring other artwork of their choice. Each room will be furnished with a bed, a lift chair, a small table, and two straight-back chairs. The hallways will be decorated with black and white pictures of many historical places and events in the St. Louis area.

Current Operations and Plans

Ms. Remedios has been recently hired as the executive director (ED) of the entire facility. The board of directors had established a strict set of minimum requirements when they began their search for an ED:

- A master's degree in gerontology or related discipline
- Current nursing home administrator's license
- A minimum of 10 years' experience in the LTC field, with a progression of management responsibilities
- Criminal background clearance

Construction of the facility is about one-third complete. Ms. Remedios and a secretary currently occupy a temporary office space in a strip mall approximately 1 mile from the construction site.

The board has been meeting twice a month. Board members have been mainly focused on timely progress of the facility's construction. Ms. Remedios visits the construction site once or twice a week, meets with the contractor, and discusses progress with the board. The board has asked her to begin marketing and staff recruitment efforts. The goal is to recruit an experienced director of nursing within the next 5 to 6 months so the facility can begin planning for Medicare and Medicaid certification. In addition, all department head positions should be filled 2 months before the facility opens. The department heads will be heavily involved in recruiting and training qualified associates. The goal is to have adequate staffing in all areas to serve the facility's residents at 25% capacity when it opens its doors.

An entrepreneur is the primary contributor for the start-up of the facility, which will be operated as a for-profit venture. The entrepreneur chose the name Blissful Gardens in honor of her late mother, Mrs. Hatbliss, who was an avid gardener and left behind a fairly substantial estate. Part of the proceeds from the estate was designated to fill some need in the local community. Before she passed away, Mrs. Hatbliss was in a local nursing home, and the family did not have good experiences with the care she had received. Hence, the daughter decided to dedicate the funds to develop a resident-friendly, yet sophisticated and top-notch facility where people would not only feel comfortable and valued, but they would also receive the best services and care available in the community. According to the philosophy expressed by the board of directors, "resident-friendly" means that the facility will provide the comforts of one's own home and the associates will help nurture the residents so that each individual could continue to enjoy his or her golden years and realize self-fulfillment. To maintain high standards, the independent living section will be 100% private pay, and the goal is to have 75% private-pay residents in the nursing center.

Board Composition and Funding

The eight-member board has the following composition:

- Chairman of the board: a local board-certified internist with experience in geriatrics. Mrs. Hatbliss was his patient for many years.
- Financial adviser: the president of a local bank.
- The chief executive officer of a local manufacturing business.
- The chief operating officer of a managed care organization.
- Legal counsel: an attorney with a prestigious local law firm.
- Two local well-known small-business owners.
- A retired school superintendent.

The estate of Mrs. Hatbliss provided \$2 million. Total start-up costs have been estimated to be between \$3.2 and \$3.5 million. The board has secured a loan of \$1 million from a local bank, with a line of credit approved for another \$500,000. Local businesses will be solicited for donations for some of the equipment. Plaques will be displayed on the walls to recognize such donations.

Market Area and Competition

There are four medical systems located within 15 miles of Blissful Gardens. Two of the hospitals have their own LTC facilities. These hospital-operated facilities, with a total of 22 beds, present the only competition in the immediate area. One of these facilities, located 5 miles away, recently came under scrutiny for alleged health and safety violations. The media aired some unfavorable stories. The other hospital facility is 12 miles away and is running at full capacity with a waiting list.

The local community is ethnically diverse and has a stable economy because of its proximity to St. Louis. Most of the people settled in this area are either retired or are middle-aged, the median age of the population being 52. The average household income in the area is \$100,000. New businesses have been steadily opening up in the area. A new shopping mall is being built approximately 8 miles from Blissful Gardens. A new condominium community, about 7 miles away, opened 6 months ago.

Main Goals

The facility's utilization is projected to be at 50% capacity 6 months after opening and at 75% by the end of its first year of operation. To achieve this goal, a relationship must be established with the two hospitals that do not have their own LTC facilities. The board anticipates that the facility will start turning a profit by the end of its second year of operation. One of the board members is a good friend of the owner of a local talk radio station, who could be tapped to help promote the facility.

The board assigned Ms. Remedios several tasks to complete and report back.

Assignment

1. Develop a mission statement for Blissful Gardens.
2. One of the first tasks Ms. Remedios must undertake is to prepare a recruitment plan to hire management personnel. Outline your plan. Justify each position, and provide the main qualifications these individuals must possess.
3. Prepare a marketing plan for Blissful Gardens.

4. Assuming that the facility will open on January 1, prepare a budget for the first year of operation. Can this operation be profitable by the end of its second year?

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Glossary

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A

Abuse (1) Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a patient. (2) Fraud committed against a public program such as Medicare or Medicaid.

Access The ability of a person needing services to obtain those services.

Accountable care organization (ACO) An integrated group of providers who work collaboratively to improve the overall health status, care efficiency, and satisfaction with care for a defined population.

Accounts payable Money owed to vendors from whom goods, supplies, and services have been purchased on credit.

Accounts receivable Amounts due from patients and third-party payers for services that the facility has already provided.

Accreditation Accreditation of a nursing facility by the Joint Commission, previously named Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Accrual-basis accounting The commonly used method of accounting in which revenues and expenses do not match cash inflows and outflows.

Acquired Immune Deficiency Syndrome (AIDS) AIDS develops when a person infected with the human immunodeficiency virus (HIV) undergoes a breakdown of the immune system and becomes susceptible to serious illness and death from other viruses, parasites, fungi, and bacteria.

Activities of daily living (ADLs) The most commonly used measure of disability. ADLs determine whether an individual needs assistance in performing six basic activities: eating, bathing, dressing, using the toilet, maintaining continence, and getting into or out of a bed or chair (transferring). Grooming and walking a distance of eight feet are sometimes added to evaluate self-care and mobility.

Activity Active or passive involvement of long-term care residents in any activities, outside the activities of daily living, that provide meaning and personal enrichment.

Activity theory A theory of aging that suggests that people in old age seek to remain active in meaningful ways.

Acuity The level of severity of a patient's condition.

Acute conditions Episodic conditions that require short-term but intensive medical interventions.

Adaptive rehabilitation Use of adaptive equipment and devices under the direction of a licensed therapist.

Administrative information system Information technology that is designed to assist in carrying out financial and administrative support activities such as payroll, patient accounting, billing, accounts receivable, materials management, budgeting and cost control, and office automation.

Administrative law Rules and regulations formulated by the departments or agencies of the executive branch of government to carry out the intent of statutory law.

Administrator-in-training (AIT) An internship with a certified preceptor required for an NHA license in some states.

Admission agreement A contract that spells out the services the nursing home will provide and the cost of those services.

Adult day care A community-based nonresidential service that enables a person to live with family but receive professional services in a daytime program in which nursing care, rehabilitation therapies, supervision, and social activities are available.

Adult foster care (AFC) homes Small, family-run homes licensed to provide room, board, supervision, and personal care to nonrelated adults who are unable to live independently. These neighborhood homes are also called "group homes."

Advance directive A written statement prepared by a competent individual indicating his or her desires for medical treatment in case this person loses the capacity to make decisions.

Advertising All forms of paid, non-face-to-face communication with a target audience.

Affordable Care Act Also known as Obamacare, it is the shortened name commonly used for the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010.

Ageism Prejudicial treatment of elders based on stereotypes and misconceptions.

Agent Someone authorized to act on behalf of another (a principal); for example, a corporation generally authorizes the nursing home administrator to represent it or to act on its behalf.

Aging in place An individual's preference and ability to live in one's own home or familiar surroundings where the person's changing needs over time are accommodated.

Aging report see *Aging schedule*.

Aging schedule Also called an "aging report," it shows the length of time that various amounts within each resident's account have been outstanding.

Agitation Verbal, vocal, and motor activities that are repetitive and outside of socially acceptable norms.

AIDS See *Acquired Immune Deficiency Syndrome*.

AIT See *administrator-in-training*.

All-inclusive rate A bundled fee that includes in a single rate all services and supplies furnished to a resident.

Allopathic medicine Medical approach—as practiced by physicians trained as doctors of medicine (MDs)—that views medical treatment as active intervention to produce a counteracting reaction in an attempt to neutralize the effects of disease.

Almshouse See *poorhouse*.

Alzheimer's disease A progressive degenerative disease of the brain, producing memory loss, confusion, irritability, and severe functional decline. The disease becomes progressively worse and eventually results in death.

Ambulatory Being able to move about.

Ancillaries Services and products, such as pharmaceuticals, catheters, dressings, incontinence pads, oxygen, etc.

Antibiotic stewardship The effort to evaluate and improve how antibiotics are prescribed by clinicians and used by residents.

Antisepsis Removing or destroying microorganisms.

Aphasia Impaired ability to communicate.

Apraxia A speech disorder in which the tongue, lips, and vocal cords are unable to work together. As a result, the person is unable to say what he or she wants to say.

Arbitration A process in which a neutral third party hears both sides in a dispute and renders a decision that is binding on both parties.

Area Agencies on Aging Agencies established in local communities under the 1973 amendments to the Federal Older Americans Act of 1965 to address the needs of Americans aged 60 and over. Among other services, these agencies assess clients' needs and determine eligibility for services best suited to meet their needs.

Area of refuge A zone of safety within a building that is protected from the effects of fire and smoke and that provides direct access to an exit.

Asepsis Absence of harmful microorganisms called pathogens. It refers to the practice of clean procedures, such as hand-washing.

Assault A threatening act in which physical contact need not occur, but the assaulted individual reasonably believes that the aggressor is capable of an imminent physical act. See *battery*.

Assessment The process by which health care professionals attempt to reliably characterize the resident's physical health, functional abilities, cognitive functioning, psychological state, social well-being, and past and current use of formal services.

Assets The financial value of everything a business owns, as shown on the balance sheet.

Assisted living facility A residential setting that provides personal care, 24-hour supervision, social activities, recreational activities, and some nursing and rehabilitation services, but not skilled care.

Audiologist A health care professional who is specially trained and licensed to provide direct clinical services to individuals with hearing or balance disorders.

Authorization card A card that employees are asked to sign, sometimes under coercion, to indicate the employee is willing to join a union.

Autism A complex developmental disability that typically appears during the first 3 years of life and is the result of a brain disorder. It affects the person's social interaction and communication.

Autonomy A cluster of notions that include self-determination, freedom, independence, and liberty of choice and action.

Average daily census The average number of residents per day over a specified period, such as a week, a month, or a year.

B

Bad debt Monies for services already rendered and legitimately owed to the facility but are deemed uncollectible.

Balance sheet A financial statement that summarizes the financial position (assets, liabilities, and equity) of an organization at a given date, such as the last day of a month or the last day of a year.

Bargaining unit A distinct group of employees who may reasonably be grouped together for the purpose of unionization and collective bargaining.

Battery An action in which intentional touching occurs without consent from the other individual. See *assault*.

Bed-hold When a resident is temporarily out of the facility (at a hospital or with family), but the bed is being held and must be paid for.

Benefit period Under Part A of Medicare, it refers to a period of time that begins when a patient is hospitalized for a particular spell of illness and ends when the patient has not been an inpatient in a hospital or has received skilled nursing care in a skilled nursing facility for 60 consecutive days for that particular spell of illness.

Beneficiary A person who is covered under a public or private health insurance plan.

Best practices Evidence-based practices. Also see *clinical practice guidelines*.

Biologicals Products made from natural sources, which may be human, animal, or microorganisms.

Biophilia The human tendency to pay attention to, affiliate with, and respond positively to nature.

Blind receiving A method in which the person who receives merchandise is given the original order that shows the specific items to be received but not their quantities; the quantities received are recorded by the receiver.

Board of directors (board of trustees) See *governing body*.

Bona fide See *good faith*.

Bottom line Profit or loss shown at the bottom of an income statement.

Breach of contract A civil wrong involving the violation of a legal agreement between two parties.

Budget A tool for exercising financial control. It sets expectations that become financial objectives that the nursing home administrator is responsible for achieving.

Budgeting The process of financial planning.

Bundled rate A price that includes all services a resident may require.

C

Capitation Payment of a predetermined fixed monthly rate per person to include all covered services.

Care plan See *plan of care*.

Case management A coordinating function in which a trained professional identifies the special needs of long-term care clients and determines which services would be most appropriate within the constraints of available financing to pay for services.

Case mix Aggregate level of clinical severity (acuity level) of residents in a facility.

Cash flow statement A summary of transactions that increase or decrease cash during a given period, such as a month or a year.

Census Number of residents in a facility on a given day.

Census mix See *payer-mix*.

Census range Anticipated range of resident census used for budgeting.

Certificate of need (CON) State laws that require a state planning agency to approve building of a new facility or expansion of an existing one.

Certification (1) Federal authorization required for a facility to admit Medicare and Medicaid patients. (2) A process by which a nongovernmental agency or association recognizes the competence of individuals who have met certain qualifications as determined by the agency or association.

Certified nursing assistant (CNA) A nurse aide who has completed at least the minimum training required by regulations.

Channels of distribution A marketing term that refers to the mechanisms used for bringing products and customers together to create an exchange.

Charge A fee that is established by the nursing facility for a particular service or product.

Chronic condition A medical condition that persists over time, is generally irreversible, and can result in complications if left untreated.

Civil law Body of laws governing private legal affairs, such as private rights and duties, contracts, and commercial relations.

Claim A bill submitted to the fiscal intermediary claiming payment for services provided.

Client-centered care See *person-centered care*.

Clinical information system Information technology that is designed to be used by various clinicians to support the delivery of resident care.

Clinical practice guidelines Evidence-based standardized protocols, also called best practices, indicated for the treatment of specific health conditions.

Cognitive impairment A mental disorder that is indicated by a person having difficulty remembering, learning new things, concentrating, or making decisions that affect the individual's everyday life.

Cohousing A type of collaborative housing in which residents actively participate in the design and operation of their own neighborhoods.

Collection period Number of days' worth of revenue that is in accounts receivable.

Collective bargaining Good-faith negotiation between a union and management.

Common law Body of legal principles and precedents that have been handed down in the form of court decisions.

Comorbidity The simultaneous presence of two or more health problems.

Compensatory damages Damages awarded by a court to "make the person whole again." Also see *punitive damages*.

Competent In reference to legal competence, a person who is of sound mind and of legal age.

Consideration In contract law, something of value promised to another in exchange for something else of value.

Consistent assignment A practice in which residents have the same caregivers assigned to them.

Constitutional law Law based on the Constitution of the United States.

Continuing care retirement community (CCRC) Also called a life-care community, it is an organization that integrates and coordinates the independent living and other institution-based components of the long-term care continuum. Different levels of services are generally housed in separate buildings, all located on one campus.

Continuity theory A theory that assumes that the experiences of one's earlier years prepare an individual to adapt to and cope with the demands of aging.

Continuous activity programming An approach in which a person with dementia is always in the presence of a staff member who engages the patient in meaningful activities.

Continuous quality improvement (CQI) An ongoing undertaking to improve quality throughout the nursing facility. It is also called "total quality management (TQM)."

Continuum of long-term care The full range of long-term care services that increase in the level of acuity and complexity from one end to the other—from informal and community-based services at one end of the continuum to the institutional system at the other end.

Contract A legally binding agreement between two or more parties to carry out a legal purpose.

Controlled substances Narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals that are governed by the Controlled Substances Act (CSA), Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Except as provided under the law, their possession and use are illegal.

Controlling The process of monitoring, evaluating, and correcting the operations of an organization.

Copayment An amount an insured must pay out of pocket each time a health care service is used.

Corporate compliance A corporation's accountability to its various stakeholders. It includes compliance with laws, regulations, and ethical standards to "do what is right."

Corporate law Statutes defining the rights and responsibilities of corporations.

Corporation A legal entity that is regarded as separate from its owners.

Cost-benefit Benefits to be derived in relation to costs for a proposal or a program.

Cost shifting The practice of charging higher rates to private payers to make up for the shortfalls in payments from the government.

Crime An offense committed against the general public regardless of whether only one or more individuals have been wronged.

Cross-contamination Transfer of disease causing organisms through contact with a dirty surface, unwashed hands, or insects.

Culture change A gradual transformation of the traditional long-term care environments and care processes driven by the sick-role model to models that promote the delivery of person-centered care in enriched environments that are also aesthetically pleasing to the senses.

Cultural competence Ability of an organization to deliver health care services in accordance with the cultural needs and preferences of the clients.

Custodial care Nonmedical care that includes routine assistance with the activities of daily living but does not include active nursing or rehabilitative treatments.

Customer Any entity that receives the product of a transaction.

D

Days of care Cumulative census over a specified period of time. Also called "resident days" or "patient days."

De minimis doctrine A legal doctrine under which a small amount of incidental time, such as waiting to clock in or out, is not compensable.

Decision making Choosing from among different alternatives.

Decision support system Information technology that provides information and analytical tools to support effective management.

Deductible An amount a beneficiary must first pay each year (or at the beginning of a benefit period for Medicare) before any benefits are payable by insurance.

Defendant A party against whom a lawsuit is brought.

Deficiency A nursing facility's failure to meet any of the regulatory standards, as determined by a survey.

Delirium A state of mental confusion that often manifests itself in the form of disorientation, incoherent speech, and physical agitation.

Dementia A general term for progressive and irreversible decline in cognition, thinking, and memory emanating from brain cells that become damaged or destroyed.

Demographic imperative Future growth of one population group at the expense of another group, such as growth of the elderly population while the younger population shrinks.

Developmental disability Physical incapacity that generally accompanies intellectual disability and often arises at birth or in early childhood.

Dietary Reference Intakes A common set of reference values, used in the United States and Canada, that are based on scientifically grounded relationships between nutrient intakes and indicators of adequacy.

Dietitian Sometimes referred to as nutritionist, a dietitian provides nutritional information and diet-related services.

Differentiation A competitive strategy in which a facility creates distinctive features that allow customers to distinguish the facility's offer from that of its competitors.

Disability A physical or mental impairment that substantially limits one or more of a person's major life activities, according to the Americans with Disabilities Act of 1990.

Discharge planning A process that includes decisions about when a resident may need to be discharged from the facility and what may be needed to make a smooth transition from one level of care to another or from the facility to living independently.

Disengagement theory A theory of aging that questions the belief that remaining active is satisfying for everyone.

Distinct part A section of a nursing home that is distinctly certified from the rest of the facility.

Docket An annotated meeting agenda that lists the items to be discussed and also provides some pertinent details and explanations for each item.

Do-not-resuscitate (DNR) order An advance directive in which a person specifies that he or she does not wish to have heartbeat or breathing restored in the event of a cardiac or respiratory arrest.

Domotics "Smart home" technology.

Dual certification Federal certification that authorizes a facility to admit both Medicare (SNF certification) and Medicaid patients (NF certification).

Durable power of attorney (DPOA) A written document that appoints another individual to make decisions on behalf of a patient.

Dysarthria Blurred or unintelligible speech due to muscle weakness or other problem.

Dysphagia Difficulty in swallowing due to a dysfunction in any phase of the swallowing process.

E

Economic strike A common type of strike by union workers that occurs when the union and management fail to reach an agreement.

Edenizing Changing a nursing home's environment by implementing the principles developed by Eden Alternative, Inc.

Efficiency A measure of outputs in relation to the resources used in producing the outputs.

Egregious conduct Conduct regarded as blatant under the law.

80:20 coinsurance Copayments under Medicare that require the beneficiary to pay 20% of the costs of medical care; the other 80% is paid by Medicare.

Elimination period In a long-term care insurance plan, the initial waiting period during which long-term care services are used but not covered by insurance.

Employment-at-will A legal doctrine according to which employment is at the will of both the employer and the employee.

Employment discrimination Failing or refusing to hire; discharging or otherwise discriminating against an individual with respect to terms, conditions, or privileges of employment; or limiting, segregating, or classifying employees in a way that it deprives an individual of employment opportunity, training, advancement, or status when such actions are in violation of a law.

End-of-life care Hospice services for the terminally ill.

Enriched environments Also referred to as “enhanced environments,” they are physically and psychologically supportive environments that promote positive feelings, harmony, and thriving, and reduce boredom and stress.

Enteral feeding Delivery of liquid food through a tube directly into the stomach.

Entrée The main dish on a menu.

Equity Also called “owners’ equity” or “stockholders’ equity,” it represents the interests or rights of the owners in a for-profit corporation.

Ethics committee A multidisciplinary forum that is generally called upon to make decisions in a resident’s best interest, particularly when there are no clear-cut solutions to a dilemma.

Ethnocentrism A belief that one’s way of life and view of the world are inherently superior to those of others and that they are desirable for others to acquire. It involves judging another’s culture as inferior to one’s own.

Evacuation Removal of residents and vital equipment from an unsafe area to a safe area during a fire or other emergency situation.

Evidence-based care/practices Delivery of services using best practices that have been established through clinical research.

Exempt employees Workers who are legally exempt from overtime provisions of the Fair Labor Standards Act.

Extramural services Community-based services that are delivered outside a person’s home and require the person to come and receive the services at a community-based location. Examples include adult day care, mental health outpatient clinics, and congregate meals provided at senior centers.

F

F-Tag A reference number that identifies a particular federal regulatory standard.

False imprisonment Unlawful restriction of freedom.

Family management A proactive approach to minimize dissatisfaction and conflict by addressing family members’ emotions about placing someone in a nursing home.

Federal preemption Federal laws supersede state and local laws.

Federalism Sharing of powers between the federal and state governments.

Felony Crime of a serious nature that is subject to a jail term of more than 1 year.

Financial accounting The recording of all financial transactions and the preparation of financial statements in accordance with the generally accepted accounting principles (GAAP).

Financing Means by which residents receiving services in nursing facilities pay for those services.

Fixed cost A cost that does not vary with the number of residents. These costs are noncontrollable.

Flexible budget An adjusted budget in which the budgeted costs are raised or lowered to reflect the actual census.

Focus group A group of about 8 to 12 people who participate in an unstructured session with a skilled moderator to discuss their thoughts and feelings about an issue, an organization, or a service.

For-profit facility A proprietary facility that distributes the profits to its owners or shareholders.

Fraud A knowing disregard of the truth that results in harm.

G

General partnership A partnership in which there is no limit on the potential liability of the partners.

Geriatrics A branch of medicine that deals with the problems and diseases that accompany aging.

Gerontology An area of knowledge that deals with the understanding of the aging process, the changes accompanying aging, and the special problems associated with aging.

Good faith A legal term that refers to actions that are generally consistent with how a reasonable person would act under similar circumstances.

Governance The act of governing. It refers to trusteeship and stewardship of an organization’s resources and capabilities to benefit its stakeholders.

Governing body Also referred to as the board of directors, board of trustees, or simply “board,” its purpose is to oversee the organization and provide broad direction. It has the ultimate legal responsibility for a facility’s operations.

Green House A small freestanding facility designed to house 10–12 residents who live together in a homelike setting.

Grievance (1) A formal expression of employee dissatisfaction about some job situation. (2) Complaint from a client, such as a resident or family member.

Gross negligence An action that involves conscious indifference to the rights, safety, or welfare of another.

Group homes See *adult foster care homes*.

Group insurance Insurance that is made available to individuals through their employers, unions, professional organizations, or consumer organizations such as the AARP or the Association of Mature American Citizens (AMAC).

Group purchasing organization A company that pools together the combined buying power of its members to negotiate discounts from vendors.

Guardian Someone who is legally empowered and charged with the responsibility to make decisions in a patient’s best interest when the patient is not legally competent to act for him- or herself.

H

Health policy The government’s decisions and actions that are intended to achieve certain purposes or goals pertaining to health care.

HIV See *human immunodeficiency virus*.

Holistic approach A philosophy that emphasizes that health care delivery should focus not merely on a person’s physical and mental needs, but should also emphasize well-being in every aspect of what makes a person whole and complete.

Home- and Community-Based Services (HCBS) Waiver Enacted under Section 1915(c) of the Social Security Act, the program allows states to offer community-based long-term care services that are not otherwise available through the Medicaid program.

Home health care Delivery of services such as nursing care and rehabilitation therapies to patients in their own homes because such patients do not need to be in an institution and yet are generally unable to leave their homes safely to get the care they need.

Hospice Cluster of special services for the terminally ill with a life expectancy of 6 months or less. It blends medical, spiritual, legal, financial, and family-support services.

Hostile environment Work environment in which unlawful behaviors of managers or coworkers create severe stress that interferes with an individual's ability to perform his or her job.

Hotel services Services such as meals, housekeeping, laundry, and maintenance services provided to residents in long-term care facilities.

Human immunodeficiency virus (HIV) A virus that gradually destroys the body's natural immune system designed to fight infections and disease.

Human resource management The organizational function of planning for human resource needs, recruitment, selection, compensation, development, evaluation, and handling of grievances and labor relations.

Hydration Adequate fluid intake to prevent dehydration.

I

ICF/IID An Intermediate Care Facility for Individuals with Intellectual Disabilities. Previously referred to as Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Impasse Failure to reach an agreement during collective bargaining.

Imprest amount A fixed amount, such as \$500, that is maintained by periodically replenishing the petty cash that has been used.

Incident Any unexpected negative occurrence involving a resident, associate, or visitor.

Income statement Also called "operating statement" or "profit and loss statement (P&L)," it furnishes a summary of revenues, expenses, and profitability for a given period of time.

Indwelling catheter A catheter that remains in the bladder to drain urine into a bag.

Inefficiency Deployment of resources without enhancing quality.

Infantilization Treating older adults as children.

Infection prevention and control A comprehensive program to prevent, recognize, and control the onset and spread of infections with the objective of protecting the residents, the staff, and visitors from contracting infections while in the facility.

Infectious waste Hazardous waste that can pose health risks from communicable infectious agents.

Informal care Unpaid services provided by family and others.

Information systems (IS) Computer-based applications used for transforming raw data into information that can be used in a variety of ways to improve operational efficiencies and the quality of services.

Informed consent The right of a patient to make an informed choice about medical care.

Injury Physical, financial, or emotional harm.

Inservice An educational session.

Instrumental activities of daily living (IADLs) Activities considered necessary for independent living. IADLs include doing housework, cooking, doing laundry, grocery shopping, taking medication, using the telephone, managing money, and moving around outside the home.

Intellectual disability Below-average intellectual functioning.

Intentional tort A willful act that violates the rights or interests of others.

Interdisciplinary See *multidisciplinary*.

Internal marketing To train and motivate the staff to provide better services.

Interoperable Electronic medical information that is available simultaneously to various health care providers.

Intimacy (1) A person's privacy during visits with family, friends, or counselors. (2) Sexual intimacy. (3) Closeness or proximity of the caregiver to the dependent elder that goes beyond mere familiarity.

Intramural services Community-based services that are taken to patients who live in their own homes, either alone or with family. The most commonly used intramural services include home health care and Meals on Wheels.

Invoice receiving A method in which items delivered are checked against the original order.

J

Job-unit contract A contract established each time a need arises for infrequent major jobs.

L

Labeling theory A theory of aging that suggests that a person's self-concept is molded by the labels others use for that person.

Leadership Influencing people to act for certain goals that represent the values and motivations—wants, needs, aspirations, and expectations—of both leaders and followers.

Learned helplessness A psychological state in which a person believes that he or she can no longer do anything for himself or herself and must depend on others.

Liabilities Economic obligations or debts.

Liability Potential damages ensuing from legal action.

Libel A written false report intended to defame another person. See *slander*.

Liberalized diet A diet that relaxes some of the restrictions of a modified diet.

Licensed practical (or vocational) nurse (LPN/LVN) An LPN or LVN is a professional nurse who has completed a state-approved program in practical nursing, which is generally 1 or 2 years in duration, and has passed a national written examination.

Licensure Licensing of a health care facility or a health care professional in accordance with state laws that require that certain conditions be met for the granting of a license.

Life Safety Code® Rules and standards developed by the National Fire Protection Association to specify numerous fire safety and other elements of building construction, fixtures, and furnishings that nursing facilities must comply with.

Limited partnership A partnership in which the individual liability of partners is limited to the extent of each partner.

Line relationship Supervisor–subordination relationship.

Litigation Legal action brought before a court of law.

Living will An advance directive specifying a person's wishes regarding medical treatment in the event this person becomes incompetent.

Local area network (LAN) A LAN links a group of computers to a central server so all LAN users can access the same information.

Long-term care (LTC) A variety of individualized and well-coordinated total care services that promote the maximum possible independence for people with functional limitations and that are provided over an extended period of time, using appropriate current technology and available evidence-based practices, in accordance with a holistic approach while maximizing both the quality of clinical care and the individual's quality of life.

M

Maintenance rehabilitation Rehabilitation that is aimed at preserving the present level of function and preventing secondary complications. It is often incorrectly called restorative care. See *restorative rehabilitation*.

Malice Knowingly doing something with the desire to cause harm.

Malpractice Negligence or carelessness in the delivery of services according to accepted standards of care so that harm is caused to the recipient of care.

Managed care An approach to delivering a comprehensive array of health care services to a defined group of enrolled members through efficient management of service utilization and payment to providers.

Management What managers do to get things accomplished on a daily basis.

Management accounting The process of preparing reports considered useful for management control and decision making.

Management by objectives (MBO) A system of management that is based on a joint agreement between supervisors and associates on what specific and measurable objectives would be accomplished over a given period of time, at the end of which the supervisors evaluate individual associates on the basis of the accomplishment of these objectives.

Margin See *operating margin*.

Market segmentation The process of dividing a large market into smaller segments in order to identify the target market.

Marketing Actions undertaken to elicit desired responses to some object from a target audience.

MBO See *management by objectives*.

MDS See *minimum data set*.

Meal plan The number of meals to be served per day

Meals on Wheels A home-delivered meals service.

Measurement Collection of meaningful data, analysis of the data, and comparison of the data to objective benchmarks of quality.

Medicaid Also called Title 19 of the Social Security Act, it is a jointly funded federal–state health insurance program for the indigent.

Medical model Delivery of health care that places its primary emphasis on the treatment of disease, relief of symptoms, and intensive use of medical technology, with little emphasis on the promotion of optimum health in a holistic context.

Medicare Title 18 of the Social Security Act to cover health care services for the elderly, certain disabled people, and those who have end-stage renal disease.

Medicare Advantage Medicare Part C.

Menu cycle A specified period of time, generally 3 to 4 weeks, during which the main items on the menus are not repeated. At the end of this period, the same daily menus are repeated in the same order.

Microbicidal Killing of microbes.

Midlevel providers See *nonphysician practitioners (NPPs)*.

Midnight census report A report verifying the presence of each resident in the facility during the night.

Minimum data set (MDS) A standardized assessment instrument that must be used to assess the physical, psychological, and psychosocial functioning of each resident admitted to a skilled nursing facility.

Misdemeanor Crime of a less serious nature than a felony. It is punishable by a jail term of less than 1 year.

Mission An organization's mission defines its basic purpose and enunciates why the organization exists.

Money Follows the Person program A project that allows Medicaid funds that had previously paid for nursing home care to be transferred to community-based services when a person transfers from a nursing home to the community.

Multidisciplinary (or interdisciplinary) A team approach to problem solving or delivery of care in which all key disciplines, such as nursing, food service, therapy, social work, and activities, participate and make joint decisions.

Multisensory stimulation (MSS) Also known as "multisensory behavior therapy (MSBT)," it involves stimulation of all the primary senses—touch, hearing, sight, smell, and taste—through a combined effect of textured objects, soft music, colored lighting, aromas, and favorite foods. Also see *Snoezelen*.

N

Negative-pressure ventilation A system that allows air to move from a clean to a soiled area, and not vice versa.

Negligence Failure to exercise the degree of care that a reasonable person would exercise in similar circumstances.

Net assets For a nonprofit organization, Net assets = Total assets – Total liabilities.

NF (nursing facility) Federal certification that authorizes a facility to admit Medicaid beneficiaries.

Nonexempt employees Workers who are paid an hourly rate, which must at least equal the minimum wage established under law. Nonexempt employees are also entitled to overtime pay.

Nonphysician practitioners (NPPs) NPPs are clinical professionals who practice in many of the areas in which physicians practice but who do not have an MD or DO degree. The two main types of NPPs who practice in long-term care settings are nurse practitioners and physician assistants.

Nonprofit A form of ownership in which the entity must serve a charitable purpose in exchange for tax-exempt status. Nonprofit organizations are prohibited by law from distributing profits to any individuals.

Nonselective menu A menu that does not regularly offer a choice of entrées to all residents.

Nourishments Light foods or snacks that are served in between the main meals.

Nurse aide registry A registration system for certified nursing assistants that all 50 states and the District of Columbia maintain. The registries enable facilities to verify the certification status of a nurse aide.

Nurse practitioner (NP) NPs are advanced practice nurses who provide health care services similar to those of primary care physicians. Some NPs specialize in geriatrics.

Nursing Home Compare A CMS program that provides web-accessible quality-related information on all Medicare and Medicaid certified facilities in the nation.

Nutritional screening Identifying residents who may be at risk for nutritional problems.

Nutritional supplements Commercially prepared oral formulas given to residents when special nutritional issues exist.

O

Occupancy rate Percentage of total beds occupied.

Occupational therapists (OTs) Therapists who provide a broad range of therapies that help patients recover or maintain the daily living and work skills. Their goal is to help patients achieve independence and satisfaction in all facets of their lives.

Occupational therapy Therapies tailored for the adaptive use of the upper extremities for performing various tasks. It can address fine motor skills, adaptive equipment, splints, and other support mechanisms to facilitate the performance of daily tasks.

Ombudsman A trained professional who works independently with area nursing home residents and their families to resolve concerns they may have about their lives in a facility.

Open-call contract A contract established with preferred contractors to provide services on an as-needed basis.

Operating margin Total profit (or loss) as a percent of total revenue.

Ordinance A law passed by a local government, such as a county, city, or municipality.

Ordinary negligence Failure to exercise the degree of care that a reasonable person would have exercised in similar circumstances.

Organizing Determination of what tasks are to be done, who is to do them, how the tasks are to be grouped, who reports to whom, and where decisions are to be made.

Osteopathic medicine Medical approach—practiced by doctors of osteopathic medicine (DOs)—that emphasizes the musculoskeletal system of the body such as correction of joints and tissues.

Outbreak More cases of an infection than expected that are identified among a specific group of people over a given period of time.

Outcome An actual result obtained from medical, nursing, and other clinical interventions.

Outcome surveillance Verifying to ensure that the staff are identifying and reporting evidence of a suspected or confirmed infection or communicable disease.

Outpatient services Any health care services that do not require an overnight stay in a facility.

P

Package price See *bundled rate*.

Palliation Medical care that is focused on relieving unpleasant symptoms such as pain, discomfort, and nausea.

Par level The minimum number of units of an item (generally linens) the facility should maintain in its inventory, including items in circulation and in storage.

Paraprofessional A caregiver who generally does not require a license to practice and works under the supervision of a licensed professional. Examples include certified nursing assistants and therapy assistants.

Parenteral nutrition Delivering a special liquid nutritional formulation directly into the bloodstream, when the gastrointestinal tract is not functioning properly.

Partnership An association of two or more individuals or organizations for the purpose of carrying out a business for profit.

Passivity A decline in human emotions, withdrawal from interactions with others and surroundings, and a decrease in motor activity.

Pathogen Disease-causing organism.

Pathological waste Human waste that may contain human tissue, blood, or body fluids.

Patient days See *resident days*.

Patient Driven Payment Model Medicare reimbursement that incorporates many aspects of a resident's condition in establishing payments.

Payables See *accounts payable*.

Payer mix Also called "census mix," it is the mix of residents by payer type, such as Medicaid, Medicare, private pay, etc.

Per diem Per day, such as a per-diem rate of reimbursement.

Per patient day (PPD) or per resident day (PRD) A revenue or cost amount for each resident day.

Perpetual inventory system Maintaining a continuous record of the quantity on hand for each item.

Personal care Basic assistance with light activities of daily living and services such as meals and recreation.

Person-centered care A philosophy that integrates physical layout and design with empowerment of the residents, families, and staff. Also called *client-centered care*.

Physiatrist Physician who has specialized in physical medicine and rehabilitation.

Physical inventory system An inventory system in which each item in storage is actually counted, generally once a month.

Physical therapist (PT) A rehabilitation professional who has specialized in the treatment of musculoskeletal disorders (loss of function associated with bones, joints, spine, and soft tissue), neuromuscular disorders (loss of function associated with the brain and nervous system, e.g., stroke), recovery from cardiopulmonary problems, and severe wounds. PTs specialize in the restoration of various activities of daily living functions.

Physical therapy (PT) Treatments geared toward improving ambulation, range of motion, physical strength, flexibility, coordination, balance, and endurance. It also includes fitting and training residents to use artificial limbs, canes, and walkers.

Physician assistant (PA) A trained professional who can perform physical examinations, diagnose and treat illnesses, order and interpret laboratory tests, and make rounds at long-term care facilities under the direction of a physician.

Picketing A concerted action by striking union employees in which they patrol the perimeter of a facility displaying placards that call attention to a labor dispute.

Plaintiff Party who brings a lawsuit before a court to seek damages or other legal remedies.

Plan of care (care plan) A written plan developed through team participation of various professional disciplines to clearly outline how each identified need of a given resident will be addressed and what specific goals will be accomplished.

Planning Defining or clarifying the organization's purpose, establishing objectives, and planning a course of action to achieve those objectives.

Policy makers The term generally applies to legislators and decision makers in legislative bodies and regulatory agencies who are actively involved in crafting laws and regulations to address public issues.

Poorhouse A government-operated institution during colonial and postcolonial times where the destitute of society, including the elderly, the homeless, the orphan, the ill, and the disabled, were given food and shelter, and conditions were often squalid.

Positioning Staking out an organization's position in the target market.

Positioning statement In developing a marketing strategy, it describes how the facility should be positioned in the market.

Positive disciplining An approach to disciplining in which the total responsibility for correcting a problem is placed on the associate.

Preadmission Screening and Resident Review (PASRR) Screening required under federal law to ensure that when people have a mental illness, mental retardation, or developmental disability, they are placed in a nursing home only if they need nursing home care.

Preceptor A nursing home or assisted living administrator who meets prescribed qualifications and has been certified to mentor interns in an administrator-in-training program.

Presenteeism Employees coming to work despite illness or unsuitability to work.

Pressure ulcer Also referred to as a "pressure sore" or "decubitus ulcer," it is a localized area of soft-tissue injury resulting from compression between a bony prominence and an external surface.

Preventive maintenance (PM) Routine inspections and performance of certain tasks that are carried out to prevent unexpected equipment failures.

Primary care Basic, routine, continuous, and coordinated medical care rendered by a primary care physician or a midlevel provider such as a physician's assistant or nurse practitioner.

Private laws Laws that affect an individual, family, or small groups of people.

Private-pay residents Residents in a nursing home who have a personal or private source of funding to pay for the services.

Process surveillance Review of staff practices to identify whether facility infection prevention and control policies and procedures are being followed.

Productivity Maximization of quality for each unit of resources used in delivering health care.

Program evaluation Systematic appraisal of a program to determine whether expected results are being achieved.

Programming Structured methods of delivering needed services by developing and carrying out a meaningful plan.

Promotion Communication system that creates awareness of the product, its features and benefits, and its location of purchase, and also reassures the customer after the purchase has taken place.

Prospective payment system (PPS) A method of reimbursement based on case mix rather than on the facility's costs.

Provider An organization or individual that delivers health care services and gets reimbursed for the services delivered.

Psychosocial A constellation of social and emotional needs and the care provided to meet those needs.

Psychotropic drug Any drug that affects brain activities associated with mental processes and behavior. These drugs include antipsychotics, antidepressants, anxiolytics (anxiolytics), sedatives, and hypnotics.

Public facility A facility owned by the government.

Public laws Laws that affect society as a whole.

Public policy Decisions and actions of the government that are intended to address current and potential issues that the government believes are in the best interest of the public.

Public relations Also called "community relations," public relations refers to a formal program of communication with external stakeholders and the community at large.

Publicity Nonpaid communication of information about the facility and its services.

Punitive damages Damages awarded in excess of the actual losses suffered by a plaintiff to make a public example of the defendant because of egregious conduct.

Q

Quality Consistent delivery of services that maximize the physical, mental, social, and spiritual well-being of all residents, produce desirable outcomes, and minimize the likelihood of undesirable consequences.

Quality Assurance/Performance Improvement (QAPI) A comprehensive quality improvement program that certified nursing facilities are required to implement.

Quality of care Achievement of desirable clinical and satisfaction related outcomes.

Quality of life The total living experience, which results in overall satisfaction with one's life. The integration of social, environmental, and personal factors—including safety, comfort, personal preferences, dignity, interpersonal relations, and pain management—into the delivery of care.

Qui tam relator A whistleblower, under the False Claims Act, who has knowledge that a person or an entity is submitting false claims or otherwise defrauding the federal government.

R

Rational decision making A systematic process of making decisions that begins with carefully evaluating the status of a given situation and articulating what is desired.

Reality orientation A form of therapy for confused or disoriented individuals that consists of reiteration of the person's identity, orientation to time and place, and reinforcement of consistency in daily routine.

Reasonable accommodation Actions such as alteration of facilities and the work environment as well as job restructuring to focus on the essential functions, and altering or eliminating nonessential aspects of a job in order to accommodate a disabled employee.

Receivables See *accounts receivable*.

Reconditioning Thorough cleaning of certain areas, particularly resident rooms.

Registered nurse (RN) A professional nurse who has completed an associate's degree, a diploma, a bachelor's degree, or a master's degree in nursing, and has been licensed as a registered nurse.

Regulations Administrative interpretations of statutes, containing details on carrying out the statutes. Regulations carry the force of law.

Rehabilitation Evaluation of physical function and interventions to achieve the highest possible level of function and independence.

Reimbursement (1) Method used by a payer to determine the amount of payment. (2) The amount that is actually paid to a facility on behalf of a resident.

Reliability Reliability of a measurement instrument reflects the extent to which the same results occur from repeated applications of a measure.

Reminiscence Remembering and in some way reliving past experiences. It is considered important for emotional well-being. Photo albums, memorabilia, and old news clips can be used as aids.

Requirements of Participation Federal regulations as prescribed by the Nursing Home Reform Act of 1987 for the certification of nursing homes.

Resident council An independent, semiformal body made up of all residents who are able to participate. The purpose of this forum is to empower the residents so they can have a say in the operations of the facility.

Resident days Cumulative census (number of residents) over a specified period of time. Also called "days of care."

Respite care Any temporary long-term care service (adult day care, home health, or temporary institutionalization) that enables family caregivers to take time off while the patient's care is taken over by the respite care provider.

Respondent superior Also called "vicarious liability," it is a legal doctrine that holds a corporation liable for the tortious acts of its employees.

Responsible party A person, such as a spouse or relative, who handles a resident's private financial affairs.

Restorative rehabilitation Rehabilitation therapy aimed at regaining or improving function through short-term intensive treatments given by licensed therapists.

Restraint A device used to restrict a person's freedom of movement.

Risk management The identification, analysis, and reduction or prevention of risks.

Routine contracts Contracts for services that are performed on a regular basis.

S

Sanitizing Reducing microbes to relatively safe levels on an inanimate object.

Scope (of deficiency) In the context of a deficiency, the number of residents who are potentially or actually affected as a result of not meeting a regulatory standard.

Secondary disability Functional loss of capabilities that were previously unaffected.

Security audit An examination of all physical security measures and potential lapses.

Selective menu A menu that offers a choice between two entrées from which each resident can make a selection.

Self-managed work team (SMWT) A group of associates who are together responsible for performing a range of tasks, including scheduling, planning of tasks, and monitoring the team's performance.

Semantic differential A technique used by marketing researchers in which people are asked to rate a facility and its competitors on dimensions such as quality, reputation, friendliness of staff, comfort, décor, etc.

Semifixed costs Also called "semivariable costs" or "step-variable costs," these costs remain fixed within parts of the census range.

Senior center A local community center for older adults where seniors can congregate and socialize. Many centers offer a daily meal. Others sponsor wellness programs, health education, counseling services, information and referral, and some limited health care services.

Sensory stimulation Therapy to stimulate the senses in people with dementia or those in comatose or vegetative states. It may involve use of stuffed animals for tactile stimulation, sounds, taste and smell, or visual stimulation. Also see *multisensory stimulation*.

Severity (of deficiency) In the context of a deficiency, the extent of actual or potential harm and negative health outcomes as a result of not meeting a regulatory standard.

Sharps Any objects that can cut or puncture, such as needles, blades, broken glass, and nails.

Sick-role model Proposed by Talcott Parsons, in the sick role the patient is expected to relinquish control to medical personnel and comply with their directives.

Situational model A model of leadership that suggests that a leader should apply an appropriate measure of both directive and supportive behaviors as dictated by the competence and commitment of each worker or group.

Skill mix The ratio of a particular skill type to the total staff. For example, the ratio of registered nurses, licensed practical nurses, and nursing assistants to total nursing staff.

Skilled nursing care Physician-directed care provided by licensed nurses and therapists. It may include monitoring of unstable conditions; clinical assessment of needs; and treatments such as intravenous feeding, wound care, dressing changes, or clearing of air passages. The patient may also require rehabilitation therapies such as physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Skilled nursing facility (SNF) A federal certification that authorizes a facility to admit Medicare beneficiaries.

Slander An oral false report intended to defame another person. See *libel*.

Smoke compartment A space of 22,500 square feet or less that is protected by fire barriers inside a building.

SNF See *skilled nursing facility*.

Snoezelen A Dutch term for multisensory stimulation through soft music, aromatherapy, textured objects, colors, and food.

Social support A variety of assistive and counseling services to help people cope with situations that may cause stress, conflict, grief, or other emotional imbalances. The goal is to help people make adjustments to changing life events.

Sole proprietorship Single ownership in which the business is not incorporated.

Speech/language pathologists (SLPs) Also referred to as "speech therapists," they assess, diagnose, and treat speech, language, and cognitive disorders. They also treat dysphagia.

Speech/language pathology (Speech therapy) Therapy focusing on individuals with communication problems, including disorders of speech, language, feeding, and swallowing.

Spend down Spending one's assets and income down to Medicaid eligibility thresholds by incurring medical or remedial care expenses.

Staff relationships Advisory relationships in an organization.

Stakeholder Any constituent group that has an interest in what a nursing facility stands for and what outcomes it produces.

Standard precautions (SPs) General infection control precautions to be used when delivering hands-on care to any resident, or when handling soiled articles of linen and clothing. It requires the use of gloves, gowns, and masks as necessary to avoid contact with body fluids.

Statement of position In developing a marketing strategy, it describes the existing market position of a facility.

State Survey Agency Agency responsible in each state for monitoring compliance with the state licensure standards and the federal Requirements of Participation.

Statutory law Statutes passed by various legislative bodies, such as the U.S. Congress, state legislatures, or legislative bodies of local governments.

Strike Work stoppage as a concerted effort by unionized employees.

Subacute care Postacute services for people who may be recovering but are still subject to complications while in recovery. They require more nursing intervention than what is typically included in skilled nursing care.

Substantial compliance A level of compliance with the Requirements of Participation such that any identified deficiencies would pose a risk of only minimal harm to health and safety.

Summary judgment A court's decision that results in a prompt disposition of a legal case without a trial.

Supplemental Security Income (SSI) A federal program that provides cash assistance for food, clothing, and shelter to the elderly, blind, and disabled people who have little or no income.

Support services Basic assistive services that may be available in supportive housing units. Services may include meals, transportation, housekeeping, building security, social activities, and outings.

Supportive housing Accommodations in which certain functional and safety features are carefully planned to compensate for people's disabilities to the maximum extent possible in order to promote independence.

Surveillance In the context of infection control, identifying and reporting all cases of infection in the facility and identifying all infected residents and staff.

Survey An inspection to verify compliance with state and federal standards.

T

Target market Part of the overall market from which the nursing facility will attract customers.

Temperature danger zone The temperature range of 40°F (5°C) and 140°F (60°C) in which food bacteria thrive and multiply rapidly.

Tertiary prevention Preventing complications from chronic conditions.

Therapeutic diet A diet prescribed for treatment for a disease or clinical condition, to eliminate or decrease specific nutrients in the diet (e.g., sodium), to increase specific nutrients in the diet (e.g., potassium), or to facilitate chewing and eating (e.g., a texture modified diet).

Third party A payer other than the residents and their families. Examples of third-party payers are insurance companies, managed care, Medicare, Medicaid, and the Veterans Administration.

Thriving Living life to the fullest.

Tort A civil wrong other than a breach of contract. Tort may also involve interference with another's rights, either intentionally or otherwise.

Total care Recognizing any health care need that may arise and ensuring that the need is evaluated and addressed by appropriate clinical professionals. When evaluation and treatment are beyond the nursing home's scope of services, referral must be made to an external provider.

Transmission-based precautions Infection control precautions to follow when caring for residents who have a communicable disease. These precautions are used in addition to standard precautions.

U

Undifferentiated marketing Also called "mass marketing," it purposefully ignores market segmentation, and targets the aggregate market using the same marketing mix for the entire market.

Unfair labor practice An action declared as illegal under the National Labor Relations Act.

Union steward A unionized employee who works at the facility and officially represents the union on issues involving the labor contract.

Unit-dose system A dispensing system in which medications are prepackaged and labeled in unit-of-use form and are ready to be given to the resident.

Unity of command A principle of management according to which a subordinate should report to only one supervisor.

Upcoding Billing for services that procure a higher reimbursement than the services actually provided and that should have been billed at a lower rate of reimbursement.

Utilization Actual use of health care that occurs when people needing services have access to them.

V

Validation therapy A type of therapy in which a person's belief that he or she is actually living in the past is accepted and validated by staff members working with the resident.

Validity The extent to which a measurement instrument actually measures what it purports to measure.

Value (singular) The worth that is perceived by each party in an exchange. Value is created when the facility produces benefits that exceed, or at least equal, the inputs brought by outsiders into the exchange.

Value-based purchasing (VBP) Linking payments to resident outcomes to redistribute payments from low-quality to high-quality nursing facilities.

Values (generally plural) Principles and ideologies held sacred by an organization.

Variable cost A cost that varies with the change in the number of residents.

Variance The difference between an actual (realized) numeric value and a budgeted (expected) value.

Variance analysis An examination and interpretation of differences between what has actually happened and what was planned in the budget.

Vicarious liability See *respondeat superior*.

Vision A compelling picture of how an organization will look and function when its main objectives are achieved.

Vital signs Generally, body temperature, pulse rate, blood pressure, and respiratory rate are referred to as vital signs. Any abnormalities in these measures triggers further clinical evaluation.

Wage garnishment Any legal or equitable procedure through which some portion of a person's earnings is required to be withheld by an employer for the payment of a debt.

Wayfinding Features that can help people find their way through a large institution with relative ease.

Zoonosis Transmittal of infections from vertebrate animals to humans.



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