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The Comprehensive Manual for Nursing Home Administration

Third Edition

Brian Garavaglia, PhD

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Nursing Home Administration

Nursing home administration is a complicated specialization in healthcare. The days when the administrator was the keeper of the "home" are long gone. The long-term care industry is a progressive environment, and the nursing home administrator must constantly keep his or her fingers on the pulse of this continually changing and developing industry. Long-term care is no longer a static industry of warehousing people, as was often the case in the past; it is moving out of the shadow of the healthcare industry and into the limelight.

Due to long-term care's increasing complexity, nursing home administration is a multifaceted field of study that is every bit as challenging as administration in the acute care sector. Its administrators are much more visible to the workers they manage and to the residents they oversee than are hospital administrators, which makes the job even more complex. For instance, not only is the administrator the CEO of the facility, but he or she is also the chief financial officer, the director of HR, the director of plant operations, the director of marketing, and, ultimately, the person responsible for all medical services the facility renders. In what other industry does a person hold that much responsibility?

Given the complexity, nursing home administration is not for the fainthearted—it is a demanding profession that requires tremendous time and energy. It can be difficult to understand the responsibility of the nursing home administrator, but being the person who is on call 24 hours each day and is responsible for the residents, family members, and workers found within the facility is an enormous task. Those who enter the profession must do so because of dedication to servicing those who live in the long-term care environment.

This book aims to provide the nursing home administrator with the knowledge that he or she needs to succeed in long-term care administration. Of course, no book can replace hands-on experience, but it helps explain what the job entails before you enter the field.

To that end, this book will discuss many of the important areas of long-term care administration. It starts with a brief history of the industry and provides an important gerontological understanding of older adults. It also examines other areas, such as basic medical terminology and the health issues and biological changes that older adults typically encounter. In addition, it provides some important principles for understanding HR management, financial management, management theory, group and organizational theory, infection control and sanitization, plant operations, and regulatory environment in long-term care.

Learning about the industry is a daunting task—no one can understand it overnight. Because the industry is constantly evolving, continuous education and keeping abreast with the changes in the industry are important. This edition addresses important new developments in the field. For the first time since 1987, there have been large-scale changes in the industry's regulatory procedures. Although the changes are wide-ranging, this edition will include some of the new procedures for nursing home surveys and address the new regulatory numbering of important regulations. Furthermore, it will touch on some of the new rules that have been, or are being, introduced in the industry.

Although no single book can do justice to the industry in its entirety, this book will provide a basic understanding for newcomers as well as advanced knowledge and skills for industry veterans. Rather than being a definitive statement on the subject, it complements other books and materials covering this area, and it provides important information for those who want to venture into this challenging and complex industry.

The Current Nursing Home Landscape

The nursing home landscape is continually changing. Many smaller facilities are giving way to larger long-term care companies. The nursing home environment is becoming more progressive, admitting not only elderly individuals but also younger members, especially for short-term rehabilitation needs. Additionally, the growth of assisted living facilities has influenced the occupancy rate of nursing homes. The following subsections discuss the current status of this industry in greater detail.

Types of nursing homes

There are three major types of nursing homes: for-profit nursing care facilities, nonprofit nursing care facilities, and government-owned nursing care centers. As illustrated in Table 1.1, there are more for-profit nursing care facilities in the United States than there are non-profit and government-owned facilities. Regulatory requirements are the same for all three types of nursing care centers; the major difference is in the tax laws that pertain to the different nursing homes.

That being said, take care when using these terms. Many people believe that for-profit facilities make incredibly large profits compared to nonprofit facilities. Although it's true that profit margins are greater for the for-profit facilities, the margins are usually minimal, with many for-profits running close to breaking even; a common margin is approximately 2%–3%.

See Table 1.1 for the different types of ownership for nursing homes in the United States as of 2017.

Table 1.1 Different types of ownership for nursing homes in the United States as of 2017

As of 2017	
For profit	70%
Nonprofit	23%
Government-owned	7%

Source: The Kaiser Family Foundation, statehealthfacts.org.

Payer source

Medicaid provides by far the most reimbursement for nursing home care, and it usually requires older adults to spend down their resources to be eligible for coverage. Medicare, a plan that can cover up to 100 days of skilled nursing care, provides a better reimbursement rate but accounts for far less reimbursement overall.

CHAPTER

2

The Language of the Healthcare Culture: Biological and Psychosocial Aspects of Aging

Nursing home administrators do not have to be clinical specialists, such as physicians or nurses, nor do they have to be gerontologists, understanding the larger complexity of the older adult population. However, they *do* need some basic knowledge about aging and the biological, psychological, social, and cultural aspects of this population. This knowledge is essential, as nursing home administrators are more than just businesspeople—unlike hospital administrators, they often interact much more closely with their staff and with the resident population.

This chapter will examine the major topics and terminology related to aging that you will encounter in your daily management and work as a nursing home administrator. It will provide a basic level of knowledge that helps you communicate with and understand older adults and the long-term care industry.

Aging and the Elderly

Every society affords different levels of prestige to the elderly and varying access to resources based on age. In the United States, the number of aged individuals has increased significantly over the past century. In 1900, half of all Americans were under the age of 23 (the median age), and less than 5% of the population was older than 65. Since then, the median age has risen to 37.7 years, and 14.9% of the population is now at least 65 years old (United States Census Bureau, *www.census.gov/quickfacts/table/PST045215/00)*. Thus, we live in a truly graying society.

The elderly population is also the fastest-growing age group in our society; it is growing more than twice as quickly as the population as a whole. Two major reasons for this astronomical growth are increasing life expectancy and the aging of the baby boomers (i.e., those born between 1946 and 1964). Today, many of the early-year baby boomers—a considerable portion of the population—are reaching their sixth decade of life. As this group continues to age, it will become part of the aged population and will have a growing impact on the long-term care industry.

Due to the increased needs of this population, two fields dedicated to the elderly population are expanding: gerontology and geriatrics. Gerontology is the scientific study of aging and the elderly. This multidisciplinary field consists of biologists, psychologists, sociologists, and even anthropologists who are interested in the various facets of aging. Geriatrics is a medical specialty that is growing to meet the medical needs of the elderly, and geriatricians are physicians who are specially trained to treat diseases that are associated with the elderly. Both groups of individuals have greatly increased our knowledge base about the aging process.

Of course, no two people age in the same way. Therefore, we must make a distinction between chronological and functional aging:

- Chronological aging is the number of years a person has lived. This kind of aging is a constant, in that every 365 days a person adds another year to his or her life.
- Functional aging is highly variable. Two people who are 40 years old might be chronologically the same age, but their functional age might differ drastically. One 40-year-old might view themselves as young and engage in youthful, vigorous exercise daily, whereas the other individual might say that they feel old and must start to slow down. One individual might have the biological structure of a 25- or 30-year-old, whereas another individual's body might show signs of age that greatly exceed their chronological age. Long-term care administrators are usually aware of such differences, often noticing the spry 85-year-old who is alert and active and their 85-year-old roommate who has a slow thought process, has ponderous physical features, and engages in little activity.

Life Expectancy, Life Span, and Change

Life expectancy, or the number of years one can expect to live from the time of birth, has also increased dramatically. In 1900, life expectancy was less than 50 years, and today it is more than 70 years (The World Almanac, 2012). As of 2015, the average life expectancy in the United States is 78.8 years of age, with an average life expectancy of 76.3 for men and 81.2 for women (CDC, 2016). With this increase in life expectancy and the aging of the baby boomers, we can expect the portion of the population that is 65 years of age or older to increase to 19%–20% over the next 30 years.

Table 2.1 demonstrates this dramatic change in life expectancy over the past 100 years. The population of 85-year-olds is currently the fastest-growing portion of the overall population; these adults may prompt continued growth in long-term care as well as in the need for qualified people in this field.

Table 2.1 Life expectancy for the population of the United States from 1900 to 2015

Year	Life expectancy
1900	47.3
1910	50.0
1920	54.1
1930	59.7
1940	62.9
1950	68.2
1960	69.7
1970	70.8
1980	73.7
1990	75.4
2009	78.2
2015	78.8

Source: CDC, www.cdc.gov/nchs/products/databriefs/db244.htm

Often, the term "life span" is used interchangeably with "life expectancy." However, the two concepts are different. Life expectancy is the number of years one can expect to live from the time of birth, and this number has increased dramatically since the beginning of

Medical terminology, abbreviations, and specialties

To understand the healthcare culture, you have to learn to speak some of its language. The following lists cover basic medical terms, abbreviations, and frequently addressed specialties—in other words, cultural language and symbols that you should get to know.

Movement terms

1. Abduction: movement away from the midline of the body
2. Adduction: movement toward the midline of the body
3. Inversion: turning movement of the foot and leg inward
4. Eversion: turning movement of the foot and leg outward
5. Pronation: hand movement downward
6. Supination: hand movement upward
7. Flexion: contraction of muscle
8. Extension: elongation of muscle
9. Superior: top of
10. Inferior: below or under
11. Posterior: to the back of
12. Ventral: to the front of
13. Proximal: toward the trunk of the body
14. Distal: movement outward from the trunk

Medication administration terms

1. PRN: as needed
2. PO: by mouth
3. IM: intramuscular
4. IV: intravenous
5. Epidermal: within the top layer of the skin (epi means above)
6. Sublingual: under the tongue
7. Sub Q: subcutaneous
8. GTTS: drops

CHAPTER

3 Long-Term Care Management Personnel

Even though the administrator is ultimately responsible for the facility that he or she oversees, no administrator can be responsible for overseeing every aspect of the long-term care environment. Therefore, administrators must hire competent individuals to oversee their respective areas and then have to trust their judgment. It is important to delegate responsibility in this way, and those who hold levels of oversight responsibility must be aware that they ultimately answer to the administrator. They need to communicate with the administrator so that he or she is always aware of what is happening in the departments and providing feedback where necessary.

When administrators try to exert their authority over each department without depending on the managers to make informed decisions, they circumvent the autonomy of and trust in their managerial team. This approach makes managers and staff question their own abilities. The administrator has created an atmosphere that is nonproductive, with managers and workers looking over their shoulders to make sure they are doing what the administrator wants and not what they view as best.

Instead, remember that the management team is an asset to any administrator. Administrators should frequently tap this resource to learn what can be improved and should learn from staff in areas where they are more fully informed or even expert. To do so effectively, administrators must have some working knowledge of nursing, dietary, social services, maintenance, and activities—in other words, all departments. This will allow them to maintain state and federal compliance, as well as to ask informed questions so that they can obtain clear, helpful answers. This chapter describes the major management areas in long-term care and many of the responsibilities they hold.

The Administrator

The administrator is responsible for leading, planning, controlling, and organizing the facility. He or she is the facility's CEO; they are ultimately responsible for ensuring that day-to-day operations comply with state and federal regulations and for leading the facility in a manner that promotes the provision of optimal healthcare. The administrator must answer to the owner(s) or other members of the governing body. Federal regulations state the following in regard to administration:

> *A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being of each resident (CMS,* State Operations Manual*, 483.70).*

Although that statement is somewhat vague, from it you can derive that administrators help to plan and lead the facility in a direction that helps workers provide sound care to all residents in all phases of their lives.

Given that much of the administrator's job relates to the business, financial, and regulatory aspects of healthcare, they must be sensitive to these important areas; owners and the board will often question them on these issues as they relate to the company's daily business affairs. For example, administrators must ensure that all quarterly Medicare credit reconciliations are submitted to the Centers for Medicare & Medicaid Services (CMS) in a timely manner. Administrators often will rely on assistance from billing agencies or accountants to help them fill out this documentation; they should then accurately document any credit balances to the best of his or her knowledge, based on the information provided by the billing agencies or accountants. Remember, the administrator signs these documents, attesting that the information is correct and therefore certifying this process.

The administrator also guards against actions that may be viewed as kickbacks, as well as inappropriate billing submissions that could lead to trouble for the facility. This area of oversight has become increasingly important, especially since the federal government is levying progressively harsher penalties against individuals who commit such offenses. In many cases, an individual's defense that they were not aware of such activity does not hold any legal weight. Thus, the administrator needs to work with the Minimum Data Set (MDS) coordinator during end-of-month closings to review Medicare billing days and to make sure that the number of days billed and the level at which they are billed are accurate. Doing so

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483.35(b)—Registered nurse

483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full-time basis.

483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

The MDS Coordinator

The Minimum Data Set (MDS) coordinator is responsible for a critical area within long-term care: ensuring that the coding and documentation of all residents are appropriate and within the mandated guidelines. The MDS is an evaluation tool that is mandated for evaluating all residents within nursing care facilities. It addresses the evaluation and coding of such areas as mood, cognitive status, pain, psychosocial status, dietary issues, activity, continence, hydration, wounds, and so forth. It can be a very valuable tool when used properly, giving a sound and comprehensive understanding of every resident.

The MDS program also computes the data and highlights issues (triggers) for which a Care Area Assessment (CAA) (as it's called under the new MDS 3.0 but formerly known as resident assessment protocols) needs to be added to further elaborate on flagged or triggered issues. This is a mouthful, to say the least, and although it is not as confusing as it sounds, one does have to interface with the program to better understand how it works.

Furthermore, the MDS coordinator must understand this process and make sure that he or she is addressing any inconsistencies within the MDS evaluation. For example, dietary and nursing may be addressing similar issues, but there may be a discrepancy in how each discipline codes for it in the MDS. To address such issues, the MDS coordinator must sensitize him- or herself toward questioning and evaluating any possibly incongruent coding features. Because this system is federally mandated, all information that the MDS coordinator codes and provides must be accurate, and submission of all data must be completed in a timely manner.

with the dietary supervisor, and getting feedback regarding where improvements are needed and how to make them.

The administrator should have some basic knowledge about food groups. They should understand the difference between carbohydrates, fats, and proteins and the impact they have on health and disease. They should be able to pose questions such as whether a particular resident has experienced a significant change in weight. In addition, it is essential that they have a basic understanding of diets, such as those that are intended to control diabetic conditions, as well as of the difference between mechanically altered diets, soft diets, thickened dietary intakes, and pureed diets.

Social Services

Federal requirements state that only facilities with more than 120 beds need to have a full-time social worker. Nevertheless, facilities of all sizes must have individuals—whether social workers, nurses, or other staff members—who address the medically related social service needs of each and every resident. Thus, it is often prudent for facilities to have a full-time social worker even when they aren't mandated to do so.

As a member of the interdisciplinary team, the social worker is responsible for maintaining accurate information on MDS assessments. He or she must provide an accurate and thorough assessment, especially in regard to each resident's psychosocial status at the time of admission, during each assessment period required by Medicare, and during the quarterly, annual, and significant change assessment protocol periods that are mandated within the federal regulations.

The social worker is responsible for assisting the MDS coordinator with any demand billing procedures. He or she may work with the director of admissions to help explain to residents (and their responsible parties) the right to contest their removal from Medicare status, their rights under Medicare billing, Medicare copays, the potential period of coverage, and technical denials based on exhaustion of Medicare coverage.

The social worker is responsible for maintaining accurate screening information and for ensuring that the Omnibus Budget Reconciliation Act (OBRA) assessments are completed in a timely manner, with the appropriate forms submitted to the appropriate agencies. Given

The staff development coordinator also conducts regular in-services to address any potential deficiencies. These sessions educate not just the nursing staff but all staff members in areas that may cover issues of safety, infection control, abuse training, lockout/tagout, and so forth. Because this person must be involved in training on a regular basis, they must be able to communicate well and must be able to tailor presentations to the audience being addressed. Thus, the staff development coordinator has to be creative as well as be well informed on what he or she is presenting to the staff. This person has to be an educator, frequently hitting the books or going online to find the latest information and providing the staff with data about healthcare best practices.

The staff development coordinator will keep the administrator briefed on planned in-services and will develop an in-service schedule. This schedule, especially as it applies to the nursing staff, will be developed with the assistance of and feedback from the DON, who can help target important clinical areas that need to be addressed or enhanced for nurse assistants and nurse education. The administrator may also call on the coordinator to establish regular in-services throughout the year regarding fire and disaster awareness, lockout/tagout information, MSDSs, and abuse and neglect protocol, among others. Monthly education schedules need to be kept on file for a length of time determined by the state.

The HR Coordinator

As mentioned previously, the HR coordinator works closely with the staff development coordinator. Workers' most common questions—regarding wages and hours worked, benefits, sick pay, unemployment, and workers' compensation, as well as labor and contractual issues related to work—will need to be addressed by HR personnel. Unlike in the hospital environment, HR personnel and the HR office in the nursing facility will not be divided into specialized areas, which means that the HR coordinator is responsible for all areas of HR; in other words, he or she is an HR generalist.

One of the major responsibilities of HR personnel is to maintain accurate employee records—and to maintain their confidentiality. Work-related records and the workers' medical records should be separated and should not be contained in the same file; moreover, both employee work-related files and medical files should be locked and not readily available to anyone other than authorized personnel. When the state labor department conducts audits, it will look for compliance with this requirement. Therefore, the HR coordinator must make sure these records are adequately safeguarded.

The following regulations found in the *State Operations Manual*, "Appendix PP—Guidance to Surveyors for Long Term Care Facilities," address the area of activities within a facility.

F679—Activities

483.24(c)—Activities

483.24(c)(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident (CMS, State Operations Manual*).*

F680—Activities director

483.24(c)(2) The activities program must be directed by a qualified professional who:

Is a qualified therapeutic recreation specialist or an activities professional who:

(i) Is licensed or registered, if applicable, by the state in which he or she is practicing; and

(ii) Is

(A) eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(B) Has 2 years of experience in a social or recreation program within the last 5 years, 1 of which was full-time in a patient activities program in a healthcare setting; or

(C) Is a qualified occupational therapist or occupational therapy assistant; or

(D) Has completed a training course approved by the state.

The Medical Director

The role of the medical director is somewhat amorphous. Federal regulations state only that the facility must designate a physician to serve as medical director and that the medical director is responsible for implementing resident care policies and coordinating medical care in the facility [483.75(i)]. Therefore, this position isn't very well defined. However, a knowledgeable medical director, who understands not only medical practices but also the long-term care industry, is an important asset for any facility.

The medical director has direct supervisory responsibility for physicians and must ensure compliance. He or she addresses any policy issues concerning medical care and advises the facility's owner, administrator, and DON of those issues. Similarly, if the administrator,

CHAPTER

4

Long-Term Care Nonmanagement Personnel

Most of the individuals who work within the long-term care organization are not management personnel, but they are no less important to the life of the organization. Most of the labor in any healthcare organization, whether a hospital, a subacute facility, an assisted living facility, or a nursing facility, is completed by individuals who, unfortunately, are not given the recognition they deserve in carrying out these physically and emotionally taxing—and absolutely essential—duties. Indeed, the physical and occupational therapy (PT/OT) assistants, nursing assistants, dietary personnel, and housekeeping staff provide most of the basic life-sustaining services to long-term care residents. The administrator should make sure to frequently interact with these staff members, acknowledging their efforts and contributions to the facility as well as educating them in areas where there are potential issues. In this chapter, we will briefly examine the roles of nonmanagerial staff members.

The Physical and Occupational Therapy Staff

Most PT/OT needs are met on a daily basis by certified physical and occupation therapists and assistants after an evaluation and treatment plan has been recommended by the licensed physical therapist or licensed occupational therapist. In long-term care facilities, especially larger organizations with several separate facilities, the PT/OT staff may be part of the organization, working on a full-time basis between numerous nursing care facilities. At times, the physical therapist or occupational therapist may be part of the managerial staff. In smaller facilities, PT/OT services are often contracted out, and although PT/OT personnel work in the facility, they are part of a larger PT organization with which the facility contracts to carry out these services.

The administrator must be aware of any issues that the PT/OT staff may have. By frequently checking in with the staff, the administrator can learn what supplies are needed to carry out more efficient services in this area. This awareness is important because many residents come to the facility for only a short period of time and to obtain PT/OT services after an extended period of hospitalization. Thus, residents and family members will inquire about this to make sure that the facility has the resources it needs and that the rehabilitation staff is competent, effective, and efficient.

Furthermore, the administrator must evaluate the services in this area to make sure that staff members provide those that are needed and that they are doing so in accordance with the care plan. The administrator, even with a contracted agency, should ask residents whether the facility is accommodating their needs and what the facility can do to make services in this area more effective.

Nursing Assistants

Nursing assistants are often viewed as the backbone of the nursing facility—they are responsible for providing some of the most basic services for sustaining residents' lives. Those who become nursing assistants must meet minimum training requirements and pass a certification test. They also must complete at least 12 hours of in-service education each year to maintain their certification. During rounds, the administrator, along with the director of nursing (DON), should monitor nursing assistants to ensure that they provide care in a manner that maintains residents' dignity. This includes informing residents of the services they will receive, speaking with residents, and providing privacy when administering care by drawing curtains and discussing treatment issues in private areas.

As the administrator walks through the building, he or she should observe whether the nursing assistants are addressing call lights and alarms quickly and without reservation. If they are not, the administrator should question them about why; often the answer is that the call light pertains to another nursing assistant's resident. The administrator must be an educator here, informing nursing assistants (and nurses) that a call light or alarm is everyone's responsibility. This mistaken compartmentalization of duties must be addressed quickly. Although it is appropriate to have certain assignments, these assignments do not preclude their ability to intervene when another resident needs assistance. Ensuring that staff understand this often means the difference between satisfied residents who do not have skin issues and upset residents who do have skin issues due to lack of efficiency in answering call lights.

Monitoring infection control protocol is also important. Are the nursing assistants washing their hands appropriately and using gloves as needed? Are they transferring possible aerosolizing infectious agents in a proper manner, and are they disposing of and containing these elements in the proper area? Also, the administrator should monitor how they handle linen. Is it done in a proper manner that is consistent with infection control protocol? If the administrator observes a deficiency in any of these areas, he or she should educate staff and help address any overt issues.

The administrator must also monitor the appearance of the nursing assistants. Are their uniforms clean, and do they present themselves in a professional manner? Are they friendly and responsive to other workers, residents, and family members? The way they present themselves is important because it inspires confidence in families, residents, and other workers. In contrast, staff members who appear sloppy, stoic, unfriendly, and indecisive in their mannerisms will not inspire confidence in visitors to the facility, who are often families deciding whether to choose your facility for their loved ones.

Nurses' aides have come under considerable regulation in long-term care. Their need to be trained and certified has become an important part of nursing home reform legislation. The following regulations governing nurses' aides are from the *State Operations Manual*, "Appendix PP—Guidance to Surveyors for Long Term Care Facilities."

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483.35(d) (1) General rule

A facility must not use any individual working in the facility as a nurse's aide for more than four months, on a full-time basis, unless:

(i) That individual is competent to provide nursing and nursing-related services; and

(ii) (A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the state as meeting the requirement of 483.151-483.154 of this part; or

(ii) (B) That individual has been deemed or determined competent as provided in 483.150(a) and (b).

483.35(d) (2) Nonpermanent employees

A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.

CHAPTER

5

Management and Organizational Structure Within Healthcare

Groups and organizations are important structural components that pattern much of our everyday behavioral existence, not only outside of but also within healthcare facilities. We spend most of our lives in groups and organizations, yet we know very little about these two components of our society.

This chapter examines the importance of groups and organizations, especially as they apply to healthcare facilities. In addition to everything else the healthcare administrator does, he or she also has to understand the dynamics that exist within and among groups and organizations.

A "group" is something very specific, and only certain interactions between people qualify as group behavior. True groups share certain characteristics: They are composed of at least two individuals and have shared goal(s), interaction (communication and influence) among its members, normative expectations (norms and roles), and identification of its members within the unit. In addition, the group must be based on the interdependency of its members.

Frequently, certain associations are classified as groups when in reality they are social categories, social aggregates, or crowds. A social category is a collection of people who share some common trait or characteristic—and this trait or characteristic is all they have in common. For example, if a healthcare administrator were to speak of the "group" of nurses in his or her nursing facility, some of whom may not ever see or be in contact with each other, that reference would technically be incorrect because the nurses exist instead as a social category. In addition, if we were to state that all administrators who are members of the American Healthcare Association (AHA) are a group, this also would be false. Both categories (i.e., administrators and members of the AHA) share a common characteristic, yet it would be foolish to assume that they also share similar goals, feelings, and aspirations.

A social aggregate consists of people who are in the same place at the same time but who interact little if at all and have no sense of belonging together. Usually, people waiting at a bus stop are a social aggregate and not a group. Although these people may interact, individuals waiting for a bus are, for the most part, a disparate collection of individuals. One individual may be waiting for the bus to go to work, another may be waiting for the bus to go shopping, and a third may be traveling to meet an acquaintance. Likewise, several healthcare workers taking their break in the cafeteria could be viewed as a social aggregate: although they may share a common place as well as perhaps an interest in taking their break in the cafeteria, there may be little other interaction among the individuals.

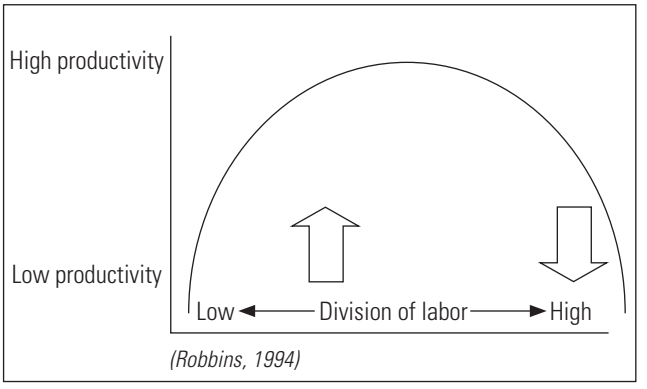
A crowd consists of a large number of people in reasonably close proximity to one another and who are reacting to a common stimulus but have little else in common. People at a rock concert are a crowd. Individuals at a sporting event would also be a crowd. Often during a medical emergency, a collection of people will gather to react to the stimulus but have little else in common—they are not a group but a crowd.

The Group

Three true social groups are known as primary, secondary, and reference groups. A primary group is a small social group in which relationships are both personal and enduring. Primary groups are intimate, in that individuals share thoughts and feelings with each other. Individuals in primary groups also engage in much more spontaneous forms of behavior because they are typically less restrained with each other. They share many activities and spend a great deal of time together. The ultimate primary group is the family.

In healthcare facilities, peer groups that form often lead to primary group relationships. For example, nurses who work a common unit—whether it is in pediatrics or orthopedics, within an Alzheimer's unit, or in another wing of a nursing facility—often develop bonds and friendships, which may lead to relationships that are more enduring and that even extend beyond the parameters of the work environment. This sometimes can augment the work experience or create problems, especially since the work setting is based on a secondary group structure. Nevertheless, members of primary groups view the group as an end in itself; people interact in these groups because of the pleasure the group brings them.

Figure 5.1 Economies and diseconomies of division of labor



General Systems Theory in Understanding Organizations

The general systems theory views organizations as analogous to the human organism, which relies on subsystems and the integration of these subsystems to stay alive. Hence, the general systems theory emphasizes holism, synergism, organicism, and gestalt (Hodge & Anthony, 1991; Kast & Rosenzweig, 1972). This means that the whole is not just the sum of the parts; the system itself can only be understood in its totality. It moves away from explaining the organizational unit using elementarism, which views the organizational whole as equal to the sum of its individual parts. Instead, the organizational system is an emergent reality that can transcend the reality of its individual parts (synergism). Some of the terminology of general systems theory is used in healthcare—"synergy," for example, is used quite frequently. Nevertheless, most healthcare administrators have a poor understanding of this theory.

The general systems theory views the system as being made up of interrelated subsystems or components, similar to the human body. Every system has at least two elements, which are interconnected and work in an interdependent fashion to maintain the system's integrity. These systems have boundaries that separate them from their environment—and just as the human body creates a boundary that separates it from its outside environment, so does the organization. However, some organizations can stretch their boundaries, whereas others have boundaries that are more circumscribed. For example, open systems have boundaries that are more permeable and that openly exchange information, energy, or material with their environments; biological systems and many forms of social systems are inherently open systems. Conversely, closed systems, such as many bureaucratically structured organizations,

objective, and develop a mission statement that is consistent with your goal. Bogardus (2004) states that, at this point, one of the best ways to formulate an effective strategy is to follow the **SMART** model. SMART stands for the following:

- **S**pecific. Goals created at this time should be specific so that the team understands them without equivocation.
- **M**easurable. The goals that one establishes, whether short or long range, must be measurable. This will prevent ambiguity and help clarify for workers whether they have achieved the goal.
- **A**ction oriented. Goals should be dynamic, not static, and they should specifically describe the actions that need to be taken.
- **R**ealistic. Here is a major problem: Many individuals do not achieve realistic and attainable goals. The goal must be attainable with the resources you have. If it is not, staff become discouraged through repeated failures.
- **T**ime based. Goals need to have a time frame for completion. Otherwise, people may loaf and continue to put them off.

The fourth stage is developing an implementation strategy. This works closely with stage three. After developing the steps and setting a realistic goal, implement your plan to work toward achieving your goal. Budgets and budgetary constraints play an important role here.

Finally, after you have put your plan into action, how has it worked? In the fifth stage, step back and realistically evaluate your progress. You may have to make adjustments. This does not mean that your plan was faulty—no one can anticipate all contingencies. What's important is that you look at the issues objectively and realistically and make the necessary changes. Nothing hurts a strategic plan more than hubris, where an individual feels that no adjustments need to be made and that the plan is perfect. That attitude will almost guarantee failure. Therefore, if adjustments need to be made, recognize them and make them when they are needed.

The marketing strategy in strategic management

Marketing is an important part of long-term care. This consumer-oriented process, which helps position one's facility in the marketplace, deals with planning as well as establishing and developing sound pricing and promotional practices. It needs to be part of every long-term care facility's strategic plan. Furthermore, because it is a consumer-driven practice, you

CHAPTER

6

Environmental Management and Building Operations

Housekeeping and maintenance issues are ongoing, and their importance is often underappreciated. However, proper preventive maintenance can help avoid larger future costs, and a good housekeeping staff helps create an environment that is attractive and accommodating to staff members, residents, and visitors. This chapter touches on some of the important issues involved in environmental management.

Preventive Maintenance

Preventive maintenance promotes the longevity of equipment and of the facility in general. It also helps to prevent injuries and associated costs. To achieve these goals, maintenance personnel should conduct weekly rounds, examining the building for issues. Furthermore, the administrator, as part of his or her daily rounds, must seek out maintenance and housekeeping issues that need to be addressed.

The administrator needs to select qualified maintenance personnel who can be trusted to carry out these important assignments. Too often, individuals are employed simply because they are handy, and although being handy is useful, the director of the maintenance department should have additional qualifications. They need to be highly skilled in electrical, plumbing, building issues, and the like. Furthermore, this person should understand the regulatory environment as it applies to nursing homes or healthcare organizations and should possess a sound working knowledge of *Life Safety Code® (LSC)*, Occupational Safety and Health Administration (OSHA), and nursing home regulations, especially as they apply to building and plant operations in healthcare facilities.

Table 6.1 Exposure times determined to cause burns at various temperatures

Water temperatures in degrees Fahrenheit	Time it takes to receive second-degree burns	Time it takes to receive third-degree burns
120	8 minutes	10 minutes
124	2 minutes	4 minutes
131	17 seconds	30 seconds
140	3 seconds	5 seconds
150	Less than 1 second	1 second

Source: www.michigan.gov/documents/mdch/bhs_alert_scalding_injuries_caused_by_excessive_hot_water__177655_7.pdf.

Heating units and appliance temperatures

Many facilities provide heating units in resident rooms and common areas. These units radiate heat, and their temperatures must be monitored and recorded to ensure that they do not get hot enough to burn a resident, family member, or staff member when touched. Generally speaking, when temperatures on these units exceed 120°F, they should be adjusted immediately to a lower and safer temperature.

Although the dietary staff should monitor food temperatures, the maintenance staff, too, must address food temperature issues by monitoring temperatures in refrigerators, freezers, and steam tables. To prevent food spoilage and possible food-borne diseases, proper refrigerator and freezer temperatures are essential. Refrigerator temperatures should be at or below 41°F, and freezer temperatures should be at or below 0°F. Administrators should examine the findings with the dietary supervisor and immediately address any concerns with the maintenance staff. Administrators should maintain a monthly record, submitted by the dietary supervisor, to make sure that temperatures comply with regulatory standards.

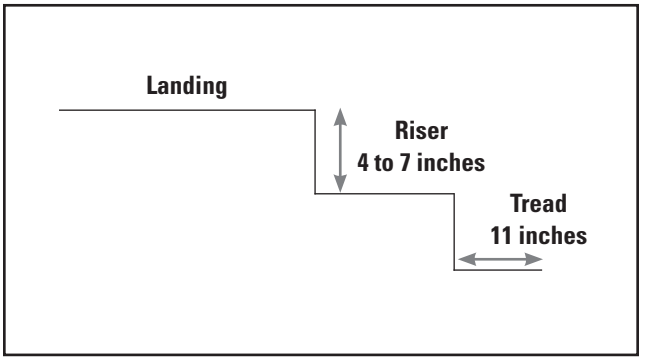
The temperature of food as it is served should be monitored monthly for compliance. The dietary supervisor should be taking temperatures of hot and cold food during each serving time and present the data to the administrator. Hot food should leave the kitchen above 140°F, and cold food should leave the kitchen at or below 41°F.

In addition, the administrator, along with the dietary supervisor, should regularly inspect the kitchen area and its equipment. Refrigerators and freezers that have difficulty maintaining proper temperatures, for whatever reason, may need to be replaced.

Stair landings

Figure 6.1 illustrates the riser and thread specifications.

Figure 6.1 Stair landing riser and thread specifications



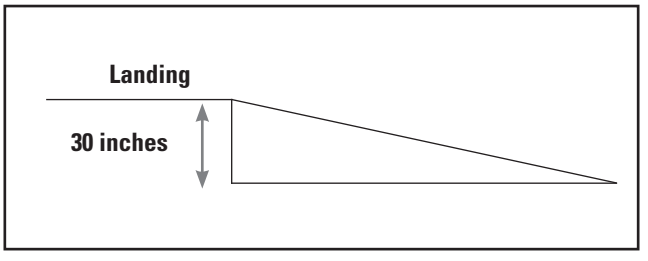
Ramps

Generally, the slope ratio of a ramp must not exceed 1:12, which means that for every one vertical unit, 12 horizontal units must exist. Put another way, for every 1-inch vertical rise, the horizontal run must be 12 inches. Furthermore, the ramp width must be at least 36 inches. A landing, similar to a staircase landing, is typically required for every increase in height of 30 inches. Handrails are required if the rise is greater than 6 inches, and the handrails should be at a height of between 34 and 38 inches.

Ramp landings

Figure 6.2 illustrates the slope of permitted landings.

Figure 6.2 Slope of permitted landings



CHAPTER

7

Human Resources: Managing Personnel

Healthcare administrators, especially long-term care administrators, are often involved in human resources (HR) management. Whereas hospital administrators can usually depend on a vice president of HR to advise and assist them, nursing home administrators and other long-term care professionals usually are themselves the directors of HR. Although they attempt to lighten the load by having someone else oversee this area, the administrator is often looked to for advice on HR issues. Therefore, they must become familiar with and understand HR. They are usually the chief negotiators for management and the chief designees for enforcing laws in this area, and they are ultimately responsible for HR and labor law compliance.

Because administrators spend so much time dealing with employees, their complaints, and issues related to staffing, employee compensation, and employee motivation, it's clear that this area of study is essential. Not only must they run a facility based on the care of the residents they serve, but they must also make sure that the available "human resources" can do so as effectively and efficiently as possible.

HR may actually be the largest area the administrator must address on a daily basis. Although finance, planning, and regulatory issues are also prominent, most administrators can attest that, on most days, they are faced with more HR issues than any other kind.

Given the other issues found in nursing homes, especially related to resident care, administrators often minimize the need for HR skills. However, as in any organization, personnel problems exist and will continue to exist. Long-term care administrators are intricately involved in recruitment, employee retention and turnover, wages, worker complaints or

the information. Kinesthetic learners do better when they can actually perform the task they are attempting to learn. While those are the three major types of learning, it doesn't mean that a person must fit into only one category. Individuals can fit into a combination of categories as well. Certain types of learning are better suited to particular tasks; for example, it's best to learn to give an injection through kinesthetic learning—by trying it yourself. That said, it's often most effective to engage all three modes of learning. It behooves the administrator to determine what type of learning strategy will produce the best results.

It may be necessary to teach, introduce, or have the staff learn something new to improve the care rendered within the long-term care environment. When new learning occurs, the term "learning curve" is often mentioned. This is nothing more than a visual depiction of learning over a period of time, and it demonstrates how learning has taken place, at what rate learning has taken place, and whether learning is continuing to take place. Four major types of learning curves exist: the positive accelerating learning curve, the negative accelerating learning curve, the S-shaped learning curve, and the plateau learning curve (Bogardus, 2004).

The positive accelerating learning curve is characterized by a slow start, followed by a continued increase in learning as the learner masters increasingly difficult elements of the task.

Figure 7.2 Positive accelerating learning curve

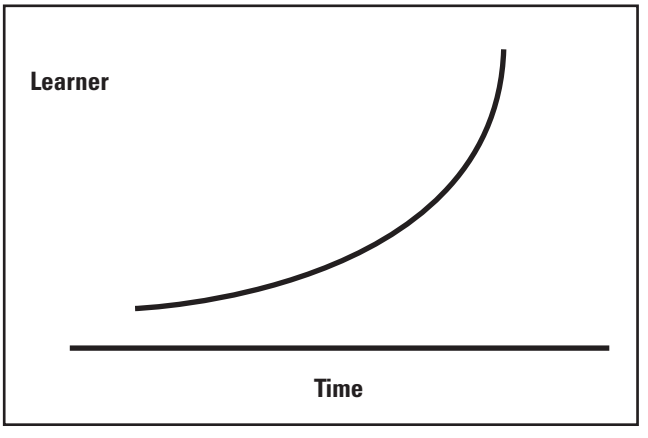
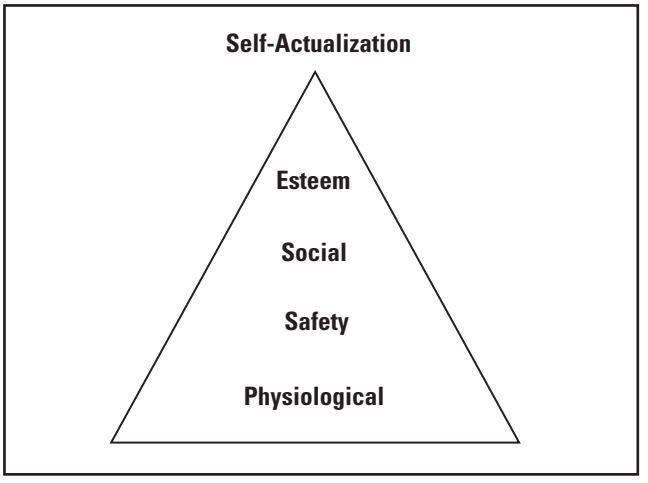


Figure 7.6 Maslow's hierarchy of needs



At the base are physiological needs that must be satisfied first, such as obtaining food, water, and shelter. Next are the safety needs, such as security and protection from harm. This model predicts that, in a work context, wages and benefits will be discussed first because they satisfy physiological and safety needs. Maslow views these needs as deficiency or D-needs, which need to be satisfied before any other needs can be examined.

Social needs are found next in this pyramid. The workplace can often help to satisfy these needs. Although healthcare organizations have formal groups that structure work activity, however, spontaneous informal groups form as well, providing friendships, affiliations, and affection—these connections also help to humanize the workplace. Healthcare administrators must be aware of the importance of these needs, and although they need to ensure that work is getting done in the formal network, they also should avoid thwarting informal groups, which satisfy important needs for individuals as well as for the facility by providing a work environment that is less alienating.

The higher-level needs, such as esteem and, potentially, self-actualization, are referred to as being or B-needs. They help the individual grow, not just as an employee but also as a person. Esteem needs provide recognition and respect that the employee seeks to achieve through his or her work and status in the organization. Self-actualization, which is a state that few employees attain, occurs when the employee feels a sense of completeness, achieving his or her potential to the highest level through work. As mentioned previously, although there has not been a great deal of empirical support for this motivation theory, it continues to be popular.

CHAPTER

9

The Regulatory Environment

Nursing home administrators must understand the regulatory environment. All nursing facilities in the United States, especially those receiving Medicare and Medicaid reimbursement, face inspections at least annually. Administrators may also regularly encounter recertification inspections for specific insurance groups, as well as labor audits and Occupational Safety and Health Administration (OSHA) inspections. This chapter will pay particular attention to the annual nursing home survey required of those working in collaboration with the Centers for Medicare & Medicaid Services (CMS).

Understanding Nursing Home Citations

Nursing home citations have been established by the federal government and the *Code of Federal Regulations (CFR)*. These citations, or F-tags, are identified by an alphanumeric code that starts with the letter F, followed by a number that specifies the type of violation. For example, being cited with F569 means that the surveyors found a problem with the conveyance of residents' funds. F745 means that surveyors identified problems with the facility's social services department. Administrators need to have a manual handy that explains all of the F-tags.

In addition to federal citations, nursing homes may be subject to state citations. These citations can come into play when there is no F-tag to cover a particular area or when a similar federal and state tag can be cited simultaneously. Although two such simultaneous citations may seem superfluous, it does happen.

- Physical Restraints Critical Element Pathway
- Pressure Ulcer/Injury Critical Element Pathway
- Specialized Rehabilitative or Restorative Services Critical Element Pathway
- Respiratory Care Critical Element Pathway
- Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway
- Medication Storage and Labeling
- Preadmission Screening and Resident Review Critical Element Pathway
- Extended Survey
- Hydration Critical Element Pathway
- Tube Feeding Status Critical Element Pathway
- Positioning, Mobility, and Range of Motion (ROM) Critical Element Pathway
- Hospitalization Critical Element Pathway
- Bladder or Bowel Incontinence Critical Element Pathway
- Accidents Critical Element Pathway
- Neglect Critical Element Pathway
- Resident Assessment Critical Element Pathway
- Discharge Critical Element Pathway
- Dementia Care Critical Element Pathway

The Difference Between State and Federal Surveys

In reality, there is no major difference between state and federal surveys. Both are required, as outlined under the federal regulations promulgated by CMS, but they use the same forms and follow the same guidelines for monitoring participation requirement. Federal surveys are conducted by regional CMS offices (note that CMS mandates that a random sample of 5% of nursing homes be surveyed annually by CMS' federal regulatory group), but most surveys in the United States are conducted by state regulatory departments.

States often have their own health codes and can issue citations for noncompliance with state regulatory requirements. Upon receipt of the Statement of Deficiencies form (the CMS-2567

CHAPTER

10 Consolidated Billing, the Prospective Payment System, and the MDS and PDPM

The Balanced Budget Act of 1997 (BBA), which was officially instituted in 1998, and the Balanced Budget Refinement Act of 1999 ushered in a new era of billing for long-term care facilities. Services under Medicare Part A became part of a "bundled" case-mix prospective payment system (PPS), and payment was based on a prospective payment for the category in which the resident was placed. The practices of retrospective billing and "unbundling" so that others could bill for services rendered to nursing home residents were no longer permitted. Now the skilled nursing facility (SNF) had to bill for a resident's care under Part A.

This change eliminated the problem of duplicate billing, which was common when services were unbundled and being billed for by other vendors. It centralized services and placed billing accountability in the hands of one unit—the SNF—which would be responsible for submitting financial information to the fiscal intermediary. However, the consolidated billing process is far from easy to understand and work with. Although most facilities have professional billing personnel to handle these matters, it's still helpful for administrators to understand the basic features of the system.

Consolidated Billing

The consolidated billing process is driven by the Minimum Data Set (MDS), but as of October 1, 2010, a new version of the resident assessment instrument—MDS 3.0—replaced MDS 2.0. In the new version, the number of resource utilization group (RUG) categories that the SNF bills for has expanded from 53 case-mix categories to 66. Furthermore, the MDS data are no longer transmitted to the individual states but rather to a national repository (*Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual*, 2015).

CHAPTER

11

Finance and Budgeting

Nursing home administrators do not have to be accountants or financial experts, but they do need to have some basic knowledge of accounting and finance. They should understand financial statements and be able to ask informed questions of other experts, such as the accountant(s) who compiles the nursing facility's financial reports. Even though the administrator may not be an accountant by training, he or she holds the position of chief financial officer for the facility, so he or she must understand financial principles well enough to make informed decisions.

Most facilities engage accountants either by employing them within a larger corporate structure or contracting with them to perform accounting and financial analysis. Doing so relieves the administrator of the responsibility for compiling accounting and financial reports; this job is time-consuming and must be completed by a professional who maintains strict compliance with the Generally Accepted Accounting Principles (GAAP), the standard framework of guidelines for financial accounting (more on this later). Additionally, due to the myriad new tax laws generated each year, specific forms that need to be used, and the complexity of cost accounting, especially as it relates to Medicare and Medicaid rules, an accountant who specializes in long-term care financial information is an important asset. The administrator has enough to handle—like maintaining compliance with specific state and federal regulations, handling staff issues, addressing project development and plant operation issues, setting specific budgets, and developing marketing plans—without also having to worry about creating accounting and financial reports.

This is not to say that administrators are totally hands-off in this area; in fact, the administrator usually handles the internal accounting, which can include establishing budgets; calculating monthly Medicare revenue; completing trust fund auditing, interest allocation,

To understand retained earnings, let's look at a simple example. John Doe owns the XYZ Nursing Home. His retained earnings were $150,000 on January 1, 2015. Given an owner's equity of $285,000, including capital stock with possible dividends, we will construct a statement of retained earnings for the XYZ Nursing Home. Also, instead of the balance sheet reflecting April 30, we'll change the fictional date to reflect December 31. The statement of retained earnings would look something like this:

Statement of Retained Earnings for XYZ Nursing Care Facility for Year Ending December 2015

John Doe, Capital Balance from Preceding Year:	$150,000
Add Net Income for 2015:	$85,000
Total Retained Earnings:	$235,000
Minus Paid Dividends:	($10,000)
Total Retained Earnings for 2016:	$225,000

Moving back to the balance sheet for a minute, James Gill, author of *Financial Analysis—The Next Step*, distinguishes between a safe corporation and a risk corporation. In his book, he states that a safe corporation demonstrates "a low return, a large equity base, and slow growth with little debt and short-term assets." Conversely, he states that a risk corporation demonstrates "a high yield, high long-term assets, outside funds supporting over half of the business, a small equity base, fast growth, and large earnings fluctuations."

Let's examine what this means. A risk corporation demonstrates some important features, the following of which are the most glaring:

1. High long-term assets. You might think this is good, but numerous long-term assets can equal reduced liquidity, leading to a reduced amount that one can allocate to pay off one's current bills.
2. A large amount of outside funds supporting the business. This means the business is highly leveraged and that many outside individuals, due to unpaid bills, have a legal claim on it.
3. Small equity base. This leads to less equity available to place into the business, and it does not make owners happy when their net worth in the company is reduced.

Conversely, a safe company has more current assets and therefore greater liquidity. Debt is reduced, especially long-term debt, which allows more funds to be allocated to deal with

Therefore, your short-term obligations will suffer if the resources owed to you are not available for deployment. Try to keep your average close to 30 days, and limit any increasing deviations from that benchmark 30-day period. To do so, you must closely and frequently inspect the accounts aging document.

A second important efficiency indicator is the accounts payable average payment period ratio. Just as your facility expects efficient and prompt remittance of accounts receivable, your creditors expect prompt, timely remittance of payment that is due to them. Here is how to figure out the accounts payable average payment period ratio:

$$\textbf{Accounts payable average payment period ratio} = \frac{\text{Accounts payable}}{\text{Supplies expense}} \times 365$$

Most accounts come with terms, which are usually 30 days from the day of receipt. Waiting too long to pay your suppliers can cause a number of problems:

1. It places you on poor terms with your creditors, who may cancel your contracts or remove you from their credit terms and place you on cash-on-delivery status
2. Your credit standing is impacted dramatically, which can affect your business when you try to enter into future contracts
3. You may compound your debt, not only on each account for its respective supplier but also in aggregate

As we already examined with capitalization ratios, adding too much debt may create a cycle in which you fail to meet your short-term *and* your long-term obligations.

Therefore, try to keep your payables average to 30–45 days. Doing so inspires confidence in your current creditors as well as any future ones, and it prevents you from getting into the "catch-up" cycle, in which you're always trying to catch up with payments. If you have already entered this catch-up cycle, you probably will continue to be plagued with trying to catch up on your payments.

To help avoid this challenge, when entering into a new contract, do not be afraid to negotiate terms. Especially if you feel that certain terms are too stringent, try to negotiate so that they are more compatible with your needs and support the solvency of your facility.

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