The Comprehensive Guide to Nursing Home Administration,

Second Edition

Brian Garavaglia, PhD, FACHCA

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How to Access the Quiz Questions

Nursing home administrators have a multitude of responsibilities in running a compliant and efficient facility. ***The Comprehensive Guide to Nursing Home Administration, Second Edition***, is a complete desk reference that encompasses the knowledge and guidance administrators need.

This updated edition provides insight into resident care regulations, facility reimbursement, and the clinical and rehabilitative elements of skilled nursing services. Author Brian Garavaglia, PhD, FACHCA, details the roles and responsibilities of nursing home administrators, and professionals both new and seasoned can test their knowledge with the accompanying quizzes.

Plus, this book can be used as a study guide to prepare for the National Association of Long Term Care Administrator Boards (NAB) Nursing Home Administrator (NHA) exam. The accompanying e-book contains over 1,200 practice questions, plus an answer key. The questions are separated by chapter to allow readers to test their knowledge on each section of the book. In addition, a final test is available that is approved by the NAB for 16.75 CEUs.

This educational offering has been reviewed by the National Continuing Education Review Service (NCERS) of the National Association of Long Term Care Administrator Boards (NAB) and approved for 16.75 clock hours and 16.75 participant hours.

To access the quiz questions, go to the downloads section for this title at *www.hcpro.com/downloads/12564*.

About the Author

Brian Garavaglia, PhD, FACHCA

Brian Garavaglia, PhD, FACHCA, is a healthcare administrator and college instructor. He has worked in healthcare for more than 27 years within the acute, subacute, and long-term care settings and has been actively involved in healthcare as an administrator, program director, consultant, and clinician. Affiliated with colleges and universities in the Detroit area as well as in Arizona, Dr. Garavaglia has also been active in education. He has presented numerous professional workshops on various topics including aging and management, and he has also served as a lecturer within graduate medical education for family care and internal medicine residents, providing education on the issues of dementia, cognitive changes as part of the aging process, and other mental health issues related to older adults. Dr. Garavaglia holds the distinction of being a Fellow in the American College of Health Care Administrators. He is the author of more than 100 articles and editorials and has published two previous books pertaining to healthcare management. His primary areas of interest are gerontology, especially gerontological concerns within long-term care organizations, and social neuroscience, as well as social and organizational psychology, specifically group behavior and decision-making in healthcare/business organizations.

Introduction

Healthcare administration is a very difficult profession. It has become especially complex due to the changes within the social and political landscape of our country that have come to shape our legislation and regulatory requirements within the healthcare industry, and long-term care is no exception. Nevertheless, these are changes that we need to embrace. Many of these massive changes have advanced the healthcare industry in general and the long-term care industry in particular. However, not all changes have been positive, and it is an industry that continues to struggle. With approximately 18% of our gross domestic product devoted to healthcare alone, you can see why healthcare is such an important part of our social, economic, and political agenda. Furthermore, given the expense of healthcare, it is evident that there are concerns for addressing costs in all areas of the healthcare industry, especially in a nation that invests more capital in healthcare than any other country.

Healthcare administrators must deal with many issues. Often, the choices they make are difficult and not always popular. Many decisions are predicated on the social, economic, and political situations that they are part of and that impact their position within healthcare administration. In this book, I attempt to present many of the important elements that are needed as part of the healthcare administrator's working knowledge—in particular, nursing home administration. As will be seen, this is no easy task, because the duties of nursing home administrators are extensive and cover an expansive area of knowledge.

There was once a time when the nursing home administrator was looked at as the "head of the home" for the old and infirm. They were viewed as individuals who were nothing more than custodial guardians, and those in this position really needed very little skill, especially if you were to compare them to their counterparts within the area of hospital administration. To this day, I am still not an admirer of the term "nursing home administrator," as connotations of subordinate levels of knowledge still exist. In reality, this is not the case, and the education and healthcare experience among administrators in all areas of healthcare, whether it is a hospital, nursing home, or hospice and home care, have become more convergent than divergent. Overall, they share many more similarities in core knowledge and managerial science than differences.

An example of this is Alan Mulally, who is currently Ford Motor Company's president and CEO. Trained as an aeronautical engineer, Mulally spent a long tenure at Boeing. Most would not question his credentials as an airline executive. However, when he was appointed at Ford Motor Company to the position of president and CEO in 2006, many could not quite understand why a major automobile company would hire someone with no experience

in the industry to lead the company. Quite frankly, they could not fathom that there would be a transferability of knowledge and managerial skills from the airline industry to the automobile industry. However, as I write this introduction, Mulally continues to demonstrate strong leadership and managerial ability, even in an industry in which he has spent only a few years of his total management career. In addition, in 2011, *Chief Executive Magazine* named him CEO of the year. This does not mean that he has not had to face many struggles. In our current economy, many businesses continue to face daunting challenges, and Ford Motor Company is no exception to this rule. However, Mulally's achievements demonstrate how knowledgeable individuals, with a sound understanding of important management principles and leadership skills, can continue to succeed regardless of the entity they are overseeing. It is not the type of organization that creates the quality administrative professional; it is the administrative professional, with skills and leadership potential, who ultimately makes the difference. Therefore, even in healthcare, managerial and leadership skills transcend specialty.

It is my hope that this book will provide an important tool for nursing home administrators. As you will see, it provides a considerable level of knowledge for those traversing the area of healthcare administration. It is by no means a total statement in this area. Yet, as you read, you will hopefully learn a considerable amount of information that will enhance your administrative skills. The breadth of information included is great, providing biological, psychological, and social knowledge of the aging process. This book also includes basic medical terminology, anatomy, pharmacology, and common diseases that administrators often encounter. Also addressed are core management principles; principles of group, team, and organizational development; as well as an important theoretical base that needs to be part of the working knowledge of any management professional. The book includes information pertaining to the important personnel found within the nursing home environment and the myriad regulatory requirements that need to be understood. It looks at various clinical and bottom-line topics, such as infection control, finance, budgeting, and billing, especially in relation to the Minimum Data Set process. Finally, it examines human resources, regulatory requirements in this area, worker health and preventive maintenance, and human factor engineering in the nursing home setting.

It is my hope that this book not only serves as a resource for those who wish to become administrative professionals but also helps to advance the skills of those who are already in the field. My goal is to share information and insight that furthers the knowledge and careers of nursing home administrators, thus simultaneously benefiting the patients they serve.

Best wishes to all,

Dr. Garavaglia

1 Nursing Home Administration

Nursing home administration is now a very complicated specialization in healthcare. The days of being the keeper of the "home" are long gone. The long-term care industry is a progressive environment, and the nursing home administrator has to constantly keep his or her fingers on the pulse of this industry, which is continually changing and developing. Long-term care is not a static industry of warehousing people, as was often the case in the past. Moreover, it is moving out of the shadow of being the stepchild of the healthcare industry and into the limelight.

Because of increasing complexity in long-term care, nursing home administration is a multifaceted field of study that is every bit as challenging as administration in the acute care sector. Furthermore, long-term care administrators are much more visible to the workers they manage and to the residents they oversee than is the hospital administrator, adding even more complexity to the job. 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 definitive director of plant operations, the preeminent person for marketing, and ultimately the one responsible for all medical services the facility renders. Think of that level of responsibility. In what other industry does a person encounter such responsibility?

Nursing home administration is not a profession for the fainthearted. It is a demanding field that requires a tremendous amount of time and energy. It is often difficult for many to understand the responsibility that exists for the nursing home administrator. 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. It is a profession that you must enter because you are dedicated to servicing those who live in the long-term care environment.

This book aims to provide the nursing home administrator with many important skills that he or she needs to succeed in long-term care administration. Of course, no book can replace the actual hands-on experience you will receive on the job. But it helps to understand what the job entails before you enter the field.

Toward 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 you with an important gerontological understanding of older adults. It also examines other areas, such as basic medical terminology, principles, 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 how the regulatory environment works in long-term care.

In reality, this is a daunting task. No one can understand the industry overnight. Furthermore, because the industry is constantly evolving, continuous education and keeping abreast with the changes in the industry are important. There are so many things to understand that no single book can do justice to the industry in its entirety. However, this book will provide both a basic and a more advanced understanding of many areas. It is meant to help those who are new to the industry, as well as to be a reference guide for those who are already in the industry. Rather than being a definitive statement on the subject, it complements other books and materials covering this area and 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 a more progressive environment as well, no longer admitting only elderly individuals but also younger members, especially for short-term rehabilitation needs. Furthermore, the growth of assisted living facilities has affected the nursing home industry and influenced the occupancy rate of nursing homes. The following subsections discuss the current status of the nursing home industry in more detail.

Types of nursing homes

There are three major types of nursing homes: for-profit nursing facilities, nonprofit nursing care facilities, and government-owned nursing care centers. As you can see in the list that follows, there are more for-profit nursing care facilities in the United States than there are nonprofit and government-owned facilities. Regulatory requirements do not differ for any of these types of nursing care centers. The major difference concerns the tax laws that pertain to the different nursing homes.

That being said, you should be careful when using these terms. Many people think that for-profit facilities make incredibly large profits when compared to nonprofit facilities. Although the profit margins are greater for the for-profit facilities, the margins are usually not large, with many for-profits running close to breakeven; a common margin is approximately 2%–3%.

The following details the different types of ownership for nursing homes in the United States as of 2014:

	As of 2014
For-profit	68.9%
Nonprofit	24.1%
Government-owned	6.2%
Source: The Kaiser Family Foundation, statehealthfacts.org.	

Payer source

Overwhelmingly, Medicaid provides the most reimbursement for nursing home care. Medicaid usually relies on 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 a lower level of payment. Furthermore, private plans and private pay also account for a fairly low level of payment for long-term care stays.

The following was the distribution for nursing home payment in the United States as of 2014:

	As of 2014
Medicaid	62.5%
Medicare	14.2%
Private/other	23.3%
Source: The Kaiser Family Foundation, statehealthfacts.org.	

Common citations

The most commonly cited nursing home deficiency for inspections during 2014 was for infection control. Infection control has overtaken accident/environment, which was previously the most commonly cited deficiency and has currently dropped to number two. Food sanitation, quality of care, and unnecessary drugs round out the top five nursing home deficiencies as of 2014.

The following are the top 10 nursing home citations in the United States in 2014:

Infection control	42.5%
Accident/environment	39.7%
Food sanitation	38.9%
Quality of care	33%
Unnecessary drugs	25.6%
Pharmacy consultation	23.9%
Comprehensive care plans	23.5%
Clinical records	19.7%
Dignity	19.4%
Qualified personnel	17.7%
Source: The Kaiser Family Foundation, statehealthfacts.org.	

Average number of citations

In 2014, nursing homes in the United States received an average of 8 citations. This has actually gone down by 2 citations on average since 2009. However, the numbers of citations among the states, including the District of Columbia, vary considerably. For instance, Washington, DC, has the highest level of average nursing home citations for 2014, with 19.3 citations on average. However, the District of Columbia has only 19 nursing care facilities. Conversely, Rhode Island, with 82 nursing homes, had the lowest average number of citations, averaging 2.3 citations among nursing homes in 2014. Therefore, there was a range of 17.1 from the highest to the lowest scores. Moreover, when examining the data below, the large drop in citations from 2009 to 2014 was marked by 42 states, including the District of Columbia, witnessing decreases in the average nursing home citations rate.

The following are the average number of nursing home citations in 2014 as well as the average change from 2009:

	Average in 2014	Change from 2009
United States	8	-2.5
Alabama	5.6	-0.6
Alaska	16.3	+8.8
Arizona	6.8	-11
Arkansas	7.8	-4.4
California	12.1	-0.5
Colorado	16.4	+6.0
Connecticut	10.3	-1.0
Delaware	13.4	-3.5
District of Columbia	19.3	-2.7
Florida	6.6	-4.1
Georgia	3.4	-3.8
Hawaii	7.0	-3.7
Idaho	11.9	-1.5
Illinois	8.8	-0.5
Indiana	8.9	-3.9
Iowa	5.5	-3.5
Kansas	10.8	-4.4
Kentucky	6.1	-1.5
Louisiana	6.3	-5.8
Maine	4.8	-4.6
Maryland	12.4	-3.4
Massachusetts	4.4	-1.6

	Average in 2014	Change from 2009
Michigan	9.7	-3.3
Minnesota	8.1	-3.5
Mississippi	5.3	-2.9
Missouri	7.7	-4.3
Montana	10.5	+0.6
Nebraska	6.8	-0.6
Nevada	13.9	+0.4
New Hampshire	3.5	-2.9
New Jersey	5.4	-3.1
New Mexico	7.4	+1.3
New York	6.6	-1.0
North Carolina	4.1	-1.6
North Dakota	8.6	+1.1
Ohio	5.0	-3.5
Oklahoma	13.9	-0.4
Oregon	5.8	-1.4
Pennsylvania	7.2	-0.4
Rhode Island	2.3	-2.0
South Carolina	6.0	-2.3
South Dakota	7.4	+1.4
Tennessee	6.3	+0.2
Texas	9.0	-0.2
Utah	9.4	+2.3
Vermont	9.0	-1.3
Virginia	10.0	-1.4
Washington	10.5	-2.1
West Virginia	11.2	-0.7
Wisconsin	8.6	-0.9
Wyoming	12.7	+1.6
Source: The Kaiser Family Foundation, statehealthfacts.org.		

The five-year period between 2009 and 2014 witnessed a considerable average decline in the number of overall nursing home citations in the United States. However, given the decrease in citations on a numerical level, the severity of citations has also decreased during this period of time.

When this question is examined over recent years, the following becomes apparent: In 2003, approximately 24.8% of facilities received one or more citations at the severe deficiency level. That figure dropped to 23.8% in 2004. By 2007, the number of facilities that received at least one severe deficiency citation rose again to 27.7%.

As of 2009, 24.7% of facilities received at least one severe citation. Moreover, as of 2014, consistent with the overall decrease in the number of citations over the same five-year period of 2009 to 2014 examined above, there was a 4.2% decline in the number of severe deficiencies. Therefore, since 2006, when severe deficiencies reached their peak, a healthy decline has continued to occur.

Year	% of facilities receiving a severe deficiency
2003	24.8%
2004	23.8%
2005	26.0%
2006	27.7%
2007	26.6%
2008	25.7%
2009	24.7%
2014	20.5%
Source: The Kaiser Family Foundation, statehealthfacts.org.	

Number of nursing homes in the United States

As of 2014 there were 15,401 nursing homes in the United States. Since 2009, this is a reduction of 257 nursing homes. California and Texas, the two most populated states, also rank one and two in the number of nursing homes, with California having 1,178 nursing homes and Texas with 1,211 nursing homes. Texas has actually gained in the number of nursing homes since 2009, having the largest number of nursing homes of any state. Generally speaking, the larger the state, the more nursing care facilities it has. Also, many of these states have a considerably large number of older adults, at least at nominal levels, which creates a need for long-term care.

When we further look at the data, what becomes evident is that even during periods of cost containment and cutbacks in reimbursement to many nursing care centers, the industry growth rate has slowed, and in fact, since 2009, as mentioned above, there has been a net reduction in the number of nursing homes in the United States. Of the 50 states and the District of Columbia, 28 states witnessed declines in the number of nursing homes found in their state between 2009 and 2014. Georgia was the state that witnessed the greatest reduction in nursing homes, with a loss of 67 nursing care facilities over this five-year period.

The following are the numbers of nursing homes in the United States in 2014 and the change nationally and in each state since 2009:

	As of 2014	Net change from 2009
United States	15,401	-257
Alabama	226	-4
Alaska	18	+3
Arizona	138	+4
Arkansas	228	-3
California	1178	-48
Colorado	214	+2
Connecticut	229	-12
Delaware	46	-2
District of Columbia	19	--
Florida	687	+14
Georgia	288	-67
Hawaii	26	-22
Idaho	78	-1
Illinois	761	-28
Indiana	528	+33
Iowa	442	-3
Kansas	339	+2
Kentucky	287	+5
Louisiana	280	-6
Maine	103	-4
Maryland	228	-2
Massachusetts	414	-17
Michigan	434	+6
Minnesota	377	-10
Mississippi	204	+1
Missouri	512	-3
Montana	83	-4
Nebraska	218	-8
Nevada	53	+3
New Hampshire	76	-4
New Jersey	364	+6
New Mexico	72	+1
New York	628	-8
North Carolina	410	-17

	As of 2014	Net change from 2009
North Dakota	80	-4
Ohio	933	-29
Oklahoma	308	-14
Oregon	132	-5
Pennsylvania	697	-18
Rhode Island	84	+2
South Carolina	168	-11
South Dakota	111	+1
Tennessee	306	-8
Texas	1211	+37
Utah	97	--
Vermont	37	--
Virginia	287	+6
Washington	220	-14
West Virginia	117	-10
Wisconsin	387	+4
Wyoming	38	--
Source: The Kaiser Family Foundation, statehealthfacts.org.		

Nursing home occupancy rates

Nursing homes throughout the United States had an average occupancy rate of 82.3% in 2014, which is a 1.4% decrease since 2009 and a 2.5% decrease since 2007. Nursing home occupancy rates have been trending downward on a national level, and this has continued for well over a decade. One of the major reasons is that many other potential alternatives, especially in the assisted living industry, are available for elderly patients who would have once entered nursing homes. Also, considerable variance exists among the average occupancy rates in different states, going from a high of 92.6% in North Dakota to a low of 60.0% in Oregon.

Out of the 50 states and the District of Columbia, only 11 states have occupancy increases from 2009 to 2014, and most were quite miniscule, in the tenths of a percent. Delaware experienced the largest, with a 3.7% increase, but they also have one of the smallest during home populations with only 46 facilities in their state. Of the states that had reductions in occupancy rates, five demonstrated marked reductions from 2009 to 2014, led by Vermont at 5.1%, Wisconsin at 4.9%, Hawaii at 4.3%, Indiana at 4.2%, and South Carolina at 4.1%.

Nursing home occupancy rates in the United States in 2014		Change from 2009
United States	82.3%	-1.4%
Alabama	86.2%	-0.6%
Alaska	89.8%	+2.5%
Arizona	70.2%	-6.5%
Arkansas	72.1%	-0.7%
California	86.1%	+1.3%
Colorado	86.1%	-1.6%
Connecticut	87.5%	-2.8%
Delaware	88.3%	+3.7%
District of Columbia	91.2%	-1.6%
Florida	88.4%	+0.6%
Georgia	85.6%	-2.0%
Hawaii	88.7%	-4.3%
Idaho	68.6%	-3.2%
Illinois	77.3%	-1.3%
Indiana	76.6%	-4.2%
Iowa	79.7%	-0.6%
Kansas	80.7%	-2.5%
Kentucky	87.3%	-2.7%
Louisiana	75.0%	+3.6%
Maine	90.0%	-1.7%
Maryland	88.1%	+0.8%
Massachusetts	86.8%	-2.3%
Michigan	85.2%	-0.2%
Minnesota	89.9%	-1.4%
Mississippi	87.4%	-1.9%
Missouri	72.7%	+0.3%
Montana	67.8%	-3.3%
Nebraska	76.3%	-3.1%
Nevada	79.2%	-3.5%
New Hampshire	90.0%	+0.5%
New Jersey	86.3%	-3.5%
New Mexico	78.6%	-3.0%
New York	90.1%	-2.3%
North Carolina	83.7%	-1.9%
North Dakota	92.6%	+2.9%
Ohio	84.4%	-1.5%

Nursing home occupancy rates in the United States in 2014		Change from 2009
Oklahoma	66.5%	-0.3%
Oregon	60.0%	-2.4%
Pennsylvania	90.5%	-0.3%
Rhode Island	92.0%	+0.7%
South Carolina	87.2%	-4.1%
South Dakota	91.7%	-0.2%
Tennessee	78.8%	-7.5%
Texas	70.5%	-0.9%
Utah	66.1%	+1.3%
Vermont	84.8%	-5.1%
Virginia	88.4%	-0.4%
Washington	80.9%	-2.2%
West Virginia	86.8%	-1.9%
Wisconsin	80.9%	-4.9%
Wyoming	79.3%	-0.6%
Source: The Kaiser Family Foundation, statehealthfacts.org.		

Nursing hours per resident

The bulleted list below details the number of nursing hours per resident within nursing care facilities. Overall, as of 2014, a nursing home resident in the United States receives an average of approximately 1.6 hours of licensed nursing care, either from a licensed practical nurse and/or licensed vocational nurse or from an RN. This is a slight increase of 0.1 hours since 2009. When other nursing staff members are examined—in particular, certified nurse assistants—and they are included with licensed nurses, each resident receives an average of approximately 4.0 hours of nursing care nationally as of 2014. Again, this was a slight increase of 0.1 hours since 2009. When you examine total nursing staff hours by state, including the District of Columbia, 30 states place above the national average, 11 states fall below the average, and another 10 are at the average.

Overall, the trend over a five-year period from 2009 to 2014 was a very slight increase in both licensed nurse hours and total nursing staff hours. However, the increase may not necessarily be due to an increase in staff, but a decreasing overall occupancy rate nationally. The greatest deviation above the national average was found in Alaska, with total nursing staff hours being at 5.4 nursing hours per resident. The lowest deviation below the average was shared by two states: New Mexico and South Dakota. In both of these states, the total number of nursing hours per resident was 3.6.

Average number of nursing hours per resident day in all certified nursing home facilities in 2014 were as follows:

	Licensed nurse hours	Total nursing staff hours
United States	1.6	4.0
Alabama	1.7	4.1
Alaska	2.2	5.4
Arizona	1.9	4.4
Arkansas	1.5	4.2
California	1.8	4.2
Colorado	1.8	4.2
Connecticut	1.6	4.1
Delaware	1.8	4.3
District of Columbia	2.1	4.9
Florida	1.7	4.4
Georgia	1.5	3.7
Hawaii	1.6	4.2
Idaho	2.0	4.6
Illinois	1.5	3.7
Indiana	1.9	4.1
Iowa	1.4	3.7
Kansas	1.4	4.1
Kentucky	1.7	4.2
Louisiana	1.5	3.7
Maine	1.5	4.5
Maryland	1.7	4.1
Massachusetts	1.7	4.1
Michigan	1.6	4.2
Minnesota	1.6	4.0
Mississippi	1.7	4.1
Missouri	1.3	3.8
Montana	1.5	4.0
Nebraska	1.5	4.0
Nevada	1.8	4.1
New Hampshire	1.6	4.1
New Jersey	1.7	4.1
New Mexico	1.3	3.6
New York	1.6	3.9

	Licensed nurse hours	Total nursing staff hours
North Carolina	1.6	4.0
North Dakota	1.5	4.4
Ohio	1.7	4.0
Oklahoma	1.3	3.8
Oregon	1.5	4.7
Pennsylvania	1.8	4.0
Rhode Island	1.3	3.9
South Carolina	1.9	4.3
South Dakota	1.2	3.6
Tennessee	1.7	4.0
Texas	1.5	3.8
Utah	1.7	4.3
Vermont	1.7	4.3
Virginia	1.7	4.0
Washington	1.7	4.3
West Virginia	1.7	4.0
Wisconsin	1.5	4.1
Wyoming	1.5	3.9
Source: The Kaiser Family Foundation, statehealthfacts.org.		

Nursing home demographics

The landscape of nursing homes in the United States has changed dramatically. Nursing homes are no longer the only facilities that can assist with the needs of the elderly. With the growth of assisted living and adult family homes, the rates of nursing home admissions have also changed. Furthermore, with an increasingly larger population of younger adults now entering nursing homes—many who are in their middle adult years—the demographic composition has changed dramatically. With the increasingly large array of options that older adults have available to them, nursing homes have decreased in number from approximately 19,100 in 1985 to 15,401 in 2014. However, at the same time, the total number of beds and the average number of beds have increased. This appears to reflect the decline of many small nursing homes and the fact that many larger companies have co-opted many of these smaller facilities, which often are owned by a single or small group of owners (Hooyman and Kiyak, 2008).

A common misconception often centered on aging is related to the number of older adults who actually live in nursing homes. In reality, the actual segment of the elderly population in nursing homes at any one time is currently only 4% (Hooyman and Kiyak, 2011). In fact, there has been a decrease in the number of older adults in nursing homes, which was at 5.4% in 1985 (Hooyman and Kiyak, 2011). This reduction reflects many of the

new options that older adults have as alternatives to nursing home care, especially the rise of assisted living facilities. Nevertheless, the lifetime risk of entering a nursing home increases with age. Regarding the age of the nursing home population, 13.2% of the nursing home population is made up of individuals under the age of 65 and the young-old—those between the ages of 65 and 74 years. Those who are middle-old, between 75 and 84 years, make up 35.6% of the nursing home population. Finally, the old-old, those 85 years of age and older, make up 51.2% of the nursing home population (Hooyman and Kiyak, 2011). Regarding racial composition, 85.6% of the population is white, 11% is African-American, and 3.4% of the nursing home population is made up of other racial groups (Hooyman and Kiyak, 2011). When examining the demographic profile of nursing homes further, the following is revealed: The average age of nursing home residents is 84 years (Hooyman and Kiyak, 2011). Because men have a shorter life expectancy than women, women residents disproportionately comprise the nursing home population (Hooyman and Kiyak, 2011). Hooyman and Kiyak (2008 and 2011) also list other important features regarding the nursing home population:

- As mentioned, women dominate, with the nursing home population being 74% women
- Sixty-six percent of the nursing home population is either widowed or divorced
- A considerable amount of the population is cognitively impaired, with 40% of residents having a diagnosis of dementia
- A considerable number of residents (82%) need assistance with multiple activities of daily living (ADL)
- Ninety-eight percent require assistance with at least one ADL
- Fifty-one percent need help with five or more ADLs
- The average nursing home size is 109 beds
- Eighty-eight percent of nursing residents are 65 years of age or older

Culture Change

With the passage of the Nursing Home Reform Act, also known as the Omnibus Budget Reconciliation Act of 1987 (OBRA), major nursing home reforms were implemented. This resulted in a movement away from an institutional setting where residents' rights were minimized and toward a greater emphasis on the resident, not the patient, living in a home-like environment. However, change in the resident environment was still slow. Individuals in the long-term care industry still faced issues concerning how to make the long-term care environment more hospitable for residents. Attempting to change this environment and the culture that was part of long-term care has been difficult and has required overcoming some formidable forces.

One formidable force was tradition. For years, nursing homes were looked at as being a place where people came to die. Older people went to a "home" so that they could get others to take care of them. Warehousing older adults in an institutional setting to deal with many of their healthcare needs and basic care needs was what nursing homes were all about. They were not looked at as progressive environments but rather as secondary remnants or offshoots of the more primary healthcare sector, which was dominated by the major hospitals. Therefore, nursing homes were regarded as areas of placement for those who were not salvageable by the acute care setting. Furthermore, specialization in the area often was nonexistent. Geriatric and gerontological specialists were few and far between, with most experts in the medical field having training that emphasized care of a much younger clientele.

Things have started to change, and within the past couple of decades, training in the medical area by physicians and nurses has gradually emphasized care of the older adult. This has led to a major cultural change. Today, many physicians who work in long-term care are becoming certified as medical directors for long-term care environments. Also, we have seen a growth in the number of geriatric physicians, although most physicians who still work in long-term care environments are not geriatricians by training. Many nurses also are specializing in geriatric nursing. Even in the nonmedical arena, today many social workers and psychologists are being specially trained to work with the unique elements that older adults present as a group. Furthermore, nurse assistants also have to be specially trained, obtaining 75 hours of training from an approved program as well as passing a certification test before they can work within the long-term care arena.

Even with many of these changes, however, the nursing facility was often viewed as being a less-than-progressive area of healthcare. Evolution in this area has continued, with many nursing care facilities offering many forms of specialty care, such as short-term rehabilitation for older and younger adults. Many facilities are also specializing in Alzheimer's care, respiratory care for ventilator-dependent residents, dialysis services, and myriad other services, and they provide in-house professionals who run these programs. So today, many long-term care environments are becoming progressive and are far from the static medical environments that emphasized basic nursing practice for the bedfast or totally dependent residents of years past.

Recently, we have seen a greater emphasis on trying to move one step further in reducing the institutionalization that is found in nursing facilities. Dr. William Thomas was a major innovator here. He developed the Eden Alternative, which attempted to emphasize a more home-like environment. It encouraged nursing facilities to allow residents to engage in meaningful activities that would allow further personal growth. It allowed for small plants and gardens for residents to take care of, to instill a sense of purpose, and it even encouraged caring for pets. The Eden Alternative also allowed older adults to take part in childcare if it was available at the facility, in an attempt to deinstitutionalize the environment and make older adults' lives more meaningful.

Another new concept is the Green House concept, which attempts to separate residents into smaller groups of individuals, occupying the same communal area within the larger facility. Typically, instead of having a hallway of 20 rooms with 60–80 residents, the Green House concept pulls together smaller units of individuals, often between eight and 10 residents, into home-like or community environments. The 8–10 residents are looked at as living in a single home, which is often served by a nurse and a few certified nurse assistants. Taking out things such as the nurses' station, which is very institutional, and allowing each resident to have his or her own bathroom and shower is also encouraged to create a more home-like environment.

Today, most nursing homes are still institutional: The "medical model" of care for long-term care residents still continues to dominate in most nursing homes throughout the United States. Furthermore, many nursing care facilities in lower-socioeconomic areas cannot afford to make some of the changes mentioned earlier, since such changes are often costly. That being said, many nursing homes have moved away from being the warehouses for the old, the infirm, the mentally ill, or the mentally challenged that was often the norm in years past. However, changing the culture has still been a slow process. Furthermore, time is needed to determine whether nursing care facilities will ever reach the ideal where they will become the truly home-like and noninstitutional environment that is often mentioned as the goal.

Nursing Home Administrator Requirements

Nursing home administrators have become an increasingly professionalized group of healthcare administrators. Today's nursing home administrators are usually well trained and college educated. Many have postgraduate degrees. Commensurate with the personal growth witnessed among nursing home administrators are important professional organizations that reflect this increasing professionalism. For instance, the American Healthcare Association has many chapters in various states addressing issues within long-term care administration, especially on the political level. The National Association of Long Term Care Administrator Boards is the key organization that oversees testing on the national level and provides credentials for nursing home administrators. The American Association of Healthcare Administrators aids administrators in their development as professionals.

Because the nursing home administrator today is not just a caretaker or innkeeper but rather is a professional and well-trained individual, the profession has grown as the level of professionalism has grown. Figure 1.1 demonstrates some state-by-state requirements. As you can see, most states require a minimum level of education, which is often a bachelor's degree. Also, most states require some level of administrator-in-training or preceptor training, with states differing in the number of hours they require. Furthermore, you can see that national and state testing is often the norm. Finally, most states require a level of continuing education to maintain licensure.

FIGURE 1.1

State-by-state nursing home administrator requirements

State	Minimum age	Degree required	Preceptor training	National testing	State testing	CEUs
Alabama	19	AA	Yes	Yes	Yes	24/annual
Alaska	19	BA		Yes	No	0
Arizona		BA	No	Yes	Yes	50/biennial
Arkansas	21	AA		Yes	Yes	20/annual
California	18	BA	Yes	Yes	Yes	40/biennial
Colorado	21	AA	Yes	Yes	Yes	0
Connecticut		0		Yes		0
Delaware	18	Other	Yes	Yes	No	48/biennial
District of Columbia	18	BA	Yes	Yes	Yes	40/biennial
Florida	18	BA	Yes	Yes	Yes	40/biennial
Georgia						
Hawaii	21	BA	Yes	Yes	No	0/biennial
Idaho	21	BA	Yes	Yes	Yes	20/biennial
Illinois		0	Yes	Yes	Yes	0
Indiana		Other	Yes	Yes	Yes	40/biennial
Iowa		BA	No	Yes	No	40/biennial
Kansas	18	BA	Yes	Yes	Yes	50/biennial
Kentucky	21	BA	No	Yes	No	30/annual
Louisiana	21	BA	Yes	Yes	Yes	15/annual
Maine		0				0
Maryland	21	BA	Yes	Yes	Yes	40/biennial
Massachusetts	18	BA	Yes	Yes	No	40/biennial
Michigan	18	Other		Yes	Yes	36/annual
Minnesota	21	BA	No	Yes	No	20/biennial
Mississippi	21	Other	Yes	Yes	Yes	40/biennial
Missouri	21	Other	Yes	Yes	Yes	40/annual
Montana	18	Other		Yes	Yes	25/biennial
Nebraska	19	AA	Yes	Yes	No	50/biennial
Nevada	21	BA	Yes	Yes	No	30/biennial
New Hampshire	21	BA	No	Yes	Yes	40/biennial
New Jersey	18	BA	Yes	Yes	No	60
New Mexico		BA	No	Yes	Yes	24/annual
New York	21	BA	Yes	Yes	No	48/biennial
North Carolina	18	Other	Yes	Yes	Yes	30/biennial
North Dakota	18	BA	Yes	Yes	Yes	20/annual
Ohio	18	BA	Yes	Yes	Yes	20/annual
Oklahoma	21	BA	Yes	Yes	Yes	24/annual
Oregon		BA	No	Yes	Yes	20/annual
Pennsylvania	21	Other	No	Yes	Yes	48/biennial
Rhode Island	18	BA		Yes	No	40/biennial
South Carolina	21	BA	Yes	Yes	Yes	20/annual
South Dakota	18	BA	Yes	Yes		40/biennial
Tennessee	18	AA	Yes	Yes	Yes	18/annual
Texas		BA	Yes	Yes	Yes	40/biennial
Utah		0	No	Yes	No	40/biennial
Vermont	18	BA	Yes	Yes	Yes	40/biennial
Virginia		BA	Yes	Yes	No	20/annual
Washington		BA	Yes	Yes	No	36/biennial
West Virginia	21	BA	Yes	Yes	Yes	20/annual
Wisconsin		0				0
Wyoming		BA	No	Yes	No	25/annual

Source: Compiled from information on the National Association of Long-Term Care Administrator Boards' website: http://www.nabweb.org/

It is interesting to note that many long-term care administrators have qualifications and credentials that are similar to those of hospital administrators. Nursing homes are no longer viewed as being managed by marginalized individuals who have little training in management. Today's long-term care administrators must fulfill many requirements to obtain their license. Most have gone through rigorous levels of training, on a college level, through preceptor oversight and through studying for their state and national boards.

Assisted living facilities

Assisted living has grown dramatically in recent years. In fact, the reduction in nursing home beds is related to the growth in assisted living facilities. Assisted living facilities adhere to the social model of care rather than the medical model that has dominated nursing care facilities. Assisted living arrangements place greater emphasis on autonomy for the individual, as compared with nursing homes, which often house many more dependent individuals. However, because assisted living arrangements have taken on the social model, the facilities are much less institutional, which has been an attractive marketing point.

Assisted living arrangements were not meant to deal with many of the chronic conditions that you find in nursing care centers. In fact, the basis of most assisted living arrangements is built on the need to assist residents with some of the ADLs but to allow them to remain independent, avoiding much of the clinical oversight you find in nursing care facilities. Most assisted living facilities allow residents to live in their own apartment that typically has a small kitchen, living room, bedroom, and bathroom so that they can live independently, for the most part. Many also will allow some residents to bring their cars to the facility so that they can come and go with minimal oversight.

However, because assisted living has gained in popularity, such facilities have witnessed many more individuals with greater levels of chronicity in illness, which was not the initial plan for most of these communities. Therefore, many different levels of assisted living exist, some of which allow individuals with mild cognitive impairments or mild levels of dementia to live by themselves or with a spouse, some not allowing this type of person to live in the community, and some that are not much different from elderly independent living arrangements. Moreover, because of these different levels of assisted living arrangements, the levels of professional staff also vary considerably, with some that have a nurse on staff 24 hours each day and others that have no daily medical staff.

Since the rise in healthcare has become an important issue in our country, assisted living communities have been targeted to assist with reducing the cost of long-term care. Today, many residents who would have been placed in nursing care facilities, which are usually more expensive, now reside in assisted living facilities. Many states have allowed Medicaid waivers, which allow state funding for those residing in this type of situation, and in which

the state can reimburse less for assisted living settings than they would for skilled nursing care environments. However, this has also led to the argument by many that those who are in need of proper skilled nursing home care are being placed within an assisted living environment that may not address their needs appropriately, all for the sake of reducing more expensive costs found in nursing homes.

Assisted living communities usually offer meal arrangements that allow many elderly to eat at least two meals daily in a community setting. Because these facilities are based on the social model, activities personnel will often arrange trips or outings for residents. They also will often arrange for nurses to come and provide free blood pressure checks, as well as for podiatrists to provide podiatry services.

As mentioned, because many older adults are opting for assisted living rather than nursing home care, the population at assisted living facilities is frailer than it was intended to be. The following are some of the prevailing demographics found in the assisted living population (Hooyman & Kiyak, 2011):

- The average age is 85
- There is a range of approximately 40%–67% who show signs and symptoms of dementia
- Twenty-three percent of the assisted living population has a diagnosis of Alzheimer's disease
- Approximately 33% have significant hearing and visual impairment
- Approximately 72% require assistance with bathing
- Approximately 57% require assistance with dressing
- Approximately 75% need assistance with medication or managing finances
- Only about 20% can perform all of their ADLs without assistance

As you can see, if assisted living communities continue to progress in this direction, the care that is offered will become more expensive. Furthermore, if they continue to take in more individuals with chronic care issues, similar to many nursing home residents, the type of staff may also have to be upgraded, with more medical professionals being part of this environment.

Continuing care and retirement communities

Continuing care and retirement communities (CCRC) have also become popular recently. CCRCs are a type of community to deal with what is called "aging in place," meaning that the CCRC contains the spectrum of living

arrangements that the elderly will need without having to move. These communities typically provide a spectrum of care that ranges from independent living to assisted living and finally to nursing home care. This type of housing is particularly attractive for elderly couples who may have different care needs but do not want to be separated by a greater geographic distance.

A major premise behind CCRCs is that if individuals can no longer take care of themselves in an independent living arrangement, and if they need assistance with many of the ADLs, they can move to an assisted living area without having to move off campus. Therefore, they will not have to leave behind many individuals whom they have come to know and befriend, since they are just moving to a different area on campus. Furthermore, if the individual eventually requires greater medical oversight, these communities can accommodate the individual through the nursing care facilities.

The American Association of Homes and Services for the Aging has estimated that 98% of these communities provide apartment-style living arrangements; another 81% provide assisted living arrangements on campus, and 95% also provide a nursing home on-site (Hooyman and Kiyak, 2008, p. 443). As is evident, the strength of these communities is that they can accommodate a large spectrum of required services for the elderly, without the elderly having to move long distances each time they may need a different level in living arrangements and care.

Adult foster care

Adult foster care arrangements are usually smaller in nature, often licensed to allow only five or six residents to live together. Many of these facilities deal with elderly who do not need extensive medical care. These facilities can often vary in their makeup. Some adult foster care facilities will admit the frail elderly, those who have developmental disabilities, and younger adults as well as older adults who may have dementia care needs. Other foster care homes may admit only those with dementia. Furthermore, some may not admit elderly residents with dementia.

People with nursing assistant skills usually provide care at these facilities. These individuals may also provide medication to residents, including injections if they need them, as well as providing residents with ADL assistance.

Because the care in adult foster care is less expensive than that in nursing homes, those who do not need nursing homes are often referred to assisted living or adult foster care homes. The quality of adult foster care homes also varies considerably, with some providing high-quality care and others requiring considerable improvement in the provision of care.

The Evolution of the Nursing Home Industry

In the United States, we have witnessed an increasing role of government in assisting older adults. This was not always the case. For much of history, older adults in the United States, along with other individuals who were

poor or infirm, did not have the protection of the state. Relief policies for assisting older adults with infirmity in England during the seventeenth and eighteenth centuries were quite restrictive. However, starting in the nineteenth century, old-age relief policies actually became more restrictive in the United States, with a reduction in restriction found in England. This had a considerable impact on how the elderly were treated, especially those who were infirm, frail, and in need of assistance.

In colonial America, a rural existence dominated. Many older adults lived on farms with their families. It was common for many such adults to pass on their farm or homestead to their children; in return, many were taken care of by their families (Williamson, 1985). However, some did not have this level of property or this type of family protection. These elderly adults often faced precarious situations.

Many colonists had come to the United States from England with ideas on how to address the needs of those who required assistance. However, the new environment helped to shape many ideas that would come to follow in the colonies. Mutual aid in many communities became the standard for dealing with the poor, frail, ill, and elderly. Because most communities were isolated, community solidarity became an important force to assist those in need. Most communities were willing to take care of their own poor, frail, and ill elderly. However, elderly who were outsiders to the community were often shunned. The safety net for these elderly failed to exist on the community level (Williamson, 1985).

Many of the colonies would come to shape their aid toward the elderly due to influence from the Elizabethan Poor Laws of 1601 passed in England. The laws that came to evolve among the colonies frequently set requirements for providing aid, including determining who was eligible for community aid. Most communities also passed laws that were influenced by the English Law of Settlement and Removal of 1662, which essentially stated that elderly in need who were not part of the community could be passed on to other communities to determine whether they wanted to support them (Williamson, 1985).

In many communities, elderly individuals would be taken care of by neighbors or other individuals whom the community paid to assist the elderly. However, those who were too ill and infirm to be cared for by their neighbors or community members were often placed in almshouses as a last resort. These institutional arrangements were the forerunners of modern-day institutional settings.

In the nineteenth century, a new ideology arose regarding how the elderly should be treated. The English Poor Law of 1834 had an important impact on shaping the thinking of the communities in the United States during this time. According to Williamson (1985), there was a misinterpretation of this law in the United States, where it was thought that the English were eliminating any assistance outside an institutional environment. It was believed that assistance for the elderly, the blind, or other needy groups should be provided only in institutions.

New York took on a major initiative that would come to influence other states. The Country Poorhouse Act of 1824 stated that an almshouse should be created in each county of New York. Therefore, during the first part of the nineteenth century, the aim was to institutionalize those in need, which for our discussion especially included the elderly. Thus, the emphasis became indoor relief (relief provided within an institutional environment) rather than outdoor relief, which was predominately provided by the community itself. As Williamson writes, by 1900, most almshouses held a population that was dominated by elderly individuals.

By 1900, most relief for the elderly was found within an indoor, institutionalized environment, whereas in England, relief for the elderly was more predominant in outside institutions. Policies for dealing with the elderly who needed assistance in the United States focused more on custodial care within a formalized institutional arrangement. Conversely, within England, care and relief for the elderly was more likely to emphasize community assistance (Williamson, 1985).

During this period of history, the individualism of American society, shaped strongly by the doctrine of social Darwinism, which viewed assistance of any type as impeding the need for individuals to "pull themselves up by their bootstraps," which in turn would lead to the survival of the most adaptive individuals, came to dominate and shape Americans' view of elderly support. Even charity support was opposed, interfering with the supposedly social Darwinist laws of survival. Individuals who could not assist themselves were now viewed as expendable. Therefore, it was thought that the natural laws leading to the elimination of those who could not help themselves survive should not be interfered with and should be allowed to run their course.

With the advent of the twentieth century, the acute care hospital became the place where many people with curable illnesses went for treatment. Rest homes, as nursing homes at that time were called, although few in number, were really not centers for medical care inasmuch as they were custodial care facilities. Furthermore, as large psychiatric facilities were built, often housing many individuals with severe mental illnesses who would stay there for years if not the rest of their lives, these hospitals also became places were many elderly, especially those with cognitive impairment, were warehoused. In fact, it was estimated that by the mid-1940s, 24% of all individuals over 60 years of age would end up within this type of institution as a source of old-age housing (Hess & Markson, 1980). Furthermore, most institutions that housed elderly were often not regulated, nor did they require a licensed administrator to oversee the facility. It was common for many individuals with little or no experience to oversee facilities that housed older adults.

In the 1940s and 1950s, nursing homes started to become more strongly regulated, calling for licensing and other regulatory requirements. However, major expansion of the industry reached its zenith with the creation of Medicare and Medicaid in 1965 and 1966. The 1960s was a decade that not only witnessed legislative expansion for the elderly but also led to the rise of many nursing care facilities. In fact, between the years of 1963 and 1974,

the number of nursing homes increased by 131% (Hess & Markson, 1980). The 1960s and early 1970s saw tremendous growth in the nursing industry. After that period, nursing home growth continued but slowed to single-digit increases.

The middle to late 1980s was an era of considerable legislative change within long-term care. A 1986 report by the Institute of Medicine (IOM) pointed out the need for nursing home reform due to the extreme deficiencies that have continued to exist, such as warehousing, placing patients in restraints for staff convenience, and medicating beyond resident needs, just to name a few. The federal government raised its eyebrows and requested reform in this area. The IOM report led legislators to act quickly to bring about much needed changes, which led to the most sweeping legislation in the history of the nursing home industry: The Nursing Home Reform Act, or OBRA. This legislation affected almost every area of the nursing home industry. Published in the *Federal Register* and promulgated under the *Code of Federal Regulations*, it required nursing homes to provide residents with more rights and to standardize the requirements for nursing home participation for facilities receiving Medicare and Medicaid funding.

Over the past few years, there has been an increasing dominance of major companies overseeing nursing home care. In the past, many facilities were owned and operated by private owners and were in some way connected with hospitals. Today, however, there are major healthcare companies that have taken over the landscape of long-term care, not just within the nursing home area but in the assisted living area as well. These companies focus their specialization on this particular area of care within the larger healthcare industry. They often build their organizations around a large number of individuals who have specialized in various areas of long-term care. Often, these larger long-term care companies buy out smaller facilities, which have become fewer and fewer in number.

The large companies supply a vast amount of worker capital to help address almost every phase of long-term care. However, the increased dominance of large companies overseeing the long-term care environment is not without issues. Due to their size, many are quite bureaucratized, which leads to some major areas of inefficiency. Because each nursing care facility often has its own unique clientele and in turn is part of its own unique geographic region, many large companies do not factor these important points into management decisions they make on a companywide basis. They often make uniform, singular decisions that may be intended to impact various facilities in the same way but in many cases do the opposite. The promulgation of homogenized mandates from the central office, although providing the standardization that the executive team often seeks, frequently fails to address managing healthcare organizations that are quite diverse. This type of micromanaged, one-size-fits-all approach is typically a miscalculated and poorly managed approach to providing quality healthcare. This and other problematic processes will be further addressed in a later section of the book (see Chapter 5: Management and Organizational Structure Within Healthcare).

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