Virginia Department of
Health Professions
Board of Long-Term Care Administrators

**Agenda**
**Full Board Meeting**

**June 23, 2026**
**Board Room 4**
**10:00 a.m.**

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**Call to Order – Kimberly Brathwaite, ALFA, Chair**

- Welcome and Introductions
- Mission of the Board
- Emergency Egress Instructions

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**Approval of Minutes** (p. 4-19)

- Board Meeting – September 24, 2025
- Legislative/Regulatory Committee Meeting – March 13, 2026

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**Ordering and Approval of Agenda**

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**Public Comment**

*The Board will receive public comment on agenda items at this time. To allow ample time for the Board to conduct its business, public comment will be allocated up to a maximum of 20 minutes. The Board will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.*

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**Agency Report – David E. Brown, DC, Director**

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**Staff Reports**

- Executive Director's Report - **Corie E. Tillman Wolf, JD, Executive Director** (p. 22-37)
- Discipline Report – **Annette Kelley, MS, CSAC, Deputy Executive Director**
- Licensing Report – **Sarah Georgen, Board Administrator**

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**Board Counsel Report – Sara Blose, Senior Assistant Attorney General**

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**Committee and Board Member Reports**

- Legislative/Regulatory Committee Report – **Pamela Dukes, MBA, Committee Chair**
- NAB Annual Meeting Report – **Jasmine Montgomery, NHA, Vice-Chair**

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**Legislative and Regulatory Reports (p. 39)**

- Legislative Report – **Erin Barrett, Director of Legislative and Regulatory Affairs**
- Report on Status of Regulatory Actions - **Matt Novak, Agency Regulatory Coordinator**

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**Board Actions – Erin Barrett, Matt Novak, Corie Tillman Wolf**

- Adoption of the Electronic Meeting Policy (Virginia Code § 2.2-3708.3) (p. 42-44)
- Review and Consideration of Recommendations from Legislative/Regulatory Committee
    - Adoption of Proposed Regulations for Periodic Review (Chapters 18VAC95-15, 18VAC95-20, and 18VAC95-30) (p. 47-74)
    - Adoption of Proposed Revisions to Board Bylaws (p. 76-89)
    - Adoption of Policy Document - Board Policy on Processing Requests for Additional Examination Attempts (p. 91)

**Presentations**

- Updates from the Office of Licensure and Certification – **April Dovel, Director, Office of Licensure and Certification, Virginia Department of Health**
- Virginia's Nursing Home Administrators and Assisted Living Facility Administrators: 2026 Workforce Reports – **Yetty Shobo, PhD, Director, and Barbara Hodgdon, PhD, Deputy Director, Healthcare Workforce Data Center** (p. 93-156)
- Overview of the PositiveAge AIT Webinar Series – **Dana Parsons, Vice President & Legislative Counsel, LeadingAge Virginia**

**Board Member Development**

- Training and Development Topics for 2026 – **Corie E. Tillman Wolf**
- Overview of Discipline Cases and Sanctions – **Annette Kelley**

**Next Meeting –** September 9, 2026

**Business Meeting Adjournment**

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to the Code of Virginia.

# Approval of Minutes

Virginia Department of
Health Professions
Board of Long-Term Care Administrators

# Draft Minutes
## Full Board Meeting

**September 24, 2025**

The Virginia Board of Long-Term Care Administrators convened for a full board meeting on Wednesday, September 24, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room #4, Henrico, Virginia.

**BOARD MEMBERS PRESENT:**

Kimberly Brathwaite, ALFA, Vice-Chair
Todd Barnes, NHA
Pamela Dukes, MBA, Citizen Member
Charles Gaskins, DDS, Citizen Member
Latonya Hughes, PhD, RN, NHA
Jasmine Montgomery, NHA
Dennis Pregent, ALFA, NHA

**BOARD MEMBERS NOT PRESENT:**

Lynn Campbell, LPN, Citizen Member
Felita Creekmore, ALFA

**DHP STAFF PRESENT FOR ALL OR PART OF THE MEETING**:

Erin Barrett, Director of Legislative and Regulatory Affairs
Sarah Georgen, Board Administrator
Annette Kelley, MS, CSAC, Deputy Executive Director
Arne W. Owens, Agency Director
Matt Novak, Policy and Economic Analyst
Corie E. Tillman Wolf, JD, Executive Director
Joi Yancey, Administrative Support Specialist

**BOARD COUNSEL**

Sara Blose, Senior Assistant Attorney General

**OTHER GUESTS PRESENT**

Michelle Grachek, National Association of Long Term Care Administrator Boards
Judy Hackler, Virginia Assisted Living Association
Val Hornsby, Virginia Department of Health
Lisa Kirby, NHA, Chair
Joani Latimer, State Long-Term Care Ombudsman
Dana Parsons, LeadingAge Virginia
Betsy Archer, LeadingAge Virginia
Jennifer Yañez Pryor, Virginia Commonwealth University
Haig Darakjian, Virginia Assisted Living Association

## CALL TO ORDER

Ms. Brathwaite called the meeting to order at 10:04 a.m. and asked the Board members and staff to introduce themselves.

With five board members present at the meeting, a quorum was established in order for the Board to conduct business.

Ms. Brathwaite welcomed Todd Barnes, NHA, to his first meeting as a newly appointed Board Member.

Ms. Brathwaite read the mission of the Board, which is also the mission of the Department of Health Professions.

Ms. Brathwaite reminded the Board members and audience about microphones, computer agenda materials, and breaks.

Ms. Tillman Wolf then read the emergency egress instructions.

## APPROVAL OF MINUTES

Ms. Brathwaite opened the floor to any edits or corrections regarding the draft minutes for a Board meeting and Formal Hearing held on June 24, 2025. The minutes were approved as presented.

## ORDERING OF THE AGENDA

Ms. Brathwaite opened the floor for any additional items to be added to the agenda.

Upon a ***MOTION*** by Ms. Dukes properly seconded by Ms. Montgomery, the Board voted to accept the agenda. The motion passed unanimously (5-0).

## PUBLIC COMMENT

There was no public comment.

## BOARD MEMBER RECOGNITION

Ms. Brathwaite recognized past Board member, Lisa Kirby, for her service and dedication to the Board of Long-Term Care Administrators from 2021 to 2025. She announced that Ms. Kirby's first term expired on June 30, 2025, and provided brief remarks on her tenure with the Board.

## AGENCY REPORT – Arne W. Owens, Agency Director

Mr. Owens welcomed the Board Members back to the Perimeter Center and welcomed Mr. Barnes on his recent appointment to the Board.

Mr. Owens reported on Executive Order Number Fifty-Two (2025), which establishes Nursing Home Oversight and Accountability Advisory Board and directs Virginia's executive agencies to strengthen oversight of the state's nearly 300 nursing homes by filling inspector vacancies, improving recruitment and retention, and establishing a regional office in Northern Virginia. Mr. Owens reported that Ms. Tillman Wolf was appointed to the Advisory Board to represent the Department of Health Professions (DHP).

Mr. Owens stated that DHP remains focused on internal operations and ongoing initiatives, with a continued emphasis on improving efficiency across all areas.

Mr. Owens stated that for the upcoming 2026 General Assembly session beginning in January, DHP has submitted legislative proposals to the Secretary's Office. He said that the proposals are still under review, and that updates will be provided as developments occur. Additionally, Mr. Owens stated that the General Assembly will be reviewing the next biennial budget, which is set to take effect on July 1, 2026.

With no questions, Mr. Owens concluded his report.

## STAFF REPORTS

### *Executive Director's Report – Corie E. Tillman Wolf, JD, Executive Director*

*Welcome and Congratulations*

Ms. Tillman Wolf introduced and welcomed Todd Barnes, NHA, who was recently appointed to the Board. She also congratulated Ms. Brathwaite and Ms. Dukes on their reappointment to second terms on the Board.

*Board Updates*

Ms. Tillman Wolf provided a comprehensive update on activities since the Board's last meeting, including the delivery and planning for a number of presentations by Board staff for LeadingAge Virginia, the State Long Term Care Ombudsman Program, and for Enforcement staff.

She reported on her appointment to the Governor's Nursing Home Oversight and Accountability Advisory Board, and her participation in the Advisory Board's meeting held on September 15, 2025. She stated that Mr. Barnes is also a member of the Advisory Board. She stated that materials from the meeting were provided to Board members for their information.

Ms. Tillman Wolf reported on communications to licensees to include information on the PositiveAge Virtual AIT Leadership Program and an upcoming newsletter.

Ms. Tillman Wolf discussed ongoing collaborations with stakeholders regarding AITs, training, and information sharing.

Additionally, Ms. Tillman Wolf provided an update on the biennial budget process and highlighted an approved request for funding in the Board's budget to support expert case reviewers for disciplinary cases. She emphasized that this initiative is intended to alleviate workload for Board members and staff, expedite the case review process, and reduce the backlog of disciplinary cases. Recommendations from the Board's

expert reviewers regarding disposition of cases will be submitted to the Board Chair or the Special Conference Committee Chair for final approval.

*Complaints Against Administrators*

Ms. Tillman Wolf provided data indicating a significant increase in complaints filed against administrators from the end of calendar year 2024 through mid-2025. She reported an 85% increase in cases received within the past year, with an average of approximately 30 cases received per quarter. She noted that the overall volume of cases continues to trend upward.

*Follow-Up Case Data (FY19-FY24)*

Ms. Tillman Wolf presented updated data regarding complaints received concerning administrators within their first three and first five years of licensure. She noted that the proportion of complaints involving these newly licensed practitioners fluctuated significantly between fiscal years 2019 and 2024. Over the six year period, administrators who had been licensed within the previous three years accounted for 35% of all complaints, representing a substantial share of the total caseload. Administrators who were in their first five years of licensure represented 46% of all complaints received during this time period.

She further reported that complaints related to business practices, standard of care (diagnosis/treatment), and abuse/abandonment were also the leading types of cases filed against administrators during the reporting period.

*NAB Updates*

Ms. Tillman Wolf announced that the NAB Mid-Year Meeting is scheduled for October 29–31, 2025, in Santa Fe, New Mexico.

She also reported that she was recently appointed as Chair of the State Governance and Regulatory Issues Committee, as the previous Chair had stepped down.

She further reported that the Professional Practice Analysis (PPA) is currently underway. The PPA will serve as the foundation for reviewing the Domains of Practice and updating the Exam Blueprint.

Dr. Hughes arrived at 10:26 a.m.

*2025 Board Meeting Schedule*

Ms. Tillman Wolf reminded Board members of the remaining 2025 Board meeting schedule.

- December 2, 2025

Ms. Tillman Wolf announced the schedule for the 2026 Board meetings.

- March 18, 2026
- June 23, 2026
- September 17, 2026

- December 16, 2026

*Notes and Reminders*

Ms. Tillman Wolf stated that a Conflict of Interest Form was provided for Board members' review and signature, based on a new policy from the agency, ensuring that Board Members notify the Executive Director as soon as possible if there is a conflict of interest for disciplinary case review.

Ms. Tillman Wolf provided reminders to the Board regarding attendance at meetings and hearings, as well as updates to contact information. She thanked members for their service and dedication to the Board.

With no questions, Ms. Tillman Wolf concluded her report.

***Discipline Report – Annette Kelley, MS, CSAC, Deputy Executive Director***

As of August 31, 2025, Ms. Kelley reported the following disciplinary statistics:

- 108 Patient Care Cases
  - 0 at Informal
  - 0 at Formal
  - 26 at Enforcement
  - 78 at Probable Cause
  - 4 at Administrative Proceedings Division

- 48 Non-Patient Care Cases
  - 0 at Informal
  - 0 at Formal
  - 24 at Enforcement
  - 23 at Probable Cause
  - 1 at Administrative Proceedings Division

- 4 Compliance Cases

Ms. Kelley reported the following Total Cases Received and Closed:

- Q4 2022 – 19/17
- Q1 2023 – 23/39
- Q2 2023 – 14/22
- Q3 2023 – 18/23
- Q4 2023 – 23/18
- Q1 2024 – 24/14
- Q2 2024 – 26/22
- Q3 2024 – 26/36
- Q4 2024 – 27/30
- Q1 2025 – 21/16
- Q2 2025 – 26/16
- Q3 2025 – 34/30
- Q4 2025 – 48/19

Ms. Kelley noted an increase in the number of cases received recently by the Board for Quarters 3 and 4 of 2025.

*Complaint Source Data*

Ms. Kelley reviewed the complaint source data for July 1, 2024, to August 27, 2025. She reported that a total of 152 complaints were received, with the highest number submitted anonymously (46), followed by other government agencies (31), and the Department of Health Professions/non-personnel sources (23). Additional sources included unidentified others (20), employees/employers/staff (18), family members (11), self/licensees (2), and current or former residents of a facility (1). A snapshot of the data was presented to provide context on the distribution of complaint sources.

Ms. Kelley reported the top three complaint categories for licensed administrators were identified as business practice issues, abuse, abandonment, or neglect, and standard of care. Ms. Kelley presented a chart showing case submissions by region, based on the licensee's address of record. It was noted that this may not reflect the actual location of the long term care facility. She stated that the regional distribution appeared relatively balanced, with the Northern region representing the highest number of cases.

Ms. Kelley indicated that she would explore conducting a more detailed analysis of cases by region. She stated that future analyses will aim to consider the location of the facility where the administrator is employed, rather than relying solely on the licensee's address of record.

Ms. Kelley extended her appreciation to Ms. Yancey for her work in compiling the complaint source data.

With no questions, Ms. Kelley concluded her report.

***Licensure Report – Sarah Georgen, Licensing and Operations Supervisor***

Ms. Georgen presented licensure statistics that included the following information:

Current License Count – ALFA and NHA

| ALFA | Q4 – 2025 | NHA | Q4 – 2025 |
|---|---|---|---|
| ALFA | 624 | NHA | 946 |
| ALF AIT | 106 | NHA AIT | 84 |
| Preceptor | 204 | Preceptor | 212 |
| Total ALFA | 934 | Total NHA | 1,242 |

Ms. Georgen reviewed the trends in licensure counts since Q4 2020.

Ms. Georgen reported that, effective April 9, 2025, Nursing Home Administrators and Assisted Living Facility Administrators became eligible to request inactive licensure status. She noted that development of the inactive status request form and accompanying Frequently Asked Questions (FAQs) is currently underway in preparation for the 2026 renewal cycle.

With no questions, Ms. Georgen concluded her report.

## BOARD COUNSEL REPORT – Sara Blose, Senior Assistant Attorney General

Ms. Blose provided an update on a court case involving the Board.

## LEGISLATIVE AND REGULATORY REPORT

*Legislative Report; Review of Potential Agency Legislative Requests*

Ms. Barrett reviewed a draft legislative proposal included in the agenda materials, which seeks to amend the Callahan Act. The proposed amendments would allow fee actions to be implemented through exempt regulatory action, permit the Department to request general fund appropriations for discrete costs, and authorize the recovery of costs associated with investigations and disciplinary proceedings.

Ms. Barrett noted that this proposal was developed jointly with the Department of Professional and Occupational Regulation (DPOR), which the Callahan Act also governs. It was emphasized that this is a draft proposal only, and any legislative initiative must be approved by the Agency Director and the Governor's Office before proceeding. Upon approval, the agency may begin identifying patrons for the proposed legislation. She stated that no action was required from the Board at this time and that the item was presented for informational purposes only.

With no questions, Ms. Barrett concluded her report.

*Report on Status of Regulations*

Mr. Novak provided an update on the status of pending regulatory actions.

With no questions, Mr. Novak concluded his report.

## BOARD ACTION

*Waiver of Application and Fee for Registration as ALF Preceptor for Active, Registered NHA Preceptors, 18VAC95-30-180(B)(4)*

Mr. Novak stated that the Board's Regulatory Advisory Panel (RAP) for Assisted Living Facility Administrators-in-Training discussed strategies for streamlining the preceptor registration process and clarifying existing requirements related to Nursing Home Administrator (NHA) Preceptors who currently precept or intend to precept in the assisted living setting.

The RAP recommended that the Board consider waiving the application and fee requirement for separate registration of Assisted Living Facility (ALF) Preceptors who are already licensed NHAs who are actively registered as NHA Preceptors, as permitted under 18VAC95-30-180(B)(4).

Upon a ***MOTION*** by Ms. Dukes and properly seconded by Ms. Montgomery, the Board voted to waive the application and fee requirement for registration as an ALF Preceptor for active, registered NHA Preceptors pursuant to 18VAC95-20-180(B)(4). The motion passed unanimously (6-0).

*Delegation of Probable Cause Review and Recommendations to Board's Expert Discipline Case Reviewers*

Ms. Tillman Wolf reviewed current procedures for determining probable cause in disciplinary cases, which are made by Board members in consultation with staff, as outlined in Board Bylaws.

Due to the increasing volume of disciplinary cases and time constraints faced by Board members, staff have initiated efforts to secure and fund licensed expert case reviewers to assist with case review. Ms. Tillman Wolf noted that amendments to the Board's Bylaws will be reviewed by the Legislative/Regulatory Committee, with recommendations to be presented to the full Board at a later date.

In the meantime, Ms. Tillman Wolf requested that the Board consider a motion for the delegation of authority to the Executive Director to assign probable cause determinations to the Board's contracted expert case reviewers. Recommendations from the case reviewers would be forwarded to the Board Chair or Special Conference Committee Chair for final approval.

Upon a ***MOTION*** by Ms. Dukes and properly seconded by Ms. Montgomery, the Board voted to delegate authority to the Executive Director to assign the determination of probable cause to the Board's contracted expert case reviewers, who may consult with Board staff and make recommendations to the Board Chair or to the Special Conference Committee regarding case disposition. The motion passed unanimously (6-0).

**PRESENTATIONS**

*National Examinations for Long Term Care Administrators – Michelle Grachek, M.Ed, CAE, President & CEO, National Association of Long Term Care Administrator Boards (NAB)*

Ms. Grachek offered a detailed overview of the NAB examination process, including the development and structure of the Nursing Home Administrator (NHA), Residential Care/Assisted Living (RCAL) and CORE exams including the stages of exam development—job analysis, item writing and review, exam assembly, standard setting, and implementation—as well as the transition to the Linear-On-the-Fly Testing (LOFT).

Ms. Grachek also discussed the history of the NAB exams and shared examination data comparing Virginia's pass rates to national averages. For the CORE exam, Virginia had a 44% total pass rate (50% for first-time test takers, 27% for repeat test takers) compared to the national average of 61%. For the NHA exam, Virginia's total pass rate was 56% (72% for first-time test-takers, 40% for repeat test-takers) versus the national average of 53%. For the RCAL exam, Virginia had a 50% total pass rate (70% for first-time test takers, 29% for repeat test takers) compared to the national average of 69%. Additional data from July 2022 to June 2023 showed that changes in the CORE exam content outline and pass point adjustments may have influenced pass rates. She stated that these shifts may reflect the impact of the 2020 Professional Practice Analysis (PPA), which placed an increased emphasis on emergency preparedness and added content related to telehealth. Ms. Grachek noted that generational shifts, the quality of mentorship, and the loss of institutional knowledge due to retirements may also have been contributing factors. Lower overall exam pass rates since the pandemic have been noted in a number of other professions as well.

Ms. Grachek stated that the 2025 PPA survey will be distributed nationally to licensees, who will receive one CE hour for participating. She stated that the survey was a key opportunity for professionals to provide

input on what knowledge and skills are critical to the role of a senior living and health services administrator. She said that while minor changes are anticipated, no major domain revisions are expected in 2025.

Ms. Grachek stated that a review of test-taking limits is scheduled for October, with the possibility of reverting to a four-attempt limit. She also addressed exam preparation strategies, including the AIT toolkit, NAB practice exams, online study guides with interactive and game-based learning, and a recommended reference list. She reported that a follow-up with 25 successful first-time test takers revealed an average study time of four months. Ms. Grachek discussed misinformation about the exam—particularly from unaffiliated third-party providers and social media.

In response to a Board question about the comparability of practice exams to the actual exam, it was clarified that the same item writers write practice exams and are currently considered comparable. However, the NAB team may consider the feedback for further review and potential updates.

Mr. Pregent arrived at 11:13 a.m.

The Board took a break at 11:40 a.m. and reconvened at 11:53 a.m.

*LeadingAge Virginia Webinar Series – Dana Parsons, Vice President & Legislative Counsel, LeadingAge Virginia*

Ms. Parsons announced the launch of a Virtual AIT Leadership Program: Virginia's Pathway to Administrator Success, a year-long, no-cost virtual program developed by PositiveAge, the nonprofit foundation of LeadingAge Virginia. The initiative, supported by a grant from the NAB Foundation, aims to strengthen workforce development through the Administrator-in-Training Leadership Program.

The program includes ten live sessions led by experienced Virginia professionals, covering regulatory requirements, exam preparation, and professional development. Of over 50 applicants, 27 AITs have been selected so far (12 Assisted Living and 15 Nursing Home Administrators) to participate.

The first half of the program focuses on foundational topics, including licensure, training plans, AIT-preceptor relationships, and support systems, while the second half emphasizes exam readiness, setting-specific training, and career development. She stated that sessions include expert instruction, interactive questions and answers, as well as peer engagement.

*Overview of Long-Term Care Ombudsman Program – Joani Latimer, State Long-Term Care Ombudsman*

Ms. Latimer provided a presentation on an overview of Virginia's Long-Term Care (LTC) Ombudsman Program, which advocates for the rights, safety, and well-being of residents in nursing homes, assisted living facilities, and home-based care. She stated that the program operates under federal and state authority and is managed by the Department for Aging and Rehabilitative Services.

She noted that the key responsibilities of the Ombudsman program include resolving resident complaints, providing education on long-term care services and rights, supporting resident councils, and promoting systemic improvements in care quality.

She reported that nearly half (48%) of Virginia's nursing homes fall below the national average in quality ratings, highlighting common issues including staffing shortages, poor training, weak supervision, and frequent ownership changes. She stated that the program faces challenges, including under-resourced enforcement, industry resistance to regulation, and a growing trend of private equity acquisitions.

Ms. Latimer provided recommendations, including strengthening oversight, improving inter-agency coordination, increasing transparency, and addressing workforce and leadership instability.

*Residential Care/Assisted Living Exam Preparation Course – Jennifer Yañez Pryor, MA, MS, ALFA, Gerontology Graduate Program Director and Joint Program Director, Assisted Living Administration Concentration, Virginia Commonwealth University*

Ms. Pryor provided an overview of the Virginia Commonwealth University Residential Care/Assisted Living Exam Preparation Course. She stated that the course, launched in 2019, is designed to support individuals preparing for licensure in Virginia, particularly those in the Administrator-in-Training (AIT) program, individuals who have previously failed the exam, or those seeking additional guidance and support.

The curriculum focuses on reviewing content aligned with the Domains of Practice (DOP), understanding the exam structure, managing test anxiety, and identifying individual strengths and weaknesses to tailor study efforts. Feedback from participants has highlighted concerns about topics such as Finance and Human Resources, especially among those who have been out of school for an extended period. She stated that the course incorporates this feedback to provide targeted support and includes NAB resources and handouts.

Ms. Pryor stated that the course is offered twice a year, with the next session scheduled for October 2, 2025, and an additional session planned for March 26, 2026. An online, self-paced version of the course is being developed to enable year-round training and increased accessibility, starting in 2026. Ms. Pryor stated that they have received positive feedback from participants in the course who had successfully passed the exam.

**ELECTIONS**

Ms. Brathwaite stated that in accordance with the Bylaws, during the first meeting of the organizational year, the Board shall elect from its members a Chair and Vice-Chair.

Ms. Brathwaite provided remarks regarding the process of making additional floor nominations.

Ms. Brathwaite opened the floor for nominations for Chair of the Board of Long-Term Care Administrators.

Ms. Brathwaite nominated herself for the position of Chair. There were no other nominations. The nominations were closed.

Upon a ***MOTION*** by Mr. Pregent, properly seconded by Ms. Dukes, the Board voted to elect Ms. Brathwaite as Chair of the Board of Long-Term Care Administrators. The motion passed unanimously (7-0).

Ms. Brathwaite opened the floor for nominations for Vice-Chair of the Board of Long-Term Care Administrators.

Ms. Montgomery nominated herself for the position of Vice-Chair. There were no other nominations. The nominations were closed.

Upon a ***MOTION*** by Mr. Pregent, properly seconded by Ms. Dukes, the Board voted to elect Ms. Montgomery as Vice-President of the Board of Long-Term Care Administrators. The motion passed unanimously (7-0).

**NEXT MEETING**

The next scheduled meeting date is December 2, 2025.

**ADJOURNMENT**

With all business concluded, the meeting adjourned at 12:42 p.m.

_____
Corie Tillman Wolf, JD, Executive Director

_____
Date

Virginia Department of
Health Professions
Board of Long-Term Care Administrators

# Draft Minutes
## Legislative/Regulatory Committee Meeting

**March 13, 2026**

The Legislative/Regulatory Committee of the Virginia Board of Long-Term Care Administrators convened on Friday, March 13, 2026, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Training Room #1, Henrico, Virginia.

**BOARD MEMBERS PRESENT**

Pamela Dukes, Committee Chair
Felita Creekmore, ALFA, Board Member
Latonya Hughes, NHA, Board Member

**DHP STAFF PRESENT FOR ALL OR PART OF THE MEETING**

Erin Barrett, JD, Director of Legislative and Regulatory Affairs
Sarah Georgen, Board Administrator
Annette Kelley, MS, CSAC, Deputy Executive Director
Corie Tillman Wolf, JD, Executive Director
Heather Wright, Senior Licensing Specialist

**BOARD COUNSEL**

Sara Blose, Senior Assistant Attorney General, Board Counsel

**OTHER GUESTS PRESENT**

Reuben Canty, Commonwealth Senior Living
Judy Hackler, Virginia Assisted Living Association
Tracey Lewis, LeadingAge Virginia
Jasmine Montgomery, Commonwealth Senior Living

**CALL TO ORDER**

Ms. Dukes called the meeting to order at 1:36 p.m. and asked the Committee members and staff to introduce themselves.

With two Committee members present at the meeting, a quorum was established.

Ms. Dukes read the mission of the Board, which is also the mission of the Department of Health Professions.

Ms. Dukes reminded the Board members and audience about microphones, computer agenda materials, breaks, sign-in sheets, and attendance for continuing education requirements.

Ms. Tillman Wolf then read the emergency egress instructions.

## APPROVAL OF THE AGENDA

Ms. Dukes opened the floor to any additional items to add to the agenda.

Upon a **MOTION** by Ms. Creekmore and properly seconded by Ms. Dukes, the Committee voted to accept the agenda as presented. The motion carried unanimously (2-0).

## PUBLIC COMMENT

Judy Hackler, Virginia Assisted Living Association, submitted written public comments and read them aloud to the Committee (Attachment A).

## DISCUSSION AND COMMITTEE RECOMMENDATIONS

Dr. Hughes arrived at 1:46 p.m.

***Review and Consideration of Amendments - Periodic Review of Regulations (18VAC95-15-10 et seq.)***

Ms. Barrett and Ms. Tillman Wolf presented proposed amendments to Chapter 15 of the Board's Regulations. The Committee reviewed and discussed the staff recommendations for amendments for the Periodic Review of the Regulations related to 18VAC95-15-10 et seq.

Upon a **MOTION** by Ms. Creekmore and properly seconded by Dr. Hughes, the Committee voted to recommend the amendments to 18VAC95-15-10 et seq., as presented. The motion carried unanimously (2-0). (Attachment B)

***Review and Consideration of Amendments - Periodic Review of Regulations (18VAC95-20-10 et seq.)***

Ms. Tillman Wolf presented proposed amendments to Chapter 20 of the Board's Regulations. Ms. Tillman Wolf summarized recent discussions by the National Association of Long Term Care Administrator Boards (NAB) regarding the use of "Administrator Residency" terminology in lieu of "Administrator-in-Training," noting that the Board could decide to implement that terminology at a later date into the regulations.

The Committee reviewed and discussed the staff recommendations and amendments to the Periodic Review of the Regulations related to 18VAC95-20-10 et seq.

Upon a **MOTION** by Ms. Creekmore and properly seconded by Dr. Hughes, the Committee voted to recommend the changes to 18VAC95-20-10 et seq., as discussed and amended. The motion carried unanimously (3-0). (Attachment C)

***Review and Consideration of Amendments - Periodic Review of Regulations (18VAC95-30-10 et seq.)***

Ms. Tillman Wolf presented proposed amendments to Chapter 30 of the Board's Regulations, which included a pending question before the Committee related to the size of training facilities for Assisted Living

Administrator-in-Training (AIT) Programs. Ms. Tillman Wolf noted that the training facility issue was previously discussed by the Board's Regulatory Advisory Panel and referred back to the Board with a lack of consensus.

The Committee reviewed and discussed the staff recommendations and amendments to the Periodic Review of the Regulations related to 18VAC95-30-10 et seq.

Upon a **MOTION** by Dr. Hughes and properly seconded by Ms. Creekmore, the Committee voted to recommend removal of the existing requirement for the size of a training facility for Assisted Living Facility Administrators-in-Training (AITs) from 18VAC95-30-170(B)(4). The motion carried unanimously (3-0).

Upon a **MOTION** by Dr. Hughes and properly seconded by Ms. Creekmore, the Committee voted to recommend the changes to 18VAC95-30-10 et seq., excluding the existing size of a training facility, as discussed and amended. The motion carried unanimously (3-0). (Attachment D)

***Review of Proposed Revisions to Board Bylaws***

The Committee reviewed the staff recommendations and proposed Board Bylaws revisions as presented by Ms. Tillman Wolf.

Upon a **MOTION** by Ms. Creekmore and properly seconded by Dr. Hughes, the Committee voted to recommend the proposed revisions to the Board Bylaws as presented. The motion carried unanimously (3-0). (Attachment E)

***Review of Guidance Documents***

*95-4, Board Policy on the Use of Confidential Consent Agreements (December 23, 2021)*

Ms. Tillman Wolf provided Guidance Document 95-4, "Board Policy on the Use of Confidential Consent Agreements," for review by the Committee. She stated that there were no substantive changes, except for a reference revision to a policy document instead of Guidance Document 95-2. The Committee did not have any other proposed edits to the Guidance Document presented.

*95-13, Guidance on Completion of Continuing Education (December 23, 2021)*

Ms. Tillman Wolf provided Guidance Document 95-13, "Guidance on Completion of Continuing Education," for review by the Committee. Ms. Tillman Wolf noted that the Board's previous regulatory reduction amendments incorporated the Board's guidance regarding signatures on CE certificates. Ms. Tillman Wolf further noted that the Board's guidance regarding "live" CE was incorporated into the staff drafts for the periodic review of the regulations. Once the regulatory amendments are finalized, the Board may wish to remove the Guidance Document in the future. The Committee did not have any proposed edits to the Guidance Document presented.

***Consideration of Policy Document - Board Policy on Processing Requests for Additional Examination Attempts***

Ms. Tillman Wolf provided an overview of the current NAB policy regarding examination attempts and stated that the Board does not have limits, rather, it follows the limits imposed by NAB. The Committee reviewed and discussed a draft policy document regarding a board policy on processing requests for additional examination attempts for candidates who reach the maximum attempts permitted by NAB within the examination cycle.

Upon a **MOTION** by Ms. Creekmore and properly seconded by Dr. Hughes, the Committee voted to recommend the proposed policy document as presented. The motion carried unanimously (3-0). (Attachment F)

**NEXT STEPS**

Ms. Dukes stated that the recommendations of the Committee, as outlined in the motions, would be presented to the full Board for consideration at the next scheduled Board meeting on June 23, 2026, and that another Legislative/Regulatory Committee Meeting would be scheduled for a later date if necessary.

**ADJOURNMENT**

Ms. Dukes called for any objections to adjourn the meeting. Hearing no objections and with all business concluded, the meeting adjourned at 3:11 p.m.

_____
Corie E. Tillman Wolf, J.D., Executive Director

_____
Date

# Virginia Assisted Living Association

*"Virginia's Unified Voice for Assisted Living"*

To: Virginia Board of Long-Term Care Administrators Legislative/Regulatory Committee

From: Judy Hackler, Executive Director
Virginia Assisted Living Association, PO Box 71266, Henrico, VA 23255
(804) 332-2111 ~ jhackler@valainfo.org

Date: March 13, 2026

Re: Public Comments regarding Regulatory Oversight of Assisted Living Facility Administrators and Preceptors

The Virginia Assisted Living Association (VALA) often receives concerns from assisted living providers across the Commonwealth expressing frustration and desperation in addressing the severe shortage that exists of licensed assisted living facility administrators and preceptors as well as available training facilities for individuals to become an administrator in training (AIT).

We appreciate Virginia ensuring an ALF AIT receives sufficient training and experiences, but we often hear from providers that operate in other states that Virginia is significantly harder to operate in than other states, especially neighboring states. These differences can make it more difficult to recruit and develop new administrators and may unintentionally discourage experienced professionals from entering or relocating to Virginia's assisted living sector. The two most common concerns that are applicable to today's discussion are:

1. **Restricting the number of times an individual may take the NAB exam** creates additional strain on individuals that may have testing disabilities or anxiety. If NAB is concerned with the pass rate being negatively impacted by repeat test takers, then there should be consideration as to why an individual failed the exam in the first place. The pass rate for first time test takers has been significantly low and continuing in that direction in recent years, which should also lead to a deeper dive into the applicability of the exam questions to the practicing industry. Many highly educated and intelligent individuals strongly passionate about caring for seniors have failed the exam, but they are excellent administrators that are fluent in Virginia's regulations.
2. With 25% of the licensed assisted living facilities having the capacity to serve less than 20 residents, **preventing** them from serving as **AIT training facilities** creates an undue burden and discriminates against smaller assisted living providers significantly restricting business operations and training opportunities. This regulation can also restrict available housing options for seniors if the smaller ALFs are not able to recruit or train administrators to oversee the operation, then the ALF will be forced to close due to its inability to comply with regulations.

We have previously shared written and oral comments with the Board of Long-Term Care Administrators, its Regulatory Advisory Panel, and this committee on these items along with other opportunities for improving Virginia's regulatory oversight of assisted living facility administrators. We welcome the opportunity to work further with the Board to improve Virginia's regulations, so they effectively ensure that long-term care administrators are well trained and qualified, while also avoiding unnecessary licensing barriers. Doing so would help support workforce development, improve regulatory consistency for multi-state providers, and ensure that qualified individuals are not unnecessarily deterred from pursuing licensure in the Commonwealth.

We appreciate the Board's willingness to engage with stakeholders and welcome the opportunity to collaborate further on practical regulatory improvements that both protect residents and support a sustainable assisted living workforce in Virginia.

# Staff Reports

# Executive Director's Report

# Domains of Practice



## Domains of Practice

Every five years, the National Association of Long Term Care Administrator Boards (NAB) conducts a Professional Practice Analysis (PPA) to ensure that NAB's licensure exams accurately represent the current scope of practice of Senior Living and Health Services administrators.

The PPA also serves as the foundation for NAB examinations and informs related work across continuing education, academic programs, exam preparation resources, and standards used by state licensing boards and HSE-accredited programs.

NAB has completed the 2026 Professional Practice Analysis (PPA) and released the updated Domains of Practice. This review builds on the previous exam blueprint and reflects direct feedback from professionals working in the field.

While much of the knowledge remains the same, the updated PPA makes several improvements to help clarify how content is organized and assessed across NAB exams. The most significant change is a move from domains with subdomains to **nine stand-alone Domains of Practice**, which will allow for clearer exam reporting and stronger alignment across exams and related resources.

## What changed in 2026?

### #1 Transition to nine stand-alone Domains of Practice

NAB has moved from a domain/subdomain structure to **nine stand-alone Domains of Practice**.
Previously, content was grouped under broader domains with multiple subdomains beneath them. This new structure simplifies the framework and improves clarity.

**What this means:**

- Each of the nine domains now stands independently
- Reporting will provide more detailed insights across all domains
- States and candidates will gain clearer visibility into content mastery

**When it takes effect:**

- Enhanced reporting will begin with examinations starting **July 1, 2027**.

## #2 Addition of Task Statements to the Examination Blueprint

The 2026 blueprint introduces a third level of detail: Task Statements.

**Previously, the 2020 blueprint included two levels:**

- Domain/Subdomain
- Knowledge, Skills, and Abilities (KSAs)

**The updated structure now includes:**

- Domains of Practice
- KSAs
- Task Statements

**What are Task Statements?**

Task statements are specific, action-oriented descriptions of the duties, behaviors, and responsibilities professionals must perform to practice safely and competently.

**Why this matters:**

- Provides clearer context for each KSA
- Explains why specific content appears on the exam
- Better connects exam material to real-world practice

## Domains of Practice: 2022 vs. 2026

| 2022 Domains (Effective through June 30, 2027, exams) | 2026 Domains (Effective with July 1, 2027, exams) | Explanation |
|---|---|---|
| **Domain 1:** Care, Services, and Supports | **Domain 1:** Quality of Care<br>**Domain 2:** Quality of Life | Resident care and services are now separated to clearly distinguish clinical care responsibilities from quality-of-life and person-centered practices. |
| **Domain 2:** Operations | **Domain 3:** Financial Management<br>**Domain 4:** Risk Management<br>**Domain 5:** Human Resources | Operational responsibilities are divided into financial oversight, organizational risk and safety, and workforce management to better reflect distinct areas of practice. |
| **Domain 3:** Environment and Quality | **Domain 6:** Care Setting<br>**Domain 7:** Regulatory Compliance | Physical environment and safety requirements are separated from regulatory and compliance responsibilities for greater clarity. |
| **Domain 4:** Leadership and Strategy | **Domain 8:** Leadership<br>**Domain 9:** Organizational Strategy | Leadership behaviors and organizational strategy are distinguished to better reflect day-to-day leadership versus long-term planning and organizational direction. |

**The 2026 Domains do not change what administrators are expected to know, but they organize practice areas in a more detailed and transparent way. If you prepared under the 2022 Domains, your foundational knowledge still applies; the content has been clarified and restructured, not replaced.**

**Download the new 2026 domains of practice:**

- CORE Domains of Practice
- NHA Domains of Practice

- RCAL Domains of Practice
- HCBS Domains of Practice
- All Lines of Service for NCERS Sponsors

**Why This Matters:**

- **Exams:** Updated domains will be reflected in the exams published **July 1, 2027**; score reporting will also be updated at that time to support expanded domain reporting.
- **Continuing Education (NCERS):** New domains will be added in the CE system in **fall 2026** for new and renewed programs.
- **Academic Accreditation:** Programs beginning or renewing accreditation in **2027** will be asked to use the new domains; key accreditation tools, like the self-assessment and crosswalk, are targeted for update in **fall 2026**.
- **Study Guide:** Updates will begin in **fall 2026**, with a goal to launch revised organization aligned to the new domains by **early 2027**.
- **Administrator Residence (AR)/AIT Preceptor Manual:** Materials are expected to be updated in **2027** to reflect the updated Domains of Practice and related KSAs.

**Download the current Domains of Practice, effective July 2022 to June 30, 2026.**

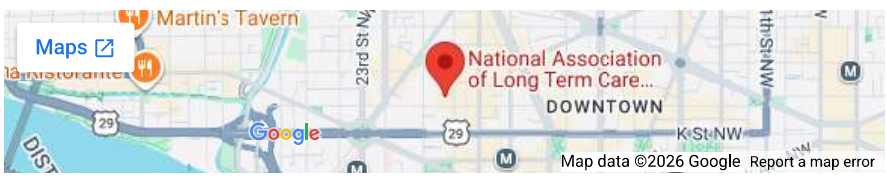
- CORE Domains of Practice
- NHA Domains of Practice
- RCAL Domains of Practice
- HCBS Domains of Practice
- All Lines of Service for NCERS Sponsors

1120 20th Street, NW Ste. 750
Washington, DC 20036, United States

Tel 202-712-9040



Our Location



| 1 | Quality of Care (Care, Services, and Supports) | 15 questions |
|---|---|---|
| **1.1** | **Medical and Nursing Care Practices** | |
| 1.1.1 | Establish and maintain policies and procedures of care and services for the care recipient's common and acute chronic conditions | |
| 1.1.2 | Educate and monitor to ensure interdisciplinary assessments and treatment of care recipient's common and acute chronic conditions | |
| 1.1.3 | Provide programs and practices to meet the acuity needs of the care recipient | |
| 1.1.4 | Maintain and standardize knowledge of medical terminology (e.g., definitions, abbreviations, prefixes, suffixes, acronyms) | |
| **1.2** | **Medication Management and Administration** | |
| 1.2.1 | Establish and maintain policies and procedures for pharmacy services | |
| 1.2.2 | Establish security processes for medication management (e.g., self-administration, med carts, med rooms) | |
| 1.2.3 | Establish processes to identify, track, monitor, and report medication errors | |
| 1.2.4 | Incorporate and monitor processes for medication storage, delivery, documentation, and disposal | |
| **1.3** | **Nutrition and Hydration** | |
| 1.3.1 | Establish and implement procedures for nutrition and hydration | |
| 1.3.2 | Identify care recipient's personal dietary preferences | |
| 1.3.3 | Address nutritional needs through dietary orders, specialized diets, and nutritional counseling | |
| 1.3.4 | Ensure appropriate clinical response to a significant change in weight | |
| 1.3.5 | Educate staff on recognition of the signs and symptoms of dehydration and malnutrition | |
| **1.4** | **Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)** | |
| 1.4.1 | Establish and maintain policies and procedures for addressing the care recipient’s functional needs | |
| 1.4.2 | Incorporate functional interventions and accommodations | |
| 1.4.3 | Ensure care recipients are assessed and appropriate interventions implemented | |
| **1.5** | **Rehabilitation and Restorative Programs** | |
| 1.5.1 | Establish and maintain policies and procedures for therapy programs and services | |
| 1.5.2 | Maintain knowledge of various therapy modalities | |
| 1.5.3 | Customize programming for restorative, wellness and rehabilitation services | |
| 1.5.4 | Ensure the provision of specialty equipment and accommodations | |
| **1.6** | **Care Recipient Assessment and Interdisciplinary Care Planning** | |
| 1.6.1 | Incorporate knowledge of service and care planning processes | |
| 1.6.2 | Establish and maintain policies and procedures for care recipient assessment and reassessment | |
| 1.6.3 | Create and identify holistic care plan goals and interventions | |
| 1.6.4 | Establish a process for timely and appropriate updates to the care plan to reflect the care recipient's needs and preferences | |
| 1.6.5 | Involve care recipient and/or their representative in the care-planning process | |
| **1.7** | **Clinical and Medical Records and Documentation Requirements for provision of care** | |
| 1.7.1 | Establish and maintain policies and procedures for creation and upkeep of medical records | |
| 1.7.2 | Maintain knowledge of physical and electronic medical records standards and necessary documentation | |
| 1.7.3 | Educate staff in appropriate documentation practices for medical records | |
| **1.8** | **Physician and Provider Services** | |
| 1.8.1 | Establish and maintain policies and procedures for physician and provider services | |
| 1.8.2 | Maintain oversight and enforce clinical practice guidelines | |
| 1.8.3 | Establish and maintain expectations for the role of the medical professionals | |
| **1.9** | **Emergency Medical Services** | |
| 1.9.1 | Establish and maintain policies and procedures for emergency response practices | |
| 1.9.2 | Ensure appropriate staff training and competencies (e.g., AED, CPR, Heimlich maneuver, first aid) | |
| 1.9.3 | Ensure knowledge and understanding of local emergency services | |
| **1.10** | **Transition of Care** | |
| 1.10.1 | Establish and maintain policies and procedures for level of care assessment and reassessment | |
| 1.10.2 | Maintain knowledge of appropriate services to meet the needs of care recipients’ acuity levels | |
| 1.10.3 | Ensure appropriate transition of care for admission, move-in, discharge, move-out, facility-initiated discharge and transfer | |
| **1.11** | **Pain Management** | |
| 1.11.1 | Establish and maintain policies and procedures to ensure the use of pain management assessments and practices to minimize pain and maximize relief | |
| 1.11.2 | Verify appropriate non-pharmacological methods for pain management are utilized prior to pharmacological methods | |
| 1.11.3 | Ensure interventions are reviewed on a routine basis to achieve the desired result | |
| **1.12** | **Ancillary Services** | |
| 1.12.1 | Establish contracts to ensure access to ancillary services (e.g., dental, diagnostic, hospice, palliative care, transportation, durable medical equipment) | |
| 1.12.2 | Establish relationships with non-affiliated medical providers (e.g., physicians, physician extenders) for in-person or telemedicine visits | |
| **2** | **Quality of Life (Care, Services, and Supports)** | **12 questions** |
| **2.1** | **Psychosocial Needs** | |
| 2.1.1 | Identify psychosocial needs (e.g., social, spiritual, community, cultural) that affect quality of life | |
| 2.1.2 | Implement practices to ensure a comprehensive evaluation is conducted to maximize care recipient's wellbeing | |
| 2.1.3 | Ensure care recipient's psychosocial needs are implemented into the care plan | |
| **2.2** | **Person-Centered Care** | |
| 2.2.1 | Promote person-centered care to ensure care recipient’s needs and preferences are incorporated to respect their dignity and autonomy | |
| 2.2.2 | Provide on-going staff education to promote person-centered care | |
| 2.2.3 | Invite the care recipient and/or responsible party to participate in the care of the recipient | |

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| **2.4** | **Care Recipient (and Representative) Grievance, Conflict, and Dispute Resolution** |
| 2.4.1 | Receive, investigate, and respond to complaints from care recipients and family members |
| 2.4.2 | Educate staff on the grievance process |
| 2.4.3 | Ensure the care recipient is protected from retaliation |
| **2.5** | **Care Recipient Advocacy and Support** |
| 2.5.1 | Facilitate opportunities for both care recipients and family members to provide input |
| 2.5.2 | Provide contact information for potential third party advocates that include the Ombudsman, regulatory oversight groups, etc. and actively participate in the resolution |
| 2.5.3 | Respond to recommendations or suggestions for improving quality of life for the care recipient |
| **2.6** | **Advance Decision-Making** |
| 2.6.1 | Encourage the development and regular review of advance directives (e.g., living will and durable power of attorney) |
| 2.6.2 | Develop a system to ensure care recipient's code status is consistent throughout all documentation and is effectively communicated to all relevant parties |
| **2.7** | **Surrogate Decision-Making** |
| 2.7.1 | Educate key staff on how to assess when a care recipient's capacity for decision making has declined |
| 2.7.2 | Initiate processes to establish the care recipient's legal decision-maker, when needed |
| 2.7.3 | Differentiate between the various legal surrogates (e.g., Guardianship, Power of Attorney, Conservatorship) |
| **2.8** | **Care Recipient (or Representative) Satisfaction** |
| 2.8.1 | Collect and analyze feedback to enhance care recipient (and representative) satisfaction |
| 2.8.2 | Implement processes to improve care recipient's (and representative) satisfaction |
| 2.8.3 | Educate staff on metrics collected for care recipient (and representative) satisfaction |
| **2.9** | **Maltreatment Recognition and Response** |
| 2.9.1 | Educate staff to identify the signs of abuse, neglect, and exploitation |
| 2.9.2 | Implement a process for reporting maltreatment, including abuse, neglect, and exploitation |
| 2.9.3 | Provide the ability to report maltreatment without the threat of retaliation |
| 2.9.4 | Implement systems to effectively respond to maltreatment incidents and to prevent future occurrences |
| **2.10** | **Mental and Behavioral Health** |
| 2.10.1 | Establish a process to appropriately assess and treat mental health needs (e.g., depression, anxiety, trauma-informed care) |
| 2.10.2 | Incorporate assessments to identify and respond to changes in cognition |
| 2.10.3 | Educate staff on comprehensive approaches to caring for individuals with memory care needs |
| 2.10.4 | Develop and execute a process to offer appropriate social supports |
| **2.11** | **Death, Dying, and Grief** |
| 2.11.1 | Educate staff on end-of-life services and practices for care recipients |
| 2.11.2 | Promote a holistic approach to the dying process based on care recipients' directives |
| 2.11.3 | Provide increased support for care recipients, family and staff throughout the grieving process |
| **2.14** | **Therapeutic Recreation and Activity Programs** |
| 2.14.1 | Incorporate therapeutic recreation and activities to provide cognitively and socially stimulating programs |
| 2.14.2 | Create a process to identify activities programs to address and support individual's needs and preferences |
| **2.15** | **Community Resources, Programs, and Agencies** |
| 2.15.1 | Identify services that can be utilized to meet care recipient needs (e.g., meals on wheels, housing vouchers, Area Agencies on Aging, Veterans Affairs) |
| 2.15.2 | Educate staff on the importance of coordinating community supports as part of care transition/discharge process |
| **3** | **Financial Management (Operations) — 10 questions** |
| **3.1** | **Budgeting and Forecasting** |
| 3.1.1 | Develop, implement, and evaluate necessary budgets (e.g., operating, capital, cash) |
| 3.1.2 | Anticipate and estimate projected revenues and expenses, including fixed and variable costs |
| 3.1.3 | Manage revenues and expenses (e.g., census, staffing, cost control) |
| 3.1.4 | Monitor the budget regularly to track financial performance and make necessary adjustments |
| **3.2** | **Financial Analysis and Reporting Requirements** |
| 3.2.1 | Operate a healthcare organization efficiently to optimize profitability and minimize losses without jeopardizing quality of care |
| 3.2.2 | Recognize the financial impact of various payor types for care recipients |
| 3.2.3 | Determine which financial statement provides specific information regarding financial operations |
| 3.2.4 | Make real-time decisions utilizing ratios and variance analyses (e.g., PPD, staffing, profit margin, break-even point, turnover, occupancy) |
| **3.3** | **Revenue and Expense Cycle Management** |
| 3.3.1 | Develop procedures for timely and accurate billing process |
| 3.3.2 | Develop and oversee a systematic approach for monitoring and collecting outstanding accounts receivable |
| 3.3.3 | Develop and oversee a system for receiving and tracking payments |
| 3.3.4 | Oversee the payroll process, including assigning responsibilities to managers to review, approve, and process timely payroll |
| **3.4** | **Revenue and Reimbursement** |
| 3.4.1 | Differentiate between third-party payor sources (e.g., Medicare, Medicaid, Veteran Administration, Private Insurance, Long Term Care Insurance) |
| 3.4.2 | Utilize health record data (e.g., EMR) to identify areas of favorable clinical outcomes to maximize clinical efficiencies and optimize financial reimbursement |
| 3.4.3 | Identify alternative payment models (e.g., Accountable Care Organizations (ACOs), Managed Care Organizations, Bundled payment models) |

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| **3.5** | **Internal Financial Management Controls** | |
| 3.5.1 | Implement a system of duties segregation to ensure the integrity of accounts | |
| 3.5.2 | Limit staff access to funds to ensure the integrity of accounts | |
| 3.5.3 | Identify potential areas of risk and implement controls to mitigate the risk | |
| **3.6** | **Supply-Chain and Inventory Management** | |
| 3.6.1 | Direct a process for ordering, receiving and inventorying supplies to provide quality of care | |
| 3.6.2 | Implement a system of controls to ensure fraud, waste, and abuse are minimized | |
| **4** | **Risk Management (Operations)** | **9 questions** |
| **4.1** | **Care Recipient Safety** | |
| 4.1.1 | Design and implement programs to mitigate adverse outcomes (e.g., fall prevention, elopement prevention) | |
| 4.1.2 | Establish a process to identify areas and/or care recipients' prone to adverse events | |
| 4.1.3 | Investigate and properly report resident incidents, accidents, and adverse events | |
| **4.2** | **Ethical Conduct and Standards of Practice** | |
| 4.2.1 | Establish and adhere to policies and procedures to prevent and detect criminal, civil, and administrative violations | |
| 4.2.2 | Enforce compliance with ethics standards for conduct | |
| **4.3** | **Compliance Programs** | |
| 4.3.1 | Develop and implement policies and procedures for compliance to detect, monitor, and resolve any types of behaviors that do not abide by applicable laws and regulations | |
| 4.3.2 | Ensure timely action is taken for identified areas of non-compliance | |
| 4.3.3 | Educate employees on recognizing and reporting concerns regarding ethical conduct and behavior | |
| **4.4** | **Risk Management and Legal Liability** | |
| 4.4.1 | Identify key areas of risk to develop policies and procedures to identify and mitigate risk exposure | |
| 4.4.2 | Educate staff on safety training, risk management, and protocols for incident reporting | |
| 4.4.3 | Develop crisis management procedures to respond to any incidents or areas of potential liability | |
| 4.4.4 | Educate internal and external stakeholders on the procedure to proactively reduce areas of risk and respond when incidents occur. | |
| 4.4.5 | Mitigate legal risk for incidents that may occur in the care setting | |
| **4.5** | **Quality Improvement Processes** | |
| 4.5.1 | Utilize effective improvement processes to ensure quality of care (e.g., root cause analysis, PDSA/PDCA, lean six sigma, fishbone, 5 why's) | |
| 4.5.2 | Develop, implement, and evaluate the organization's quality assurance and performance improvement programs | |
| **4.6** | **Internal Investigation Protocols and Techniques** | |
| 4.6.1 | Ensure staff understand proper procedures for documenting and reporting incidents and adverse events | |
| 4.6.2 | Identify situations that require an action plan to assess the need for legal representation | |
| **4.7** | **Insurance Coverage** | |
| 4.7.1 | Evaluate different insurance coverages to determine the most appropriate option for various scenarios (e.g., liability, property) | |
| **4.8** | **Contracting** | |
| 4.8.1 | Develop and monitor a process to oversee third party contracts and to handle any breach of contract | |
| 4.8.2 | Establish and execute a process to guide contract approvals, negotiations, renewals, and terminations | |
| **4.9** | **Information Systems Infrastructure** | |
| 4.9.1 | Design, configure, and maintain information systems infrastructure, ensuring technical controls and configurations align with organizational policies and industry best practices | |
| 4.9.2 | Implement and monitor data security measures, including access controls and technical safeguards, to protect sensitive information and maintain system integrity | |
| 4.9.3 | Ensure staff training on information technology and risks (e.g., AI tools, EMR tools) | |
| **4.10** | **Disaster and Emergency Planning, Preparedness, Response, and Recovery** | |
| 4.10.1 | Evaluate and update disaster and emergency policies and procedures | |
| 4.10.2 | Coordinate staff training and drills to effectively respond to emergency situations | |
| 4.10.3 | Develop and implement emergency preparedness plans to ensure safety, continuity of operations, and regulatory compliance during emergencies | |
| **5** | **Human Resources (Operations)** | **9 questions** |
| **5.1** | **Federal Human Resources Laws, Rules, and Regulations** | |
| 5.1.1 | Educate staff on and monitor compliance with Human Resource laws, rules and regulations (e.g., Americans with Disabilities Act, Family Medical Leave Act and the Department of Labor) | |
| 5.1.2 | Educate staff on and monitor compliance with Wage and Hour requirements (e.g., Fair Labor Standards Act, Unemployment Compensation, Workers Compensation and Consolidated Omnibus Budget Reconciliation Act) | |
| **5.2** | **Selection and Hiring Practices** | |
| 5.2.1 | Ensure that recruiting, application, interview, and hiring practices are in accordance with FLSA and Equal Employment Opportunity Commission (EEOC) standards (e.g., adverse impact, protected classes, occupational qualifications) | |
| 5.2.2 | Implement and monitor staffing to ensure care recipient needs are met and utilize outside resources to supplement staffing as needed (e.g., agency staff) | |
| 5.2.3 | Ensure that employees are screened and a thorough background check is completed utilizing required screenings (e.g. OIG Exclusion list, SAMS, State Medicaid Exclusion List) | |
| **5.3** | **Compensation and Benefits Programs** | |
| 5.3.1 | Establish and maintain policies and procedures to ensure compliance with compensation and benefit programs applicable to state and federal rules and regulations | |
| 5.3.2 | Maintain oversight of the development of compensation and benefit packages within budget and competitive allowances | |
| 5.3.3 | Design a competitive compensation package that considers wage (e.g., pay scale, merit system, shift differentials, overtime) and benefits (e.g., paid time off, healthcare insurance, retirement) | |

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| **5.4** | **Organizational Staffing Requirements and Compliance** |
| 5.4.1 | Establish staffing requirements to meet the needs of care recipients |
| 5.4.2 | Ensure staff meet all applicable professional licensing, qualifications, certifications, and credentialing requirements |
| **5.5** | **Employee Training (ongoing education)** |
| 5.5.1 | Establish policies and procedures to guide new employee onboarding and ongoing training |
| 5.5.2 | Maintain training and competency to professional standards |
| 5.5.3 | Explore internal and external opportunities for employee professional development |
| **5.6** | **Performance Evaluation** |
| 5.6.1 | Establish and maintain policies and procedures for conducting periodic formal evaluation of employee performance |
| 5.6.2 | Establish, maintain and implement policies and procedures for employee counseling, coaching, and job performance |
| 5.6.3 | Educate management staff in skills and strategies for carrying out performance evaluation systems (e.g., tools and approaches for conducting performance evaluations, methods of delivering timely and effective feedback, identifying and developing employees who meet or exceed standards) |
| 5.6.4 | Establish standards to objectively measure performance routinely and when an employee's performance or behavior does not meet standards |
| **5.7** | **Human Resource Policies** |
| 5.7.1 | Maintain and uphold human resources policies and procedures (e.g., drug-free workplace, progressive discipline, job classification, photography and video, social media and mobile phone usage) |
| 5.7.2 | Educate and communicate with employees regarding roles and responsibilities (e.g., written job description and expectations of each role, workplace rules, appropriate and sufficient continuing education) |
| **5.8** | **Personnel Recordkeeping Requirements** |
| 5.8.1 | Develop and maintain policies and procedures related to state and federal regulations related to personnel records (e.g., Age Discrimination Employee of 1967, The Fair Labor Standards Act of 1938, U.S. Equal Employment Opportunity Commission) |
| 5.8.2 | Ensure personnel records are kept in a secured environment with access limited only to authorized individuals |
| 5.8.3 | Identify additional requirements related to personnel recordkeeping, and implement practices to assure compliance (e.g., types and retention time of records, information, storage, and confidentiality requirements) |
| **5.9** | **Employee Grievance, Conflict, and Dispute Resolution** |
| 5.9.1 | Develop, implement and maintain policies, procedures, and processes to address and resolve conflicts or complaints from employees |
| 5.9.2 | Establish formal grievance procedures outlining how employees can communicate areas of discrimination, harassment, abuse, mistreatment and/or other concerns without the fear of retaliation or punitive consequences |
| 5.9.3 | Educate employees regarding the formal process for filing and resolving grievances, conflicts and disputes |
| **5.10** | **Employee Satisfaction, Engagement, and Retention** |
| 5.10.1 | Analyze organizational culture and develop tools to measure engagement, satisfaction and retention |
| 5.10.2 | Formulate a plan to increase the overall success of the organization using appropriate tools and resources (e.g., employee satisfaction surveys, exit interviews, employee retention methods and methods to reduce absenteeism and turnover) |
| **5.11** | **Cultural Competence and Awareness** |
| 5.11.1 | Develop a broad understanding of cultural competence to promote a positive, engaged and supportive culture (e.g., training programs, empathy building, conflict resolution strategies) |
| 5.11.2 | Establish a supportive culture to empower employees to embrace employee and care recipient rights |
| 5.11.3 | Encourage staff to report any violation of employee rights |
| **5.12** | **Labor Relations** |
| 5.12.1 | Foster a cooperative relationship between management and the labor force |
| 5.12.2 | Maintain knowledge of collective bargaining and labor relations laws and rules, and educate the labor force accordingly |
| 5.12.3 | Maintain knowledge of the National Labor Relations Act including negotiation, arbitration, and mediation |
| **5.13** | **Workers Compensation** |
| 5.13.1 | Ensure staff are educated on workers compensation protocols |
| 5.13.2 | Establish and enforce a comprehensive workers compensation program |
| 5.13.3 | Establish an interdisciplinary approach to mitigate risk in workers compensation claims |
| **6** | **Care Setting (Environment and Quality) — 9 questions** |
| **6.1** | **Federal Codes and Regulations for Building, Equipment, Maintenance, and Grounds** |
| 6.1.1 | Establish and maintain physical environment policies and procedures that comply with applicable requirements and regulations (e.g., LSC, FDA, EPA, Safe Devices Medical Act, NFPA) |
| **6.3** | **Safety and Accessibility** |
| 6.3.1 | Establish and uphold physical environment standards that ensure quality, safety, and accessibility for all care recipients (e.g., ADA) |
| 6.3.2 | Promote and sustain staff understanding and adherence to physical environment standards and regulations |
| **6.4** | **Environmental Services and Preventative/Routine Maintenance Programs** |
| 6.4.1 | Ensure effective environmental services including housekeeping and laundry services are provided |
| 6.4.2 | Develop a routine maintenance schedule to prevent unexpected equipment failures |
| 6.4.3 | Maintain documentation to show preventative maintenance is completed as required per policies and procedures |
| **6.5** | **Infection Control and Sanitation** |
| 6.5.1 | Plan, implement and validate infection control strategies to provide a safe and healthy environment |
| 6.5.2 | Develop and implement policies and procedures to prevent food borne illnesses by following proper food handling and storage protocols |
| 6.5.3 | Ensure a safe and secure care environment that includes consideration of infection control and sanitation (e.g., healthcare-acquired infections, linens) |
| 6.5.4 | Educate and monitor proper hand hygiene |

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| **6.6** | **Security** | |
| 6.6.1 | Develop and implement security policies and procedures to protect care recipients and staff including unauthorized entry or exit | |
| 6.6.2 | Assess care recipient's environment for safety, security, and accessibility (e.g., cameras, monitoring systems, locks, staff location reporting) | |
| **7** | **Regulatory Compliance (Environment and Quality)** | **13 questions** |
| **7.7** | **OSHA Rules and Regulations** | |
| 7.7.1 | Establish and maintain policies and procedures that comply with OSHA standards (e.g., Safety data sheets, Days Away, Restricted, or Transferred (DART), National Emphasis Programs (NEP), hazard communication, bloodborne pathogens) | |
| 7.7.2 | Ensure compliance with OSHA reporting requirements | |
| 7.7.3 | Train staff on applicable knowledge related to OSHA standards specific to their department to protect the health and safety of all individuals in the workplace | |
| **7.8** | **Mandatory Reporting Requirements** | |
| 7.8.1 | Recognize the different types of abuse (e.g., verbal, mental, physical, sexual, misappropriation of property, neglect) | |
| 7.8.2 | Assess and monitor incidents and adverse events and evaluate the need to escalate to appropriate authorities | |
| 7.8.3 | Establish, implement, and evaluate internal investigation and mandatory reporting requirements (e.g., Elder Justice Act) | |
| **7.9** | **Healthcare Record Administrative Requirements** | |
| 7.9.1 | Establish and maintain policies and procedures related to safeguarding the transmission of healthcare information. | |
| 7.9.2 | Ensure compliance with state and federal regulations regarding or pertaining to record keeping systems (e.g., record retention, backup systems) | |
| 7.9.3 | Educate and evaluate adherence to privacy acts and standards (e.g., HIPAA, HITECH). | |
| **8** | **Leadership (Leadership and Strategy)** | **13 questions** |
| **8.1** | **Organizational Behavior** | |
| 8.1.1 | Establish and lead an organizational culture that fosters professional development, employee engagement, ethical practice, and sensitivity to diverse backgrounds | |
| 8.1.2 | Establish a process for effective interdisciplinary and interdepartmental communication and coordination | |
| 8.1.3 | Utilize and adapt mission, vision, and values to drive organizational culture | |
| **8.2** | **Leadership Principles** | |
| 8.2.1 | Develop, implement, and evaluate business development and public relations practices | |
| 8.2.2 | Build employee trust to navigate change | |
| 8.2.3 | Develop strategies, tools, and practices to facilitate employee growth (e.g., mentoring, coaching, personal professional development) | |
| 8.2.4 | Employ change management processes, tools, and techniques to promote organizational transformation. | |
| **8.3** | **Governance** | |
| 8.3.1 | Fulfill the directives and mission as established by the governing body (e.g., board of directors, corporate entities, advisory boards) | |
| 8.3.2 | Effectively communicate with the governing body | |
| 8.3.3 | Comply with governing body expectations and requirements | |
| 8.3.4 | Ensure all governing body activities are aligned with federal laws and regulations | |
| **8.4** | **Professional Advocacy and Governmental Relations** | |
| 8.4.1 | Develop relationships with stakeholders and regulators (e.g., local, state, federal) | |
| 8.4.2 | Educate stakeholders and regulators on services provided, regulatory requirements, and standards of care | |
| 8.4.3 | Communicate impact of proposed policy changes | |
| **9** | **Organizational Strategy (Leadership and Strategy)** | **10 questions** |
| **9.1** | **Strategic Business Planning** | |
| 9.1.1 | Perform a market analysis to evaluate business opportunities and sustainability (e.g., new lines of service) | |
| 9.1.2 | Establish a succession plan to ensure business continuity | |
| 9.1.3 | Develop and manage strategic partnerships and alliances to drive growth and improve health care delivery | |
| **9.2** | **Business Analytics** | |
| 9.2.1 | Utilize internal and external data and tools (e.g., generative AI tools) to establish, plan, and evaluate organizational benchmarks to set goals, measure success, and guide decision-making | |
| 9.2.2 | Utilize practices based on measurable evidence (e.g., satisfaction surveys, health systems, Key Performance Indicators) | |
| 9.2.3 | Conduct feasibility studies to determine market opportunities | |
| **9.3** | **Business Development and Public Relations** | |
| 9.3.1 | Develop, execute, and evaluate a marketing plan | |
| 9.3.2 | Increase awareness of services and differentiate your organization | |
| 9.3.3 | Identify and engage in partnerships with a variety of healthcare entities | |
| 9.3.4 | Negotiate, interpret, and implement contractual agreements to optimize organizational performance and outcomes | |
| 9.3.5 | Foster an environment for business growth | |
| 9.3.6 | Utilize public relation strategies to develop meaningful stakeholder relationships | |
| 9.3.7 | Develop strategies to promote, monitor, and maintain brand awareness | |

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| 1 | Quality of Care (Care, Services, and Supports) | 12 questions |
|---|---|---|
| **1.1** | **Medical and Nursing Care Practices** | |
| 1.1.5 | Ensure that the resident receives treatment and care in accordance with professional standards of practice (e.g., pressure ulcers/injury, bowel and bladder, ostomy, dialysis, pain management) (42CFR483.25) | |
| **1.2** | **Medication Management and Administration** | |
| 1.2.5 | Establish, observe and monitor medication preparation and administration processes to ensure regulatory compliance (42CFR483.45) | |
| 1.2.6 | Verify appropriate storage and security of drugs and biologicals (42CFR483.45) | |
| 1.2.7 | Develop and maintain policies and procedures for drug regimen review, and prevention of the use of unnecessary drugs (e.g., psychotropic) (42CFR483.45(c)(5)) | |
| **1.3** | **Nutrition and Hydration** | |
| 1.3.6 | Establish and implement procedures for nutrition and hydration (e.g., nutritive value, food temperatures) (42CFR483.60, 42CFR483.25) | |
| **1.5** | **Rehabilitation and Restorative Programs** | |
| 1.5.5 | Educate staff to identify changes in condition that would require rehabilitation or restorative nursing services (e.g., range of motion, changes in mobility) (42CFR483.65) | |
| **1.6** | **Care Recipient Assessment and Interdisciplinary Care Planning** | |
| 1.6.6 | Ensure an accurate resident assessment instrument (RAI) is initiated and completed on admission and as needed in accordance with professional standards (42CFR483.20) | |
| 1.6.7 | Ensure the development and implementation of a baseline and comprehensive person-centered care plan that meets professional standards of quality care (42CFR483.21) | |
| 1.6.8 | Ensure compliance with all requirements in completing and submitting a Minimum Data Set (MDS) (42CFR483.20) | |
| **1.7** | **Clinical and Medical Records and Documentation Requirements for provision of care** | |
| 1.7.4 | Establish policies and procedures for residents to access personal medical records in a timely manner (42CFR483.10(g)(2)) | |
| **1.8** | **Physician and Provider Services** | |
| 1.8.4 | Develop policies and procedures to ensure timely visits and physician services (42CFR483.30(b)) | |
| 1.8.5 | Designate a physician to serve in the role as Medical Director and define their authority (42CFR483.70(g)) | |
| **1.9** | **Emergency Medical Services** | |
| 1.9.4 | Ensure facility personnel provides basic life support including CPR to a resident requiring such emergency care prior to arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives (42CFR483.24(a)(3)) | |
| **1.10** | **Transition of Care** | |
| 1.10.4 | Develop policies and procedures to communicate the bed hold policy and adhere to notice requirements (42CFR483.15(d)) | |
| 1.10.5 | Ensure a Pre-Admission Screening (PASRR) is completed for every resident prior to admission and as needed (42CFR483.20(k)) | |
| 1.10.6 | Develop a comprehensive program with education to ensure the transfer and/or discharge (facility or resident initiated) is documented in the medical record and notice requirements are met (42CFR483.15(c)(3-5)) | |
| **1.11** | **Pain Management** | |
| 1.11.4 | Develop policies and procedures to ensure pain management is provided to residents who require such services consistent with professional standards of practice (42CFR483.25(k)) | |
| **1.12** | **Ancillary Services** | |
| 1.12.3 | Develop policies and procedures to ensure emergency dental care (42CFR483.55) | |
| 1.12.4 | Develop policies and procedures to ensure diagnostic services are provided to meet the needs of the resident (42CFR483.50(a), 42CFR483.50(a)(1)) | |
| 1.12.5 | Assist the resident in arrangement of transportation services to and from the source of service (42CFR483.50(a)(2)) | |
| **2** | **Quality of Life (Care, Services, and Supports)** | **10 questions** |
| **2.2** | **Person-Centered Care** | |
| 2.2.4 | Develop policies and procedures to ensure residents with prior trauma receive culturally competent trauma informed care. (CFR483.25(m)) | |
| **2.3** | **Care Recipient Bill of Rights and Responsibilities** | |
| 2.3.1 | Educate staff and residents on the CMS protected resident rights. (42CFR483.10) | |
| 2.3.2 | Develop policies and procedures on informing residents of their rights in a timely manner and in a language they understand. (42CFR483.10(a)) | |
| **2.4** | **Care Recipient (and Representative) Grievance, Conflict, and Dispute Resolution** | |
| 2.4.4 | Develop policies and procedures to designate a Grievance Official to communicate and oversee the process of how to file a grievance and ensure prompt written summary of the resolution CFR483.10(j) | |
| **2.5** | **Care Recipient Advocacy and Support** | |
| 2.5.4 | Develop and implement policies to protect the rights of residents to organize and participate in resident groups in accordance with CMS guidance. (42CFR483.10(f)(5)) | |
| **2.9** | **Maltreatment Recognition and Response** | |
| 2.9.5 | Develop and implement policies to ensure timely reporting to applicable external agencies. CMS483.12(b) | |
| **2.12** | **Restraint Usage and Reduction** | |
| 2.12.1 | Develop policies and procedures to keep residents free from physical and chemical restraints (CMS483.10(e)(1) | |
| **2.13** | **Dining Experience** | |
| 2.13.1 | Protect the residents' right to choose the time, place and manner to receive meals in accordance with their personal preferences to enhance the overall dining experience (42CFR483.60) | |

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| **2.16** | **Volunteer Programs** | |
| 2.16.1 | Develop, implement and maintain policies and procedures related to training volunteers (42CFR483.95) | |
| **3** | **Financial Management (Operations)** | **8 questions** |
| **3.2** | **Financial Analysis and Reporting Requirements** | |
| 3.2.5 | Create and submit cost reports in a timely manner (e.g., Medicare, Medicaid) | |
| **3.4** | **Revenue and Reimbursement** | |
| 3.4.4 | Differentiate between third-party payor sources (e.g., Veteran Administration, private insurance, Patient Driven Payment Model (PDPM), value-based purchasing (VBP), consolidated billing) | |
| 3.4.5 | Adhere to federal regulations regarding third-party payors (e.g., admissions, expedited admission, continued stay in facility or transfer/discharge) (42CFR483.15) | |
| **3.7** | **Resident Trust Accounts for Personal Funds** | |
| 3.7.1 | Create policies to secure, manage, and audit resident funds (42CFR483.10(f)(10)) | |
| 3.7.2 | Provide documentation to the resident and/or responsible party of fund receipts and disbursements (42CFR483.10(f)(10)) | |
| 3.7.3 | Create policies to secure, manage, and audit surety bonds (42CFR483.10(f)(10)(vi)) | |
| **4** | **Risk Management (Operations)** | **7 questions** |
| **4.2** | **Ethical Conduct and Standards of Practice** | |
| 4.2.3 | Enforce compliance with ethics standards for conduct (42CFR483.95(f)) | |
| **4.5** | **Quality Improvement Processes** | |
| 4.5.3 | Develop, implement and maintain an effective comprehensive data driven Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life (42CFR483.75) | |
| 4.5.4 | Create an effective Quality Assessment and Assurance committee (QAA) (42CFR483.75) | |
| 4.5.6 | Provide mandatory staff training on the elements and goals of the Quality Assurance and Performance Improvement (QAPI) program (42CFR483.75) | |
| **4.10** | **Disaster and Emergency Planning, Preparedness, Response, and Recovery** | |
| 4.10.4 | Evaluate and update disaster and emergency policies and procedures (42CFR483.73) | |
| 4.10.5 | Coordinate staff training and drills to effectively respond to emergency situations (42CFR483.73) | |
| 4.10.6 | Develop and implement emergency preparedness plans to ensure safety, continuity of operations, and regulatory compliance during emergencies (e.g., State Operations Manual Appendix Z) (42CFR483.73) | |
| **5** | **Human Resources (Operations)** | **7 questions** |
| **5.4** | **Organizational Staffing Requirements and Compliance** | |
| 5.4.3 | Adhere to the federal reporting requirements including Payroll-Based Journal (PBJ) and National Healthcare Safety Network (NHSN) | |
| 5.4.4 | Ensure staff meet all applicable professional licensing, qualifications, certifications and credentialing (e.g., dietary manager, dietician, social worker, activity professional) | |
| **5.5** | **Employee Training (ongoing education)** | |
| 5.5.4 | Develop and administer mandatory employee training to ensure compliance with federal and state regulations, in accordance with their job descriptions (e.g., abuse & neglect, resident rights, fire safety, infection control, advance directives, feeding assistants) (42CFR483.95) | |
| 5.5.5 | Adhere to federal regulations regarding training, registry, and ongoing certifications of nursing aids (42CFR483.95) | |
| **5.6** | **Performance Evaluation** | |
| 5.6.5 | Conduct performance evaluations to ensure compliance with federal and state regulations (42CFR483.152)(42CFR483.35(d)(7)) | |
| **5.8** | **Personnel Recordkeeping Requirements** | |
| 5.8.4 | Ensure employee record files contain applications and qualifications, background and abuse registry checks, health screening and immunizations, orientation, education and competency records, and performance evaluations (42CFR483.12)(42CFR483.95) | |
| **5.11** | **Cultural Competence and Awareness** | |
| 5.11.4 | Educate nursing staff on competencies and skillsets needed to provide culturally competent and trauma-informed care (F699, F726) | |
| **6** | **Care Setting (Environment and Quality)** | **7 questions** |
| **6.1** | **Federal Codes and Regulations for Building, Equipment, Maintenance, and Grounds** | |
| 6.1.2 | Ensure the building is designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public (42CFR483.90, State Operations Manual Appendix Z) | |
| 6.1.3 | Implement applicable policies and procedures to comply with Life Safety Code | |
| **6.2** | **Person-Centered Environment** | |
| 6.2.1 | Ensure a safe, clean and home-like environment for the resident | |
| 6.2.2 | Ensure a person-centered environment and that includes adequate lighting, safe temperature, and sound level control | |
| 6.2.3 | Ensure the physical layout of each resident's space incorporates the ability to personalize and maximize independence and safety (42CFR483.24) | |
| **6.3** | **Safety and Accessibility** | |
| 6.3.3 | Ensure proper outside and mechanical ventilation systems are in place to maintain a safe environment (42CFR483.90(i)(1)) | |
| 6.3.4 | Ensure resident call systems are adaptable for all care recipients to include functional adaptability based on need (42CFR.483.90(g)) | |
| 6.3.5 | Educate and verify a person-centered approach is used when determining the use of bed rails, including conducting a comprehensive assessment, the medical need and the proper use (42CFR483.25 (n)) | |
| **6.4** | **Environmental Services and Preventative/Routine Maintenance Programs** | |
| 6.4.4 | Maintain an effective pest control program (42CFR483.90 (i)(4)) | |

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| **6.5** | **Infection Control and Sanitation** | |
| 6.5.5 | Maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections (ref. 42CFR483.80) | |
| 6.5.6 | Establish a system for preventing, identifying, reporting investigating and controlling infections and communicable diseases (42CFR483.80(a)(1)) | |
| 6.5.7 | Routinely educate and monitor staff to ensure compliance with all infection control practices | |
| 6.5.8 | Designate an individual who oversees an effective infection prevention and control program (42CFR483.80(b)) | |
| **7** | **Regulatory Compliance (Environment and Quality)** | **9 questions** |
| **7.1** | **Healthcare Laws, Rules, and Regulations** | |
| 7.1.1 | Ensure compliance with applicable rules, laws and regulations (e.g., OBRA of 1987, SOM Appendix PP, QSEP, CMS Policies and Memos) | |
| **7.2** | **Organizational Certification and Licensure Requirements** | |
| 7.2.1 | Adhere to licensing requirements in accordance with federal, state and local laws (42CFR483.70) | |
| **7.3** | **Regulatory Survey and Inspection Process** | |
| 7.3.1 | Develop a protocol for staff response to the regulatory survey process (SOM Chapter 7) | |
| 7.3.2 | Ensure knowledge of statements of deficiencies and develop and implement plans of correction to ensure regulatory compliance (SOM Chapter 7) | |
| 7.3.3 | Differentiate between the types of surveys (e.g., recertification, abbreviated, extended) (SOM Chapter 7) | |
| 7.3.4 | Ensure knowledge of survey terminology, time frames and enforcement remedies (SOM Chapter 7, SOM Appendix Q) | |
| **7.4** | **Procedures for Informal Dispute Resolution (IDR)** | |
| 7.4.1 | Differentiate between Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR) (e.g., SOM Chapter 7) | |
| **7.5** | **Centers for Medicare and Medicaid Services (CMS) Quality Measures** | |
| 7.5.1 | Analyze and assess the impact of CMS Quality Measures on facility operations (42CFR483.75(a)) | |
| 7.5.2 | Analyze and assess the impact of CMS Five Star Rating System on facility operations (42CFR483.75) | |
| 7.5.3 | Report, review and maintain data to ensure an effective, comprehensive, data-driven QAPI program (42CFR483.75) | |
| **7.6** | **Facility Assessment** | |
| 7.6.1 | Conduct and document a facility wide assessment to determine what resources are necessary to care for its residents (42CFR483.71) | |

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| | | |
|---|---|---|
| **1** | **Quality of Care (Care, Services, and Supports)** | **20 questions** |
| **1.1** | **Medical and Nursing Care Practices** | |
| 1.1.6 | Determine the ability to meet the changing care needs of the resident in their residential care setting | |
| 1.1.7 | Determine when the changing care needs exceed the scope of practice | |
| **1.2** | **Medication Management and Administration** | |
| 1.2.8 | Develop policies and procedures in compliance with state laws to optimize a medication management program within the community | |
| 1.2.9 | Establish policy and procedures for ongoing evaluation and implementation of resident self-administration of medication | |
| **1.3** | **Nutrition and Hydration** | |
| 1.3.7 | Monitor residents to assess changes in nutrition and hydration to determine if a change in level of care is needed | |
| **1.5** | **Rehabilitation and Restorative Programs** | |
| 1.5.6 | Assess and monitor residents' functionality and mobility on an ongoing basis to determine if a change in level of care is needed | |
| 1.5.7 | Coordinate rehabilitation programs with outside vendors as needed (e.g., home health, outpatient rehab) | |
| **1.6** | **Care Recipient Assessment and Interdisciplinary Care Planning** | |
| 1.6.9 | Assess and monitor residents on an ongoing basis to determine if a change in level of care is needed | |
| 1.6.10 | Develop and implement criteria and processes to determine appropriate services or alternate settings for the resident | |
| 1.6.11 | Educate all staff to monitor residents and report any changes in condition | |
| 1.6.12 | Develop criteria to evaluate the appropriateness of placement prior to move in | |
| **1.7** | **Clinical and Medical Records and Documentation Requirements for provision of care** | |
| 1.7.5 | Establish and maintain policies and procedures to ensure compliance with state laws regarding clinical medical records and documentation | |
| **1.10** | **Transition of Care** | |
| 1.10.7 | Establish policies and procedures on move-in, transfer, move-out, and involuntary discharge based on the scope of services allowed in the care setting | |
| **2** | **Quality of Life (Care, Services, and Supports)** | **20 questions** |
| **2.1** | **Psychosocial Needs** | |
| 2.1.4 | Engage residents to actively participate in community life, such as planning a variety of activities, social engagement and external community events and outings | |
| 2.1.5 | Educate staff in addressing the psychosocial needs of residents, encourage community life participation, identify withdrawn behaviors and respond appropriately | |
| **2.2** | **Person-Centered Care** | |
| 2.2.5 | Enable residents' choice in management of their daily schedule | |
| 2.2.6 | Educate staff to encourage and respect the individual resident needs and preferences | |
| 2.2.7 | Develop a framework to embody person-centered care within the community | |
| **2.3** | **Care Recipient Bill of Rights and Responsibilities** | |
| 2.3.3 | Establish policies and procedures to address the responsibilities of the community to uphold resident rights | |
| 2.3.4 | Create systems to identify infringements on resident rights | |
| 2.3.5 | Educate staff and residents on resident rights | |
| **2.5** | **Care Recipient Advocacy and Support** | |
| 2.5.5 | Coordinate robust resident and family councils to empower the residents to direct their lives within the community | |
| **2.13** | **Dining Experience** | |
| 2.13.2 | Establish a dining experience that promotes resident choice (e.g., menu planning, dining times) | |
| **2.14** | **Therapeutic Recreation and Activity Programs** | |
| 2.14.3 | Design activities programs to meet the needs and preferences of the residents (e.g., outings, types of activities, special events) | |
| 2.14.4 | Create an environment to enhance resident engagement | |
| 2.14.5 | Employ, train, and evaluate appropriately qualified activity staff | |
| **2.16** | **Volunteer Programs** | |
| 2.16.2 | Ensure coordination of volunteer programs | |
| 2.16.3 | Screen, orient, and train volunteers | |
| **3** | **Financial Management (Operations)** | **4 questions** |
| **3.2** | **Financial Analysis and Reporting Requirements** | |
| 3.2.6 | Determine the financial impact of changes in levels of care, including rate increases and ancillary services | |
| **4** | **Risk Management (Operations)** | **4 questions** |
| **4.1** | **Care Recipient Safety** | |
| 4.1.4 | Develop strategies to identify and monitor residents for changing care needs to mitigate risk for adverse events (e.g., fall prevention, elopement prevention) | |
| **6** | **Care Setting (Environment and Quality)** | **8 questions** |
| **6.2** | **Person-Centered Environment** | |
| 6.2.4 | Establish a culture to promote choice, comfort, and cleanliness | |
| 6.2.5 | Implement a home-like environment that supports the well-being and safety of all care recipients (e.g., lighting, sound, temperature, design) | |
| **7** | **Regulatory (Environment and Quality)** | **4 questions** |
| **7.1** | **Healthcare Laws, Rules, and Regulations** | |
| 7.1.2 | Ensure compliance with all applicable rules, laws and regulations | |
| **7.2** | **Organizational Certification and Licensure Requirements** | |
| 7.2.2 | Evaluate and monitor community certification and licensure policies and procedures to remain compliant with state and local rules and regulations | |

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| **7.3** | **Regulatory Survey and Inspection Process** |
| 7.3.5 | Maintain knowledge of the survey process |
| 7.3.6 | Create policies and procedures to comply with rules and regulations relative to the survey process |
| 7.3.7 | Educate all staff on their responsibilities to comply with all rules and regulations relative to the survey process |
| 7.3.8 | Establish procedures to respond to survey findings |

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| | | |
|---|---|---|
| **1** | **Quality of Care (Care, Services, and Supports)** | **14 questions** |
| **1.1** | **Medical and Nursing Care Practices** | |
| 1.1.8 | Provide skilled professional services in the patient's home to assess, plan, and deliver care in accordance with the patient's individualized plan of care (Home Health 42CFR 484.75). | |
| **1.2** | **Medication Management and Administration** | |
| 1.2.10 | Provide care recipient education on medication storage in the home | |
| 1.2.11 | Educate staff on content of hospice election statement addendum including medications not covered by hospice (42CFR418.106(a)(1)) | |
| **1.5** | **Rehabilitation and Restorative Programs** | |
| 1.5.8 | Ensure therapy services are available, and when provided, offered in a manner consistent with accepted standards of practice. (42CFR418.72) | |
| **1.6** | **Care Recipient Assessment and Interdisciplinary Care Planning** | |
| 1.6.13 | Assess and monitor care recipients on an ongoing basis to determine if a change in level of care is needed | |
| 1.6.14 | Educate all staff to monitor care recipients and report any changes in condition | |
| 1.6.15 | Develop policies and procedures to ensure the agency creates the individual plan of care based on each home care and/or hospice care recipient's needs (CFR 484.55, 42CFR418.56). | |
| **1.7** | **Clinical and Medical Records and Documentation Requirements for provision of care** | |
| 1.7.6 | Establish policies and procedures to ensure compliance with CMS requirements to complete and transmit comprehensive home health assessment in timely manner (CFR484.45(a)) | |
| 1.7.7 | Maintain accurate, complete, and secure clinical records for every patient receiving home health services, ensuring documentation meets regulatory standards (42 CFR 484.110). | |
| **1.8** | **Physician and Provider Services** | |
| 1.8.6 | Designate a physician to serve in the role as Medical Director and define their authority (42CFR418.102) | |
| **1.10** | **Transition of Care** | |
| 1.10.8 | Develop and implement an effective discharge planning process to ensure timely transfer of complete medical information and care goals. (42CFR 484.58, 42CFR418.26) | |
| **1.11** | **Pain Management** | |
| 1.11.5 | Develop policies and procedures to ensure pain management and symptom control (e.g., comprehensive pain assessment, interdisciplinary plan of care, patient rights). (42CFR418.52(c)(1)) | |
| **1.12** | **Ancillary Services** | |
| 1.12.6 | Ensure ongoing compliance with all Federal, State, and local laws and regulations governing laboratory services. (42CFR484.100(c), 418.116(b).) | |
| **2** | **Quality of Life (Care, Services, and Supports)** | **13 questions** |
| **2.1** | **Psychosocial Needs** | |
| 2.1.6 | Develop and maintain policy and procedure for the care recipient's psychosocial services (e.g., social worker, chaplain, bereavement) (42CFR418.64(c & d)) | |
| **2.3** | **Care Recipient Bill of Rights and Responsibilities** | |
| 2.3.6 | Maintain, monitor and enforce policies and procedures to address care recipients' rights and responsibilities (42CFR418.52) | |
| 2.3.7 | Educate staff and residents on resident rights (42CFR418.52) | |
| 2.3.8 | Inform home health care recipients and representatives of their rights and protect those rights (42 CFR 484.50) | |
| **2.4** | **Care Recipient (and Representative) Grievance, Conflict, and Dispute Resolution** | |
| 2.4.5 | Address complaints for home health care recipients and representatives rights in an accessible and timely manner. (42CFR 484.50) | |
| **2.8** | **Care Recipient (or Representative) Satisfaction** | |
| 2.8.4 | Establish policies and procedures to survey the required number of discharged care recipients and ensure data collection to meet specific quality and reporting compliance standards (42 CFR 484.250(a)) | |
| 2.8.5 | Maintain knowledge of and educate staff on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. (42CFR418.312(d)) | |
| **2.9** | **Maltreatment Recognition and Response** | |
| 2.9.6 | Develop and implement policies to ensure timely reporting to applicable external agencies. (CFR418.52(c)(6)) | |
| **2.12** | **Restraint Usage and Reduction** | |
| 2.12.2 | Develop policies and procedures to keep care recipients free from restraint or seclusion. (42CFR418.110(n)) | |
| **2.13** | **Dining Experience** | |
| 2.13.3 | For in-patient hospice individuals, furnish meals that are aligned with care recipient's needs and preferences, consistent with their plan of care, nutritional needs, and therapeutic diet. (42CFR418.110(m)) | |
| **2.16** | **Volunteer Programs** | |
| 2.16.4 | Develop, maintain and enforce volunteer services policies and procedures to comply with applicable regulations and requirements (CFR418.78) | |
| 2.16.5 | Develop and maintain a system for tracking and reporting volunteer hours to create a strong onboarding experience (CFR418.78) | |
| **3** | **Financial Management (Operations)** | **4 questions** |
| **3.2** | **Financial Analysis and Reporting Requirements** | |
| 3.2.5 | Create and submit cost reports in a timely manner (e.g., Medicare, Medicaid) | |
| 3.2.7 | Ensure timely and accurate submission of required Hospice Quality Reporting Program data in compliance with federal reporting requirements. (1814(i)(5) of the Social Security Act) | |
| 3.2.8 | Develop policies and procedures to submit quality data as specified under the expanded Home Heath Value Based Purchasing model and HHCAHPS surveys per CMS regulatory requirements for Home Health Agencies (CFR 484.355) | |

| | | |
|---|---|---|
| **3.4** | **Revenue and Reimbursement** | |
| 3.4.6 | Identify different payment models and episodic billing. (e.g., PDGM, value-based purchasing) | |
| 3.4.7 | Differentiate between third-party payor sources (e.g., PDGM, value-based purchasing) | |
| 3.4.8 | Ensure accurate and timely submission of required home health data (e.g., OASIS assessments, RAPs, NOAs and quality reporting measures) to CMS in accordance with Federal requirements to receive proper payment and avoid penalties. (CFR 484.205, 484.215, 484.220) | |
| **4** | **Risk Management (Operations)** | **7 questions** |
| **4.3** | **Compliance Programs** | |
| 4.3.4 | Ensure policies and procedures to comply with all state, federal, and local laws and regulations related to patient safety and health (42 CFR 484.100) | |
| **4.5** | **Quality Improvement Processes** | |
| 4.5.6 | Develop, implement, and enforce Quality Assurance and Performance Improvement (QAPI) program policies and procedures, ensuring compliance with regulations and active engagement of the interdisciplinary team throughout the process (42CFR484.65) | |
| 4.5.7 | Develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program (42CFR418.58). | |
| **4.10** | **Disaster and Emergency Planning, Preparedness, Response, and Recovery** | |
| 4.10.7 | Develop and implement emergency preparedness plans to ensure safety, continuity of operations, and regulatory compliance during emergencies (e.g., State Operations Manual Appendix Z) (42CFR484.102, 42CFR418.113(b)(1)) | |
| **5** | **Human Resources (Operations)** | **4 questions** |
| **5.4** | **Organizational Staffing Requirements and Compliance** | |
| 5.4.5 | Ensure home health staff meet all applicable professional licensing, qualifications, certifications and credentialing (e.g., Administrator, audiologist, clinical manager, home health aide, physical therapist) (42CFR484.115). | |
| 5.4.6 | Ensure hospice staff meet all applicable professional licensing, qualifications, certifications and credentialing (e.g., hospice aide, social worker, physical therapist, licensed nurse) (42CFR484.114). | |
| **6** | **Care Setting (Environment and Quality)** | **5 questions** |
| **6.2** | **Person-Centered Environment** | |
| 6.2.6 | Conduct a comprehensive safety assessment in the home to ensure staff and care recipient safety (e.g., pets, weapons, drugs, bug infestations) | |
| **6.5** | **Infection Control and Sanitation** | |
| 6.5.9 | Develop, maintain, and document a comprehensive infection control program that includes prevention, surveillance, control measures, and education for staff, care recipients, and caregivers in accordance with home health agency standards. (42CFR 484.70) | |
| 6.5.10 | Maintain and document an effective infection control program for hospice that protects care recipients, families, visitors, and personnel (42CRF418.60, 418.110) | |
| **7** | **Regulatory Compliance (Environment and Quality)** | **13 questions** |
| **7.1** | **Healthcare Laws, Rules, and Regulations** | |
| 7.1.3 | Ensure compliance with applicable rules, laws and regulations (e.g., CMS Policies and Memos, Hospice and Home Health CMS regulations) | |
| **7.2** | **Organizational Certification and Licensure Requirements** | |
| 7.2.3 | Evaluate and monitor agency certification and licensure policies and procedures to remain compliant with state, federal rules and regulations | |
| **7.3** | **Regulatory Survey and Inspection Process** | |
| 7.3.9 | Ensure the home health/hospice agency is prepared for surveys by maintaining compliance with conditions of participation | |
| **7.4** | **Procedures for Informal Dispute Resolution (IDR)** | |
| 7.4.2 | Ensure and maintain informal dispute resolution policies and procedures to comply with federal rules and regulations | |
| **7.5** | **Centers for Medicare and Medicaid Services (CMS) Quality Measures** | |
| 7.5.4 | Develop, implement, and evaluate the organization's process and performance for quality reporting | |
| 7.5.5 | Analyze and assess the impact of CMS Five Star Rating System on home health and hospice operations | |
| 7.5.6 | Analyze and assess the impact of CMS Quality Measures on home health and hospice operations | |

## DISCLAIMER

*NAB has shared a tertiary (task statement) level to the examination blueprint to give you a clear picture of the role of a senior living and health services leader. Please note that this is not an exhaustive list of everything you might need to know. As regulations and business practices change, the exam content is also updated to reflect the most current information.*

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# Legislative and Regulatory Reports

**Board of Long-Term Care Administrators**
**Regulatory Actions**
**As of June 2, 2026**

## In the Governor's Office

None.

## In the Secretary's Office

| VAC | Stage | Subject Matter | Submitted from agency | Time in current location | Notes |
|---|---|---|---|---|---|
| 18VAC95-20 | Fast-Track | Reduction of requirements for preceptors | 7/3/2025 | HHR; 88 days | Implements preceptor recommendations from RAP |

## At DPB or OAG

None.

## Recently effective/awaiting publication

| VAC | Stage | Subject Matter | Submitted for publication | Effective Date | Notes |
|---|---|---|---|---|---|
| 18VAC95-15 | NOIRA | Periodic review and implementation of resulting amendments to 18VAC95-15 | 12/29/2025 | 1/28/2026 | Announcement and implementation of periodic review for chapter 15. |
| 18VAC95-20 | NOIRA | Periodic review and implementation of resulting amendments to 18VAC95-20 | 3/9/2026 | 4/8/2026 | Announcement and implementation of periodic review for chapter 20 |
| 18VAC95-30 | NOIRA | Periodic review and implementation of resulting amendments to 18VAC95-30 | 12/29/2025 | 1/28/2026 | Announcement and implementation of periodic review for chapter 30 |

# Board Actions

# Adoption of the Electronic Meeting Policy (Virginia Code § 2.2-3708.3)

**Agenda Item: Readoption of electronic meeting policy**

**Included in your agenda package:**

- Electronic participation policy.

**Staff notes:** Virginia Code § 2.2-3708.3(D) requires public bodies to adopt electronic participation policies. The attached policy is consistent with the law and is applied across DHP.

**Action needed:**

- Motion to readopt the electronic participation policy.

# Virginia Department of Health Professions

## Meetings Held with Electronic Participation

**Purpose:**

To establish a written policy for allowing electronic participation of board or committee members for meetings of the health regulatory boards of the Department of Health Professions or their committees.

**Policy:**

Electronic participation by members of the health regulatory boards of the Department of Health Professions or their committees shall be in accordance with the procedures outlined in this policy.

**Authority:**

This policy for conducting a meeting with electronic participation shall be in accordance with Virginia Code § 2.2-3708.3.

**Procedures:**

1. One or more members of the Board or a committee may participate electronically if, on or before the day of a meeting, the member notifies the chair and the executive director that he/she is unable to attend the meeting due to:

    a. a temporary or permanent disability or other medical condition that prevents the member's physical attendance;

    b. a medical condition of a member of the member's family requires the member to provide care that prevents the member's physical attendance;

    c. the member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or

    d. the member is unable to attend the meeting due to a personal matter and identifies with specificity the nature of the personal matter.

    No member, however, may use remote participation due to personal matters more than two meetings per calendar year or 25% of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

2. Participation by a member through electronic communication means must be approved by the board chair or president. The reason for the member's electronic participation shall

be stated in the minutes in accordance with Virginia Code § 2.2-3708.3(A)(4). If a member's participation from a remote location is disapproved because it would violate this policy, it must be recorded in the minutes with specificity.

3. The board or committee holding the meeting shall record in its minutes the remote location from which the member participated; the remote location, however, does not need to be open to the public and may be identified by a general description.

# Review and Consideration of Recommendations from Legislative/Regulatory Committee

# Adoption of Proposed Regulations for Periodic Review (Chapters 18VAC95-15, 18VAC95-20, and 18VAC95-30)

**Agenda Item: Adoption of proposed regulatory action for periodic review**

**Included in your agenda package:**

- Draft changes to Chapter 15 as recommended by the Regulatory Committee;
- Draft changes to Chapter 20 as recommended by the Regulatory Committee; and
- Draft changes to Chapter 30 as recommended by the Regulatory Committee.

**Action needed:**

- Discussion; motion to adopt changes recommended by the Regulatory Committee.

**Project 8365 - Proposed**

**Board of Long-Term Care Administrators**

**Periodic review and implementation of resulting amendments to 18VAC95-15**

**18VAC95-15-10. ~~Decision to delegate.~~ (Repealed.)**

~~In accordance with subdivision 10 of § 54.1-2400 of the Code of Virginia, the board may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that a practitioner may be subject to a disciplinary action.~~

**18VAC95-15-20. ~~Criteria for delegation.~~ (Repealed.)**

~~Cases that may not be delegated to an agency subordinate include violations of standards of practice, except as may otherwise be determined by the executive director in consultation with the board chair.~~

**Project 8363 - Proposed**

**Board of Long-Term Care Administrators**

**Periodic review and implementation of resulting amendments to 18VAC95-20**

**18VAC95-20-10. Definitions.**

A. The following words and terms when used in this chapter shall have the definitions ascribed to them in § 54.1-3100 of the Code of Virginia:

"Board"

"Nursing home"

"Nursing home administrator"

B. The following words and terms when used in this chapter shall have the following meanings unless the context indicates otherwise:

"Accredited institution" means any degree-granting college or university accredited by an accrediting body approved by the U.S. Department of Education.

"Active practice" means a minimum of 1,000 hours of practice as a licensed nursing home administrator within the preceding 24 months.

"AIT" or "trainee" means a person enrolled in the administrator-in-training program in nursing home administration in a licensed nursing home.

"Administrator-of-record" means the licensed nursing home administrator designated in charge of the general administration of the facility and identified as such to the facility's licensing agency.

"Approved sponsor" means an individual, business, or organization approved by NAB or by an accredited institution to offer continuing education programs in accordance with this chapter.

"Continuing education" means the educational activities that serve to maintain, develop, or increase the knowledge, skills, performance, and competence recognized as relevant to the nursing home administrator's professional responsibilities.

"Domains of Practice" means the content areas of tasks, knowledge, and skills necessary for administration of a nursing home as approved by NAB.

"Full time" means employment of at least 35 hours per week.

"Hour" means 50 minutes of participation in a program for obtaining continuing education.

"Internship" means a practicum or course of study as part of a degree or post-degree program designed especially for the preparation of candidates for licensure as nursing home administrators that involves supervision by an accredited college or university of the practical application of previously studied theory.

"NAB" means the National Association of Long Term Care Administrator Boards.

"National examination" means a test used by the board to determine the competence of candidates for licensure as administered by NAB or any other examination approved by the board.

"Preceptor" means a nursing home administrator currently licensed and registered or recognized by a nursing home administrator licensing board to conduct an administrator-in-training (AIT) program.

**18VAC95-20-60. Posting of license.**

Each licensee shall post his license in a main entrance or place conspicuous to the residents and the public in the facility in which the licensee is administrator-of-record.

**18VAC95-20-80. Required fees.**

The applicant or licensee shall submit all fees in this section that apply:

| | |
|---|---|
| 1. AIT program application | $215 |

| | |
|---|---|
| 2. Preceptor application | $65 |
| 3. Licensure application | $315 |
| 4. Verification of licensure requests from other states | $35 |
| 5. Nursing home administrator license renewal | $315 |
| 6. Inactive nursing home administrator license renewal | $150 |
| 7. Preceptor renewal | $65 |
| 8. Fee for nursing home administrator late renewal | $110 |
| 9. Fee for preceptor late renewal | $25 |
| 10. Fee for late inactive licensure renewal | $35 |
| 11. Nursing home administrator reinstatement | $435 |
| 12. Preceptor reinstatement | $105 |
| 13. Duplicate license | $25 |
| 14. First wall certificate | $25 |
| ~~14.~~ 15. Duplicate wall certificates | $40 |
| ~~15.~~ 16. Reinstatement after disciplinary action | $1,000 |

**18VAC95-20-175. Continuing education requirements.**

A. In order to renew a nursing home administrator license, an applicant shall attest on the renewal application to completion of 20 hours of approved continuing education for each renewal year.

1. Up to 10 of the 20 hours may be obtained through Internet or self-study courses ~~and up to 10 continuing education hours in excess of the number required may be transferred or credited to the next renewal year~~.

2. Live coursework hours may be satisfied by attendance of:

a. In person programs or courses, or

b. Real-time, interactive programs delivered via teleconference or webcast where there is an opportunity to interact with the speaker.

3. Up to ten continuing education hours in excess of the number required may be transferred or credited to the next renewal year.

4. Up to two hours of the 20 hours required for annual renewal may be satisfied through delivery of services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for one hour of providing such volunteer services, as documented by the health department or free clinic.

~~3.~~ 5. At least two hours of continuing education for each renewal year shall relate to the care of residents with mental or cognitive impairments, including Alzheimer's disease and dementia.

~~4.~~ 6. A licensee who serves as the registered preceptor in an approved AIT or Assisted Living Facility AIT program may receive one hour of continuing education credit for each week of training up to a maximum of 10 hours of self-study course credit for each renewal year.

7. Up to two hours of the 20 hours required for annual renewal may be satisfied through attendance at a meeting of the board or a disciplinary proceeding conducted by the board at which the licensee is not a participant.

~~5.~~ 8. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following initial licensure.

B. In order for continuing education to be approved by the board, it shall be (i) related to health care administration and shall be approved or offered by NAB, an accredited institution, or a government agency or (ii) as provided in subdivision A 2 or A 7 of this section.

C. Documentation of continuing education.

1. The licensee shall retain in the licensee's personal files for a period of three renewal years complete documentation of continuing education, including evidence of attendance or participation as provided by the approved sponsor for each course taken.

2. Evidence of attendance shall be an original document provided by the approved sponsor and shall include:

a. Date the course was taken;

b. Hours of attendance or participation; and

c. Participant's name.

3. If contacted for an audit, the licensee shall forward to the board by the date requested a signed affidavit of completion on forms provided by the board and evidence of attendance or participation as provided by the approved sponsor or as documented in the NAB continuing education registry.

D. The board may grant an extension of up to one year or an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the administrator, such as a certified illness, a temporary disability, mandatory military service, or officially declared disasters. The request for an extension or exemption shall be received in writing and granted by the board prior to the renewal date.

**18VAC95-20-180. Late renewal.**

A. A person who fails to renew a license or preceptor registration by the expiration date may, within one year of the initial expiration date:

1. Return the renewal notice or request renewal in writing to the board; and

2. Submit the applicable renewal fee and late fee.; and

3. Provide evidence as may be necessary to establish eligibility for renewal.

B. The documents required in subsection A of this section shall be received in the board office within one year of the initial expiration date. Postmarks shall not be considered.

**18VAC95-20-201. Inactive licensure.**

A. A nursing home administrator who holds a current, unrestricted license in Virginia shall, upon a request for inactive status on the renewal application and submission of the required renewal fee, be issued an inactive license.

1. An inactive licensee shall not be entitled to perform any act requiring a license to practice nursing home administration or registration to serve as a preceptor in Virginia.

2. The holder of an inactive license shall not be required to meet continuing education requirements, except as may be required for reactivation in subsection B of this section.

B. A nursing home administrator who holds an inactive license may reactivate a license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the year in which the license is being reactivated; and

2. Providing proof of completion of the number of continuing competency hours required for the period in which the license has been inactive, not to exceed three years.

C. A preceptor registration for a nursing home administrator will expire as of the date that the license as a nursing home administrator becomes inactive. An expired preceptor registration may be reinstated in accordance with the provisions of 18VAC95-20-200.

**18VAC95-20-220. Qualifications for initial licensure.**

One of the following sets of qualifications is required for licensure as a nursing home administrator:

1. Degree and practical experience. The applicant shall (i) hold a baccalaureate or higher degree in a health care-related field that meets the requirements of 18VAC95-20-221 from

an accredited institution, (ii) have completed not less than a 320-hour internship that addresses the Domains of Practice as specified in 18VAC95-20-390 in a licensed nursing home as part of the degree program under the supervision of a preceptor, and (iii) have received a passing grade on the national examination;

2. Certificate program. The applicant shall (i) hold a baccalaureate or higher degree from an accredited college or university, (ii) successfully complete a certificate program with a minimum of 21 semester hours study in a health care-related field that meets the requirements of 18VAC95-20-221 from an accredited institution, (iii) successfully complete not less than a 400-hour internship that addresses the Domains of Practice as specified in 18VAC95-20-390 in a licensed nursing home as part of the certificate program under the supervision of a preceptor, and (iv) have received a passing grade on the national examination;

3. Administrator-in-training program. The applicant shall have (i) successfully completed an AIT program that meets the requirements of Part IV (18VAC95-20-300 et seq.) of this chapter and (ii) received a passing grade on the national examination; or

4. Health Services Executive (HSE) credential. The applicant shall provide evidence that the applicant has met the minimum education, experience, and examination standards established by NAB for qualification as a Health Services Executive.

**18VAC95-20-221. Required content for coursework.**

To meet the educational requirements for a degree in a health care-related field, an applicant must provide an official transcript from an accredited college or university that documents successful completion of a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services to include a minimum of three semester hours in each of the content areas in subdivisions 1 through 4 of this section, six semester hours

in the content area set out in subdivision 5 of this section, and three semester hours for an internship.

1. Customer care, supports, services: Course content shall address program and service planning, supervision, and evaluation to meet the needs of ~~patients~~ residents, such as (i) nursing, medical and pharmaceutical care; (ii) rehabilitative, social, psychosocial, and recreational services; (iii) nutritional services; (iv) safety and rights protections; (v) quality assurance; and (vi) infection control.

2. Human resources: Course content shall focus on personnel leadership in a health care management role and must address organizational behavior and personnel management skills such as (i) staff organization, supervision, communication, and evaluation; (ii) staff recruitment, retention, and training; (iii) personnel policy development and implementation; and (iv) employee health and safety.

3. Finance: Course content shall address financial management of health care programs and facilities such as (i) an overview of financial practices and problems in the delivery of health care services; (ii) financial planning, accounting, analysis, and auditing; (iii) budgeting; (iv) health care cost issues; and (v) reimbursement systems and structures.

4. Environment: Course content shall address facility and equipment management such as (i) maintenance, (ii) housekeeping, (iii) safety, (iv) inspections and compliance with laws and regulations, and (v) emergency preparedness.

5. Leadership and management: Course content shall address the leadership roles in health delivery systems such as (i) government oversight and interaction, (ii) organizational policies and procedures, (iii) principles of ethics and law, (iv) community coordination and cooperation, (v) risk management, and (vi) governance and decision making.

**18VAC95-20-400. Reporting requirements.**

A. The preceptor shall maintain progress reports on forms prescribed by the board for each month of training. The preceptor shall document in the progress report evidence of on-site supervision of the AIT training.

B. The AIT's final report of completion with the accumulated original monthly reports shall be submitted by the preceptor to the board within 30 days following the completion of the AIT program.

C. The preceptor shall maintain copies of progress and completion reports related to the training of the AIT for a period of not less than three years after the conclusion of the training.

**18VAC95-20-440. Interruption of program.**

A. If the program is interrupted because the registered preceptor is unable to serve, or if the AIT changes preceptors or training facilities, the AIT shall notify the board within ~~five~~ ten working days.

B. Credit for training shall resume when a new preceptor or training facility is obtained and approved by the board, provided a new preceptor or training facility is secured prior to the expiration of the AIT registration.

C. If an alternate training plan is developed, it shall be submitted to the board for approval before the AIT resumes training.

D. Credit for hours completed under an approved AIT program and reported to the board in accordance with 18VAC95-20-400 may be counted toward completion of an AIT program for a period of three years from the date of completion.

**18VAC95-20-470. Unprofessional conduct.**

The board may refuse to admit a candidate to an examination, refuse to issue or renew a license or registration or approval to any applicant, suspend a license for a stated period of time or indefinitely, reprimand a licensee or registrant, place his license or registration on probation with such terms and conditions and for such time as it may designate, impose a monetary penalty, or revoke a license or registration for any of the following causes:

1. Conducting the practice of nursing home administration in such a manner as to constitute a danger to the health, safety, and well-being of the residents, staff, or public;

2. Failure to comply with federal, state, or local laws and regulations governing the operation of a nursing home;

3. Conviction of a felony or any misdemeanor involving abuse, neglect, or moral turpitude;

4. Violating or cooperating with others in violating any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.), and 31 (§ 54.1-3100 et seq.) of the Code of Virginia or regulations of the board;

5. Inability to practice with reasonable skill or safety by reason of illness or substance abuse or as a result of any mental or physical condition;

6. Abuse, negligent practice, or misappropriation of a resident's property;

7. Entering into a relationship with a resident that constitutes a professional boundary violation in which the administrator uses his professional position to take advantage of the vulnerability of a resident or his family, to include actions that result in personal gain at the expense of the resident, an inappropriate personal involvement with a resident, or sexual conduct with a resident;

8. The denial, revocation, suspension, or restriction of a license to practice in another state, the District of Columbia, or a United States possession or territory;

9. Assuming duties and responsibilities within the practice of nursing home administration without adequate training or when competency has not been maintained;

10. Obtaining supplies, equipment, or drugs for personal or other unauthorized use;

11. Falsifying or otherwise altering resident or employer records, including falsely representing facts on a job application or other employment-related documents;

12. Fraud or deceit in procuring or attempting to procure a license or registration or seeking reinstatement of a license or registration; ~~or~~

13. Employing or assigning unqualified persons to perform functions that require a license, certificate, or registration~~.~~;

14. Engaging in a pattern of behavior or interaction in a health care setting that interferes with resident care or could reasonably be expected to adversely impact the quality of care and services rendered to a resident; or

15. The denial, revocation, suspension, surrender, or restriction of a license, certification, or registration to practice issued by a regulatory board in the Commonwealth of Virginia.

**Project 8364 - Proposed**

**Board of Long-Term Care Administrators**

**Periodic review and implementation of resulting amendments to 18VAC95-30**

**18VAC95-30-10. Definitions.**

A. The following words and terms when used in this chapter shall have the definitions ascribed to them in § 54.1-3100 of the Code of Virginia:

"Assisted living facility"

"Assisted living facility administrator"

"Board"

B. The following words and terms when used in this chapter shall have the following meanings unless the context indicates otherwise:

"Accredited institution" means any degree-granting college or university accredited by an accrediting body approved by the U.S. Department of Education.

"Active practice" means a minimum of 1,000 hours of practice as an assisted living facility administrator within the preceding 24 months.

"Administrator-of-record" means the licensed assisted living facility administrator designated ~~in charge of~~ as the person who is responsible for the general administration and management of an assisted living facility and who oversees the day-to-day operation of the facility, including compliance with applicable regulations, and identified as such to the facility's licensing agency.

"ALF AIT" or "trainee" means a person enrolled in an administrator-in-training program in a licensed assisted living facility.

"Approved sponsor" means an individual, business, or organization approved by NAB or by an accredited institution to offer continuing education programs in accordance with this chapter.

"Continuing education" means the educational activities that serve to maintain, develop, or increase the knowledge, skills, performance, and competence recognized as relevant to the assisted living facility administrator's professional responsibilities.

"Domains of Practice" means the content areas of tasks, knowledge and skills necessary for administration of a residential care or assisted living facility as approved by NAB.

"Full time" means employment of at least 35 hours per week.

"Hour" means 50 minutes of participation in a program for obtaining continuing education.

"Internship" means a practicum or course of study as part of a degree or post-degree program designed especially for the preparation of candidates for licensure as assisted living facility administrators that involves supervision by an accredited college or university of the practical application of previously studied theory.

"NAB" means the National Association of Long Term Care Administrator Boards.

"National examination" means a test used by the board to determine the competence of candidates for licensure as administered by NAB or any other examination approved by the board.

"Preceptor" means an assisted living facility administrator or nursing home administrator currently licensed and registered to conduct an ALF AIT program.

**18VAC95-30-20. Posting of license.**

Each licensee shall post his license in a main entrance or place conspicuous to the residents and the public in each facility in which the licensee is administrator-of-record.

**18VAC95-30-40. Required fees.**

A. The applicant or licensee shall submit all fees in this subsection that apply:

| | |
|---|---|
| 1. ALF AIT program application | $215 |
| 2. Preceptor application | $65 |
| 3. Licensure application | $315 |
| 4. Verification of licensure requests from other states | $35 |
| 5. Assisted living facility administrator license renewal | $315 |
| 6. Inactive license renewal | $150 |
| 7. Preceptor renewal | $65 |
| 8. Fee for assisted living facility administrator late renewal | $110 |
| 9. Fee for preceptor late renewal | $25 |
| 10. Fee for inactive license late renewal | $35 |
| 11. Assisted living facility administrator reinstatement | $435 |
| 12. Preceptor reinstatement | $105 |
| 13. Duplicate license | $25 |
| 14. First wall certificate | $25 |
| ~~14.~~ 15. Duplicate wall certificates | $40 |
| ~~15.~~ 16. Returned check or dishonored credit card or debit card | $50 |
| ~~16.~~ 17. Reinstatement after disciplinary action | $1,000 |

B. Fees shall not be refunded once submitted.

C. Examination fees are to be paid directly to the service or entity that administers the examination.

**18VAC95-30-70. Continuing education requirements.**

A. In order to renew an assisted living administrator license, an applicant shall attest on the applicant's renewal application to completion of 20 hours of approved continuing education for each renewal year.

1. Up to 10 of the 20 hours may be obtained through Internet or self-study courses ~~and up to 10 continuing education hours in excess of the number required may be transferred or credited to the next renewal year~~.

2. Live coursework hours may be satisfied by attendance of:

a. In person programs or courses, or

b. Real-time, interactive programs delivered via teleconference or webcast where there is an opportunity to interact with the speaker.

3. Up to ten continuing education hours in excess of the number required may be transferred or credited to the next renewal year.

4. Up to two hours of the 20 hours required for annual renewal may be satisfied through delivery of services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for one hour of providing such volunteer services, as documented by the health department or free clinic.

~~3.~~ 5. At least two hours of continuing education for each renewal year shall relate to the care of residents with mental or cognitive impairments, including Alzheimer's disease and dementia.

~~4.~~ 6. A licensee who serves as the registered preceptor in an approved ALF AIT program may receive one hour of continuing education credit for each week of training up to a maximum of 10 hours of self-study course credit for each renewal year.

7. Up to two hours of the 20 hours required for annual renewal may be satisfied through attendance at a meeting of the board or a disciplinary proceeding conducted by the board at which the licensee is not a participant.

~~5.~~ 8. A licensee is exempt from completing continuing education requirements for the first renewal following initial licensure in Virginia.

B. In order for continuing education to be approved by the board, it shall (i) be related to the Domains of Practice for residential care or assisted living and approved or offered by NAB, an accredited educational institution, or a governmental agency or (ii) be as provided in subdivision A 2 or A 7 of this section.

C. Documentation of continuing education.

1. The licensee shall retain in the licensee's personal files for a period of three renewal years complete documentation of continuing education, including evidence of attendance or participation as provided by the approved sponsor for each course taken.

2. Evidence of attendance shall be an original document provided by the approved sponsor and shall include:

a. Date the course was taken;

b. Hours of attendance or participation; and

c. Participant's name.

3. If contacted for an audit, the licensee shall forward to the board by the date requested a signed affidavit of completion on forms provided by the board and evidence of attendance or participation as provided by the approved sponsor or as documented in the NAB continuing education registry.

D. The board may grant an extension of up to one year or an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the administrator, such as a certified illness, a temporary disability, mandatory military service, or officially declared disasters. The request for an extension or exemption shall be submitted in writing and granted by the board prior to the renewal date.

**18VAC95-30-91. Inactive licensure.**

A. An assisted living facility administrator who holds a current, unrestricted license in Virginia shall, upon a request for inactive status on the renewal application and submission of the required renewal fee, be issued an inactive license.

1. An inactive licensee shall not be entitled to perform any act requiring a license to practice assisted living facility administration or registration to serve as a preceptor in Virginia.

2. The holder of an inactive license shall not be required to meet continuing education requirements, except as may be required for reactivation in subsection B of this section.

B. An assisted living facility administrator who holds an inactive license may reactivate such license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the year in which the license is being reactivated; and

2. Providing proof of completion of the number of continuing competency hours required for the period in which the license has been inactive, not to exceed three years.

C. A preceptor registration for an assisted living facility administrator will expire as of the date that the license as an assisted living facility administrator becomes inactive. An expired preceptor registration may be reinstated in accordance with the provisions of 18VAC95-30-90.

**18VAC95-30-100. Educational and training requirements for initial licensure.**

A. To be qualified for initial licensure as an assisted living facility administrator, an applicant shall hold a high school diploma or general education diploma (GED) and hold one of the following qualifications:

1. Administrator-in-training program.

a. Complete at least 30 semester hours of postsecondary education in an accredited college or university with at least 15 of the 30 semester hours in business or human services or a combination thereof and 640 hours in an ALF AIT program as specified in 18VAC95-30-150;

b. Complete an educational program as a licensed practical nurse and hold a current, unrestricted license or multistate licensure privilege and 640 hours in an ALF AIT program;

c. Complete an educational program as a registered nurse and hold a current, unrestricted license or multistate licensure privilege and 480 hours in an ALF AIT program;

d. Complete at least 30 semester hours in an accredited college or university with courses in the content areas of (i) client or resident care, (ii) human resources management, (iii) financial management, (iv) physical environment, and (v) leadership and governance, and 480 hours in an ALF AIT program;

e. Hold a master's or a baccalaureate degree in health care-related field or a comparable field that meets the requirements of subsection B of this section with no internship or practicum and 320 hours in an ALF AIT program;

f. Hold a master's or baccalaureate degree in an unrelated field and 480 hours in an ALF AIT program; or

g. Have at least three years of health care experience, to include at least one consecutive year in a managerial or supervisory role, in a health care setting within the five years prior to application and 640 hours in an ALF AIT program. For purposes of this qualification, these definitions shall apply: (i) "health care experience" means full-time equivalency experience in providing care to residents or patients in a health

care setting; (ii) "health care setting" means a licensed home health organization, licensed hospice program, licensed hospital or nursing home, licensed assisted living facility, licensed adult day program, or licensed mental health or developmental services facility; and (iii) "managerial or supervisory role" means an employment role that includes management responsibility and supervision of two or more staff.

2. Certificate program.

Hold a baccalaureate or higher degree in a field unrelated to health care from an accredited college or university and successfully complete a certificate program with a minimum of 21 semester hours study in a health care-related field that meets course content requirements of subsection B of this section from an accredited college or university and successfully complete not less than a 320-hour internship or practicum that addresses the Domains of Practice as specified in 18VAC95-30-160 in a licensed assisted living facility as part of the certificate program under the supervision of a preceptor; or

3. Degree and practical experience.

Hold a baccalaureate or higher degree in a health care-related field that meets the course content requirements of subsection B of this section from an accredited college or university and have completed not less than a 320-hour internship or practicum that addresses the Domains of Practice as specified in 18VAC95-30-160 in a licensed assisted living facility as part of the degree program under the supervision of a preceptor.

B. To meet the educational requirements for a degree in a health care-related field, an applicant must provide an official transcript from an accredited college or university that documents successful completion of a minimum of 21 semester hours of coursework

concentrated on the administration and management of health care services to include a minimum of six semester hours in the content area set out in subdivision 1 of this subsection, three semester hours in each of the content areas in subdivisions 2 through 5 of this subsection, and three semester hours for an internship or practicum.

1. Customer care, supports, and services~~;~~. Course content shall address program and service planning, supervision, and evaluation to meet the need of residents, such as (i) access to nursing, medical, and pharmaceutical services; (ii) rehabilitative, social, psycho-social, and recreational services; (iii) nutritional services; (iv) safety and rights protections; (v) quality assurance; and (vi) infection control.

2. Human resources~~;~~. Course content shall focus on personnel leadership in a health care management role and must address organizational behavior and personnel management skills such as (i) staff organization, supervision, communication, and evaluation; (ii) staff recruitment, retention, and training; (iii) personnel policy development and implementation; and (iv) employee health and safety.

3. Finance~~;~~. Course content shall address financial management of health care programs and facilities such as (i) an overview of financial practices and problems in the delivery of health care services; (ii) financial planning, accounting, analysis, and auditing; (iii) budgeting; (iv) health care cost issues; and (v) reimbursement systems and structures.

4. Environment~~;~~. Course content shall address facility and equipment management such as (i) maintenance; (ii) housekeeping; (iii) safety; (iv) inspections and compliance with laws and regulations; and (v) emergency preparedness.

5. Leadership and management. Course content shall address the leadership roles in health delivery systems such as (i) government oversight and interaction; (ii) organizational policies and procedures; (iii) principles of ethics and law; (iv) community

coordination and cooperation; (v) risk management; and (vi) governance and decision making.

**18VAC95-30-120. Qualifications for licensure by endorsement or credentials.**

A. If applying from any state or the District of Columbia in which a license, certificate, or registration is required to be the administrator of an assisted living facility, an applicant for licensure by endorsement shall hold a current, unrestricted license, certificate, or registration from that state or the District of Columbia. If applying from a jurisdiction that does not have such a requirement, an applicant may apply for licensure by credentials, and no evidence of licensure, certification, or registration is required.

B. The board may issue a license to any person who:

1. Meets the provisions of subsection A of this section;

2. Has not been the subject of a disciplinary action taken by any jurisdiction in which he was found to be in violation of law or regulation governing practice and which, in the judgment of the board, has not remediated;

3. Meets one of the following conditions:

a. Has been engaged in active practice as an assisted living facility administrator in an assisted living facility that provides assisted living care as defined in § 63.2-100 of the Code of Virginia; ~~or~~

b. Has education and experience substantially equivalent to qualifications required by this chapter and has provided written evidence of those qualifications at the time of application for licensure; ~~and~~ or

c. Holds a current, unrestricted license as a nursing home administrator in any state or the District of Columbia; and

4. Has successfully passed a national credentialing examination for administrators of assisted living facilities approved by the board.

**18VAC95-30-160. Required content of an ALF administrator-in-training program.**

A. Prior to the beginning of the training program, the preceptor shall develop and submit for board approval a training plan that shall include and be designed around the specific training needs of the administrator-in-training. The training plan shall include the tasks and the knowledge and skills required to complete those tasks as approved by NAB as the domains of practice for residential care/assisted living in effect at the time the training is being provided. An ALF AIT program shall include training in each of the learning areas as outlined in the NAB AIT Manual.

B. An ALF AIT shall be required to serve weekday, evening, night, and weekend shifts and to receive training in all areas of an assisted living facility operation.

C. An ALF AIT shall receive credit for no more than 40 hours of training per week.

D. An ALF AIT shall complete training on the care of residents with cognitive or mental impairments, including Alzheimer's disease and dementia.

**18VAC95-30-170. Training facilities.**

A. Training in an ALF AIT program or for an internship shall be conducted only in:

1. An assisted living facility or unit licensed by the Virginia Board of Social Services or by a similar licensing body in another jurisdiction;

2. An assisted living facility owned or operated by an agency of any city, county, or the Commonwealth or of the United States government; or

3. An assisted living unit located in and operated by a licensed hospital as defined in § 32.1-123 of the Code of Virginia, a state-operated hospital, or a hospital licensed in another jurisdiction.

B. Training in an ALF AIT program or for an internship shall not be conducted in:

1. An assisted living facility with a provisional license as determined by the Department of Social Services in which the AIT program is a new ALF AIT program;

2. An assisted living facility with a conditional license as determined by the Department of Social Services in which the AIT applicant is the owner of the facility; or

3. A facility that is licensed as residential only and does not require an administrator licensed by the Board of Long-Term Care Administrators~~; or~~.

~~4. An assisted living facility with a licensed resident capacity of fewer than 20 residents.~~

**18VAC95-30-190. Reporting requirements.**

A. The preceptor shall maintain progress reports on forms prescribed by the board for each month of training. The preceptor shall document in the progress report evidence of on-site supervision of the AIT training. For a person who is serving as an acting administrator while in an ALF AIT program, the preceptor shall include in the progress report evidence of face-to-face instruction and review for a minimum of four hours per week.

B. The trainee's final report of completion with the accumulated original monthly reports shall be submitted by the preceptor to the board within 30 days following the completion of the program.

C. The preceptor shall maintain copies of progress and completion reports related to the training of the AIT for a period of not less than three years after the conclusion of the training.

**18VAC95-30-200. Interruption or termination of program.**

A. If the program is interrupted because the registered preceptor is unable to serve, or if the trainee changes preceptors or training facilities, the trainee shall notify the board within 10 working days.

1. Credit for training shall resume when a new preceptor or training facility is obtained and approved by the board, provided a new preceptor or training facility is secured prior to the expiration of the AIT registration.

2. If an alternate training plan is developed, it shall be submitted to the board for approval before the trainee resumes training.

B. If the training program is terminated prior to completion, the trainee and the preceptor shall each submit a written explanation of the causes of program termination to the board within 10 business days. The preceptor shall also submit all required monthly progress reports completed prior to termination within 10 business days.

C. Credit for hours completed under an approved AIT program and reported to the board in accordance with 18VAC95-30-190 may be counted toward completion of an AIT program for a period of three years from the date of completion.

**18VAC95-30-201. Administrator-in-training program for acting administrators.**

A. A person who is in an ALF AIT program while serving as an acting administrator pursuant to § 54.1-3103.1 of the Code of Virginia shall be identified on his nametag as an acting administrator-in-training.

B. The facility shall post the certificate issued by the board for the acting administrator and a copy of the license of the preceptor in a place conspicuous to the residents and the public.

**18VAC95-30-210. Unprofessional conduct.**

The board may refuse to admit a candidate to an examination, refuse to issue or renew a license or registration or grant approval to any applicant, suspend a license or registration for a stated period of time or indefinitely, reprimand a licensee or registrant, place his license or registration on probation with such terms and conditions and for such time as it may designate, impose a monetary penalty, or revoke a license or registration for any of the following causes:

1. Conducting the practice of assisted living administration in such a manner as to constitute a danger to the health, safety, and well-being of the residents, staff, or public;

2. Failure to comply with federal, state, or local laws and regulations governing the operation of an assisted living facility;

3. Conviction of a felony or any misdemeanor involving abuse, neglect, or moral turpitude;

4. Violating or cooperating with others in violating any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.), and 31 (§ 54.1-3100 et seq.) of the Code of Virginia or regulations of the board;

5. Inability to practice with reasonable skill or safety by reason of illness or substance abuse or as a result of any mental or physical condition;

6. Abuse, negligent practice, or misappropriation of a resident's property;

7. Entering into a relationship with a resident that constitutes a professional boundary violation in which the administrator uses his professional position to take advantage of the vulnerability of a resident or his family, to include actions that result in personal gain at the expense of the resident, an inappropriate personal involvement with a resident, or sexual conduct with a resident;

8. The denial, revocation, suspension, or restriction of a license to practice in another state, the District of Columbia or a United States possession or territory;

9. Assuming duties and responsibilities within the practice of assisted living facility administration without adequate training or when competency has not been maintained;

10. Obtaining supplies, equipment, or drugs for personal or other unauthorized use;

11. Falsifying or otherwise altering resident or employer records, including falsely representing facts on a job application or other employment-related documents;

12. Fraud or deceit in procuring or attempting to procure a license or registration or seeking reinstatement of a license or registration; ~~or~~

13. Employing or assigning unqualified persons to perform functions that require a license, certificate, or registration~~.~~;

14. Engaging in a pattern of behavior or interaction in a health care setting that interferes with resident care or could reasonably be expected to adversely impact the quality of care and services rendered to a resident; or

15. The denial, revocation, suspension, surrender, or restriction of a license, certification, or registration to practice issued by a regulatory board in the Commonwealth of Virginia.

# Adoption of Proposed Revisions to Board Bylaws

# VIRGINIA BOARD OF LONG-TERM CARE ADMINISTRATORS

# BYLAWS

## ARTICLE I. GENERAL

A. The Virginia Board of Long-Term Care Administrators (Board) is established and operates pursuant to §§ 54.1-2400 et seq. and 54.1-3100 et seq. of the *Code of Virginia*. Regulations promulgated by the Board may be found in 18VAC95-11-10 et seq., "Public Participation Guidelines," 18VAC95-15-10 et seq., "Regulations Governing Delegation to an Agency Subordinate," 18VAC95-20-10 et seq., "Regulations Governing the Practice of Nursing Home Administrators," and 18VAC95-30-10 et seq., "Regulations Governing the Practice of Assisted Living Facility Administrators."

B. The Board is charged with promulgating and enforcing laws and regulations governing the licensure and practice of nursing home administrators and assisted living facility administrators in the Commonwealth of Virginia. This includes, but is not limited to, setting fees, creating requirements for licenses and registrations, setting standards of practice, and implementing a system for disciplinary action.

C. The mission of the Board and the Department of Health Professions is to ensure the delivery of safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to healthcare practitioners and the public.

## ~~Article~~ ARTICLE II. ~~Officers~~THE BOARD

### A. ~~Election, Terms of Office, Vacancies~~Members and Duties

1. The Board consists of nine members appointed by the Governor in accordance with Virginia Code § 54.1-3101.

2. Members of the Board are expected to attend all regular and special meetings of the full Board, meetings of committees to which they are assigned and all hearings conducted by the Board at which their attendance is requested by the Executive Director, unless prevented by illness or similar unavoidable cause. In the case of an unavoidable absence of any member from any meeting, the Chair may reassign the duties of such absent member.

3. In the event of two consecutive unexcused absences at any meeting of the Board or its committees, the Chair shall make a recommendation about the member's continued service to the Director of the Department of Health Professions for referral to the Secretary of Health and Human Resources and Secretary of the Commonwealth.

4. Members shall not hold a voting office in any related state professional association within the Commonwealth of Virginia that takes a policy position on the laws or regulations of the Board. Members holding a voting office in a national professional association shall abstain from voting on issues where there may be a conflict of interest present. This section shall

not apply to board members who hold a committee membership or an office with the National Association of Long Term Care Administrator Boards.

~~Election of Officers~~

**B.**

~~**1. Officers**~~

~~**2. The officers of the Virginia Board of Long-Term Care Administrators (Board) shall be a Chair and a Vice-Chair.**~~

~~**3. Election.**~~

1. The organizational year for the Board shall run from July 1st through June 30th.

~~**4.**~~ At the first meeting of the organizational year, the Board shall elect from its members a Chair and a Vice-Chair.

2.

~~**5. Terms of Office.**~~

3. The terms of office of the Chair and Vice-Chair shall be for one year. An officer may be re-elected in that same position for a second consecutive term.

4. Nominations for office shall be selected by voice vote~~open ballot~~, and election shall require a majority of the members present.

~~**6. Vacancies.**~~

~~A vacancy occurring in any office shall be filled by a special election at the next meeting of the Board.~~

5.

**C.** ~~**Article II.**~~ **Duties of Officers**

~~**1. Chair.**~~

1. ~~The~~ The Chair shall preside at all meetings~~; and conduct all business according to the Administrative Process Act and Robert's Rules~~; shall appoint all committees and committee chairpersons except where specifically provided by law; ~~shall appoint agency subordinates;~~ shall sign certificates and documents authorized to be signed by the Chair; and~~,~~ may serve as an ex-officio member of committees.

~~**2. Vice-Chair.**~~

2. ~~The~~ The Vice-Chair shall perform all duties of the Chair in the absence of the Chair, and shall assume the duties of Chair in the event of an unexpired term.

In the absence of the Chair and Vice-Chair, the Chair shall appoint another board member to preside at the meeting and/or formal administrative hearing.

3.

~~**Article III. Duties of Members**~~

~~**1. Qualifications.**~~

~~After appointment by the Governor, each member of the Board shall forthwith take the oath of office to qualify for service as provided by law.~~

~~**2. Attendance at meetings.**~~

~~Members of the Board shall attend all regular and special meetings of the full Board, meetings of committees to which they are assigned and all hearings conducted by the Board at which their attendance is requested by the Executive Director, unless prevented by illness or other unavoidable cause. In the case of an unavoidable absence of any member from any meeting, the Chair may reassign the duties of such absent member.~~

## ~~Article~~ ARTICLE ~~IV~~III. ~~Meeting~~MEETINGS

~~A. **Number.**~~

~~B.~~ The Board shall schedule at least three regular meetings in each year, with the right to change the date or cancel any board meeting, with the exception that a minimum of one board meeting will take place annually. The Chair shall call meetings at any time to conduct the business of the Board and shall convene conference calls when needed to act on summary suspensions and settlement offers. Special meetings shall be called by the Chair upon the written request of any three members of the Board.

A.

~~C. **Quorum.**~~

B. Five members of the Board, including one who is not a licensed nursing home administrator or assisted living facility administrator, shall constitute a quorum.

~~D. **Voting.**~~

C. All matters shall be determined by a majority vote of the members present.

## ~~Article~~ ARTICLE IV. ~~Committees~~COMMITTEES

~~1.~~**A. Standing Committees**~~.~~

1. As part of their responsibility to the Board, members appointed to a committee shall faithfully perform the duties assigned to the committee. The standing committees of the Board shall be the following:

~~a.~~ Legislative and Regulatory Committee

a.

~~b.~~ Credentials Committee

b.

~~Special Conference Committees~~

c.

~~2. Ad Hoc Committees.~~

The Chair may appoint an Ad Hoc Committee of two or more members of the Board to address a topic not assigned to a standing committee.

2.

**~~3.~~B. Committee Duties~~.~~**

~~a)~~1. Legislative/Regulatory Committee~~.~~

The Legislative/Regulatory Committee shall consist of two or more members, appointed by the Chair. This Committee shall:

a. ~~c~~consider matters bearing upon state and federal regulations and legislation and make recommendations to the Board regarding policy matters;

b. ~~. The Committee shall conduct a periodic review of the laws and regulations.~~ review public comment and recommend actions in response to petitions for rulemaking;

c. conduct a periodic review of the laws and regulations as required by the Board's Public Participation Guidelines and any Executive Order of the Governor;

d. develop proposals for new regulations or amendments to existing regulations;

e. review or develop proposals for legislative initiatives of the Board; and

f. review and recommend amendments to the Board's guidance and policy documents

In accordance with the Administrative Process Act, any proposed draft regulation and response to public comment shall be reviewed and approved by the full Board prior to publication. Proposed changes in ~~State laws or in the Regulations of the Board~~Board laws or regulations, guidance or policy documents, shall be distributed to all Board members for review prior to scheduled meetings of the Board.

~~b)~~2. Credentials Committee~~.~~

The Credentials Committee shall consist of two or more members appointed by the Chair and shall review all non-routine applications for licensure to determine if the applicant satisfies the requirements established by the Board. The committee shall review requests for exemptions from continuing education and may grant such requests for circumstances beyond the control of

the administrator on a one-time basis. The Committee shall not be required to meet collectively to complete initial reviews. The Committee chair shall provide guidance to staff on the action to be taken as a result of the initial review.

3. ~~c)~~ Special Conference Committee~~s.~~

The Special Conference Committee~~s~~ shall consist of two or more members appointed by the Chair. The Committee~~s~~ shall hold informal fact-finding conferences pursuant to Virginia Code §§ 2.2-4019, 2.2-4021, and 54.1-2400 of the Code of Virginia and provide guidance to staff on the disposition of disciplinary ~~-~~cases. The Chair may designate additional board members to serve as alternates on this committee who may be contacted to serve in the event one of the standing committee members becomes ill or is unable to attend a scheduled conference date. Further, should the caseload increase to the level that additional special conference committees are needed, the Chair may appoint additional committees.

## ~~Article~~ ARTICLE VI. E~~xecutive Director~~XECUTIVE DIRECTOR

~~1. Designation.~~

A. The Administrative Officer of the Board shall be designated the Executive Director of the Board.

~~2. Duties.~~

B. The Executive Director shall:

1. Supervise the operation of the Board office and be responsible for the conduct the staff and the assignment of cases to agency subordinates.
2. Carry out the policies and services established by the Board.
3. Provide and disburse all forms as required by law to include, but not be limited to, new and renewal application forms.
4. Keep accurate record of all applications for licensure, maintain a file of all applications and notify each applicant regarding the actions of the Board in response to their application. Prepare and deliver licenses to all successful applicants. Keep and maintain a current record of all licenses issued by the Board.
5. Notify all members of the Board of regular and special meetings of the Board. Notify all Committee members of regular and special meetings of Committees. Keep true and accurate minutes of all meetings and distribute such minutes to the Board members prior to the next meeting.
6. Issue all notices and orders, render all reports, keep all records and notify all individuals as required by these Bylaws or law. Affix and attach the seal of the Board to such documents, papers, records, certificates and other instruments as may be directed by law.
7. Keep accurate records of all disciplinary proceedings. Receive and certify all exhibits presented. Certify a complete record of all documents whenever and wherever required by law.

8. ~~Present the biennial budget with any revisions~~Provide budget information to the Board for review on a periodic basis~~d for approval~~.

## ~~Article~~ ARTICLE ~~VII~~: ~~General Delegation of Authority~~GENERAL DELEGATION OF AUTHORITY

### A. Delegation to Executive Director and/or Board Staff

1. ~~1.~~ The Board delegates to Board staff the authority to issue and renew licenses, registrations and certificates where minimum qualifications have been met.

2. ~~2.~~ The Board delegates to the Executive Director the authority to reinstate licenses, registrations and certificates when the reinstatement is due to the lapse of the license, registration or certificate and not due to previous Board disciplinary action, and there is no basis upon which the Board could refuse to reinstate ~~unless specified in the Board order~~.

3. ~~3.~~ The Board delegates to Board staff the authority to develop and approve any and all forms used in the daily operations of the Board business, to include, but not limited to, licensure applications, renewal forms, and documents used in the disciplinary process.

4. ~~4.~~ The Board delegates to the Executive Director the authority to sign as entered any agreement, Order or Board-approved Consent Order resulting from the disciplinary process.

5. ~~5.~~ The Board delegates to the Executive Director, who may consult with a special conference committee member, the authority to provide guidance to the agency's Enforcement Division in situations wherein a complaint is of questionable jurisdiction and an investigation may not be necessary or appropriate.

6. ~~6.~~ The Board delegates to the Executive Director, who shall consult with a member of the Board, the authority to review information regarding alleged violations of law or regulations and determine whether probable cause exists to proceed with possible disciplinary action.

7. The Board delegates to the Executive Director the authority to close non-jurisdictional cases without review by a board member.

~~7. The Board delegates to the Chair, the authority to represent the Board in instances where Board "consultation" or "review" may be requested where a vote of the Board is not required and a meeting is not feasible.~~

8. ~~8.~~ The Board delegates to the Executive Director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being convened.

9. ~~9.~~ The Board delegates to the Executive Director the authority to approve applications with criminal convictions in accordance with ~~Guidance Document 95-12~~the Board's policy, "Guidelines for Processing Applications for Licensure: Examination, Endorsement, and Reinstatement."

10. ~~10.~~ The Board delegates to the Executive Director the authority to grant an individual request for an extension of continuing education requirements for up to one (1) year for circumstances beyond the control of the administrator upon written request from the licensee prior to the renewal date.

11. ~~11.~~ The Board delegates to the Executive Director the authority to issue an Advisory Letter to the person who is the subject of a complaint pursuant to Virginia Code § 54.1-2400.2(G), when it is determined that a probable cause review indicates a disciplinary proceeding will not be instituted.

12. ~~12.~~ The Board delegates to the Executive Director the authority to offer a confidential consent agreement or a Consent Order for action consistent with any board-approved guidance document, or to negotiate a Consent Order in consultation with the chair of a Special Conference Committee or formal hearing.

13. The Board delegates to the Executive Director, who shall consult with the Board Chair, the authority to accept and to sign as entered any Consent Order for the surrender, suspension, or revocation of a license to end a pending disciplinary matter.

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15.

**B. Delegation to Board Chair**

The Board delegates to the Chair, the authority to represent the Board in instances where Board "consultation" or "review" may be requested where a vote of the Board is not required and a meeting is not feasible.

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The Board may delegate an informal fact-finding proceeding to an agency subordinate in accordance with 18VAC95-15-10 of the Board's Regulations Governing Delegation to an Agency Subordinate.

## ~~Article~~ ARTICLE VIII. ~~Amendments~~AMENDMENTS

A board member or the Executive Director may propose amendments to these Bylaws by presenting the amendment in writing to all Board members, the Executive Director of the Board, and the Board's legal counsel prior to any regularly scheduled meeting of the Board. Amendments to the bylaws shall become effective with a favorable vote of the majority of the board members present at said meeting.

Revised: _____

# VIRGINIA BOARD OF LONG-TERM CARE ADMINISTRATORS

# BYLAWS

## ARTICLE I. GENERAL

A. The Virginia Board of Long-Term Care Administrators (Board) is established and operates pursuant to §§ 54.1-2400 et seq. and 54.1-3100 et seq. of the *Code of Virginia*. Regulations promulgated by the Board may be found in 18VAC95-11-10 et seq., "Public Participation Guidelines," 18VAC95-15-10 et seq., "Regulations Governing Delegation to an Agency Subordinate," 18VAC95-20-10 et seq., "Regulations Governing the Practice of Nursing Home Administrators," and 18VAC95-30-10 et seq., "Regulations Governing the Practice of Assisted Living Facility Administrators."

B. The Board is charged with promulgating and enforcing laws and regulations governing the licensure and practice of nursing home administrators and assisted living facility administrators in the Commonwealth of Virginia. This includes, but is not limited to, setting fees, creating requirements for licenses and registrations, setting standards of practice, and implementing a system for disciplinary action.

C. The mission of the Board and the Department of Health Professions is to ensure the delivery of safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to healthcare practitioners and the public.

## ARTICLE II. THE BOARD

### A. Members and Duties

1. The Board consists of nine members appointed by the Governor in accordance with Virginia Code § 54.1-3101.

2. Members of the Board are expected to attend all regular and special meetings of the full Board, meetings of committees to which they are assigned and all hearings conducted by the Board at which their attendance is requested by the Executive Director, unless prevented by illness or similar unavoidable cause. In the case of an unavoidable absence of any member from any meeting, the Chair may reassign the duties of such absent member.

3. In the event of two consecutive unexcused absences at any meeting of the Board or its committees, the Chair shall make a recommendation about the member's continued service to the Director of the Department of Health Professions for referral to the Secretary of Health and Human Resources and Secretary of the Commonwealth.

4. Members shall not hold a voting office in any related state professional association within the Commonwealth of Virginia that takes a policy position on the laws or regulations of the Board. Members holding a voting office in a national professional association shall abstain from voting on issues where there may be a conflict of interest present. This section shall not apply to board members who hold a committee membership or an office with the National Association of Long Term Care Administrator Boards.

**B. Election of Officers**

1. The organizational year for the Board shall run from July 1st through June 30th.
2. At the first meeting of the organizational year, the Board shall elect from its members a Chair and a Vice-Chair.
3. The terms of office of the Chair and Vice-Chair shall be for one year. An officer may be re-elected in that same position for a second consecutive term.
4. Nominations for office shall be selected by voice vote, and election shall require a majority of the members present.
5. A vacancy occurring in any office shall be filled by a special election at the next meeting of the Board.

**C. Duties of Officers**

1. The Chair shall preside at all meetings;; shall appoint all committees and committee chairpersons except where specifically provided by law; shall sign certificates and documents authorized to be signed by the Chair; and may serve as an ex-officio member of committees.
2. The Vice-Chair shall perform all duties of the Chair in the absence of the Chair, and shall assume the duties of Chair in the event of an unexpired term.
3. In the absence of the Chair and Vice-Chair, the Chair shall appoint another board member to preside at the meeting and/or formal administrative hearing.

## ARTICLE III. MEETINGS

A. The Board shall schedule at least three regular meetings in each year, with the right to change the date or cancel any board meeting, with the exception that a minimum of one board meeting will take place annually. The Chair shall call meetings at any time to conduct the business of the Board and shall convene conference calls when needed to act on summary suspensions and settlement offers. Special meetings shall be called by the Chair upon the written request of any three members of the Board.

B. Five members of the Board, including one who is not a licensed nursing home administrator or assisted living facility administrator, shall constitute a quorum.

C. All matters shall be determined by a majority vote of the members present.

## ARTICLE IV. COMMITTEES

**A. Standing Committees**

1. As part of their responsibility to the Board, members appointed to a committee shall faithfully perform the duties assigned to the committee. The standing committees of the Board shall be the following:

a. Legislative and Regulatory Committee

b. Credentials Committee

c. Special Conference Committee

2. The Chair may appoint an Ad Hoc Committee of two or more members of the Board to address a topic not assigned to a standing committee.

**B. Committee Duties**

1. Legislative/Regulatory Committee

The Legislative/Regulatory Committee shall consist of two or more members, appointed by the Chair. This Committee shall:

a. consider matters bearing upon state and federal regulations and legislation and make recommendations to the Board regarding policy matters;

b. review public comment and recommend actions in response to petitions for rulemaking;

c. conduct a periodic review of the laws and regulations as required by the Board's Public Participation Guidelines and any Executive Order of the Governor;

d. develop proposals for new regulations or amendments to existing regulations;

e. review or develop proposals for legislative initiatives of the Board; and

f. review and recommend amendments to the Board's guidance and policy documents

In accordance with the Administrative Process Act, any proposed draft regulation and response to public comment shall be reviewed and approved by the full Board prior to publication. Proposed changes in Board laws or regulations, guidance or policy documents, shall be distributed to all Board members for review prior to scheduled meetings of the Board.

2. Credentials Committee

The Credentials Committee shall consist of two or more members appointed by the Chair and shall review all non-routine applications for licensure to determine if the applicant satisfies the requirements established by the Board. The committee shall review requests for exemptions from continuing education and may grant such requests for circumstances beyond the control of the administrator on a one-time basis. The Committee shall not be required to meet collectively to complete initial reviews. The Committee chair shall provide guidance to staff on the action to be taken as a result of the initial review.

3. Special Conference Committee

The Special Conference Committee shall consist of two or more members appointed by the Chair. The Committee shall hold informal fact-finding conferences pursuant to Virginia Code §§ 2.2-4019, 2.2-4021, and 54.1-2400 of the Code of Virginia and provide guidance to staff on the disposition of disciplinary cases. The Chair may designate additional board members to serve as alternates on this committee who may be contacted to serve in the event one of the standing committee members becomes ill or is unable to attend a scheduled conference date.

Further, should the caseload increase to the level that additional special conference committees are needed, the Chair may appoint additional committees.

## ARTICLE V. EXECUTIVE DIRECTOR

A. The Administrative Officer of the Board shall be designated the Executive Director of the Board.

B. The Executive Director shall:

1. Supervise the operation of the Board office and be responsible for the conduct the staff and the assignment of cases to agency subordinates.

2. Carry out the policies and services established by the Board.

3. Provide and disburse all forms as required by law to include, but not be limited to, new and renewal application forms.

4. Keep accurate record of all applications for licensure, maintain a file of all applications and notify each applicant regarding the actions of the Board in response to their application. Prepare and deliver licenses to all successful applicants. Keep and maintain a current record of all licenses issued by the Board.

5. Notify all members of the Board of regular and special meetings of the Board. Notify all Committee members of regular and special meetings of Committees. Keep true and accurate minutes of all meetings and distribute such minutes to the Board members prior to the next meeting.

6. Issue all notices and orders, render all reports, keep all records and notify all individuals as required by these Bylaws or law. Affix and attach the seal of the Board to such documents, papers, records, certificates and other instruments as may be directed by law.

7. Keep accurate records of all disciplinary proceedings. Receive and certify all exhibits presented. Certify a complete record of all documents whenever and wherever required by law.

8. Provide budget information to the Board for review on a periodic basis.

## ARTICLE VI: GENERAL DELEGATION OF AUTHORITY

**A. Delegation to Executive Director and/or Board Staff**

1. The Board delegates to Board staff the authority to issue and renew licenses, registrations and certificates where minimum qualifications have been met.

2. The Board delegates to the Executive Director the authority to reinstate licenses, registrations and certificates when the reinstatement is due to the lapse of the license, registration or certificate and not due to previous Board disciplinary action, and there is no basis upon which the Board could refuse to reinstate.

3. The Board delegates to Board staff the authority to develop and approve any and all forms used in the daily operations of the Board business, to include, but not limited to, licensure applications, renewal forms, and documents used in the disciplinary process.

4. The Board delegates to the Executive Director the authority to sign as entered any agreement, Order or Board-approved Consent Order resulting from the disciplinary process.

5. The Board delegates to the Executive Director, who may consult with a special conference committee member, the authority to provide guidance to the agency's Enforcement Division in situations wherein a complaint is of questionable jurisdiction and an investigation may not be necessary or appropriate.

6. The Board delegates to the Executive Director, who shall consult with a member of the Board, the authority to review information regarding alleged violations of law or regulations and determine whether probable cause exists to proceed with possible disciplinary action.

7. The Board delegates to the Executive Director the authority to close non-jurisdictional cases without review by a board member.

8. The Board delegates to the Executive Director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being convened.

9. The Board delegates to the Executive Director the authority to approve applications with criminal convictions in accordance with the Board's policy, "Guidelines for Processing Applications for Licensure: Examination, Endorsement, and Reinstatement."

10. The Board delegates to the Executive Director the authority to grant an individual request for an extension of continuing education requirements for up to one (1) year for circumstances beyond the control of the administrator upon written request from the licensee prior to the renewal date.

11. The Board delegates to the Executive Director the authority to issue an Advisory Letter to the person who is the subject of a complaint pursuant to Virginia Code § 54.1-2400.2(G), when it is determined that a probable cause review indicates a disciplinary proceeding will not be instituted.

12. The Board delegates to the Executive Director the authority to offer a confidential consent agreement or a Consent Order for action consistent with any board-approved guidance document, or to negotiate a Consent Order in consultation with the chair of a Special Conference Committee or formal hearing.

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# Adoption of Policy Document - Board Policy on Processing Requests for Additional Examination Attempts

Adopted:

# Virginia Board of Long-Term Care Administrators

## Board Policy on Processing Requests for Additional Examination Attempts with the National Association of Long Term Care Administrator Boards (NAB)

The National Association of Long Term Care Administrator Boards (NAB) owns and administers the national licensure examinations for administrators in the long-term care setting referred to as the CORE of Knowledge (CORE), Nursing Home Administrator (NHA), and Residential Care/Assisted Living (RCAL) exams.

Effective January 1, 2026, NAB has established limits for the number of times a candidate may attempt each examination during an examination cycle (July 1- June 30). Specifically, for the CORE, NHA, and RCAL examinations, there is a four (4) attempt limit per exam cycle. The attempt count resets each July 1st.

Where an exam candidate is ineligible to retake the CORE, NHA, or RCAL examinations due to reaching the attempt limit during the exam cycle, the candidate may present information to the relevant licensing authority that may then approve and transmit an additional attempt request to NAB on the candidate's behalf.

The Board will approve the candidate's request for an additional exam attempt within the exam cycle for transmittal to NAB pursuant to the guidelines below.

- The candidate seeking an additional exam attempt has an active licensure application on file with the Board has registered for prior attempts at NAB exams as a Virginia applicant. The Board will not consider the submission of an exam attempt request from exam candidates who have never previously applied to Virginia for licensure.
- The candidate has not had any disciplinary taken against them by a state board or by the NAB.
- The candidate has otherwise met the requirements for licensure in Virginia with the exception of passage of the NAB exam(s).
- The candidate (1) details the efforts they have made to remediate past NAB exam performance issues and to prepare for one additional attempt at taking the NAB exam(s); and (2) provides sufficient cause for requesting an additional examination attempt prior to the end of the exam cycle, at which time exam attempts reset.
- The request for an additional exam attempt is received more than 30 days after a prior exam attempt and more than 90 days from the end of the exam cycle (June 30th).
- The candidate has not submitted a prior request to the Board for an additional exam attempt.

# Presentations

DRAFT

# *Virginia's Nursing Home Administrator Workforce: 2026*

Healthcare Workforce Data Center

May 2026

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4434 (fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
***https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/***

***In total, 871 Nursing Home Administrators voluntarily participated in this survey.*** *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Long-Term Care Administrators express our sincerest appreciation for their ongoing cooperation.*

# *Thank You!*

***Virginia Department of Health Professions***

**David E. Brown, DC**
*Director*

*Healthcare Workforce Data Center Staff:*

| | | | |
|---|---|---|---|
| Yetty Shobo, PhD | Barbara Hodgdon, PhD | Rajana Siva, MBA | Christopher Coyle, BA |
| *Director* | *Deputy Director* | *Data Analyst* | *Research Assistant* |

## Virginia Board of Long-Term Care Administrators

***Chair***

Kimberly R. Brathwaite, ALFA
*Fairfax*

***Vice-Chair***

Jasmine Montgomery, NHA
*Dumfries*

***Members***

Todd Barnes, NHA
*Ridgeway*

Lynn Campbell
*Richmond*

Felita Creekmore, LPN, ALFA
*Suffolk*

Pamela Dukes, MBA
*Fincastle*

Charles Gaskins, III, DDS
*Henrico*

Latonya D. Hughes, PhD, RN, NHA
*Hampton*

Dennis Pregent, ALFA, NHA
*Powhatan*

***Executive Director***

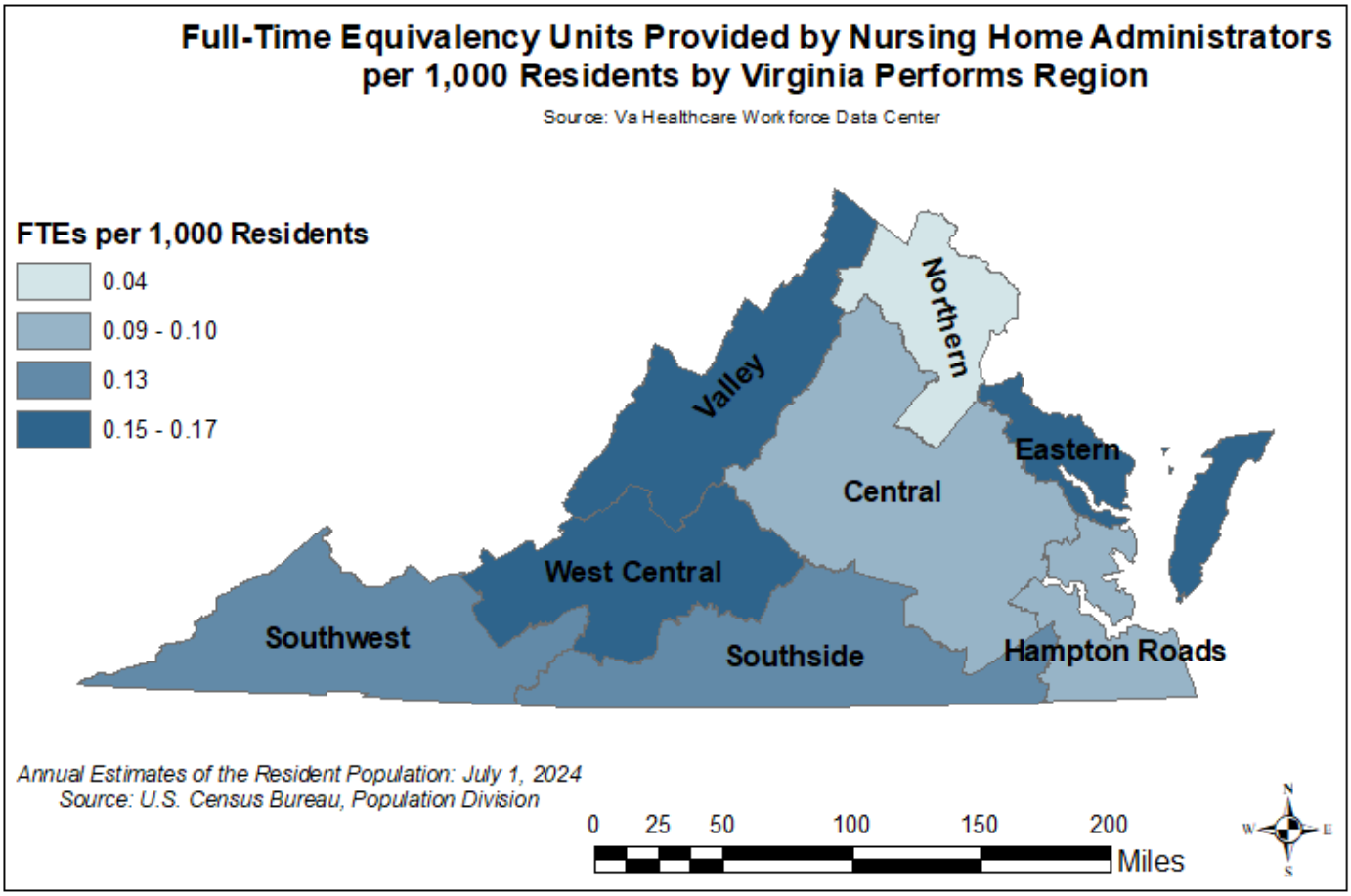
Corie E. Tillman Wolf, JD

## Contents

# The Nursing Home Administrator Workforce At a Glance:

| The Workforce | | Background | | Current Employment | |
|---|---|---|---|---|---|
| Licensees: | 992 | Rural Childhood: | 46% | Employed in Prof.: | 86% |
| Virginia's Workforce: | 783 | HS Degree in VA: | 53% | Hold 1 Full-Time Job: | 88% |
| FTEs: | 794 | Prof. Degree in VA: | 76% | Satisfied?: | 95% |
| **Survey Response Rate** | | **Health Admin. Edu.** | | **Job Turnover** | |
| All Licensees: | 88% | Admin-in-Training: | 40% | Switched Jobs: | 11% |
| Renewing Practitioners: | 99% | Masters: | 29% | Employed Over 2 Yrs.: | 46% |
| **Demographics** | | **Finances** | | **Time Allocation** | |
| Female: | 60% | Median Inc.: | $140k-$150k | Administration: | 30%-39% |
| Diversity Index: | 43% | Retirement Benefits: | 76% | Supervisory: | 20%-29% |
| Median Age: | 49 | Under 40 w/ Ed. Debt: | 61% | Patient Care: | 10%-19% |

*Source: Va. Healthcare Workforce Data Center*



## Results in Brief

This report contains the results of the 2026 Nursing Home Administrator (NHA) Workforce Survey. In total, 871 NHAs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every March for NHAs. These survey respondents represent 88% of the 992 NHAs licensed in the state and 99% of renewing practitioners.

The HWDC estimates that 783 NHAs participated in Virginia's workforce during the survey time period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's NHA workforce provided 794 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

Three out of every five NHAs are female, including 61% of those NHAs who are under the age of 40. In a random encounter between two NHAs, there is a 43% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 51% for those NHAs who are under the age of 40. The comparable diversity index for Virginia's overall population is 60%. Close to half of all NHAs grew up in a rural area, and 26% of NHAs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 15% of all NHAs work in a non-metro area of the state.

Among all NHAs, 86% are currently employed in the profession, 88% hold one full-time job, and 47% work between 40 and 49 hours per week. Nearly seven out of every ten NHAs work in the for-profit sector, while another 27% of NHAs work in the non-profit sector. At the same time, 57% of all NHAs are employed at a facility chain organization, while another 30% work at an independent or stand-alone organization. The typical NHA earns between $140,000 and $150,000 per year. In addition, 97% of all NHAs receive at least one employer-sponsored benefit. Among all NHAs, 95% are satisfied with their current work situation, including 64% who indicated that they are "very satisfied."

## Summary of Trends

In this section, all statistics for the current year are compared to the 2016 NHA workforce. The number of licensed NHAs in Virginia has increased by 12% (992 vs. 884). In addition, the size of the NHA workforce has increased by 13% (783 vs. 692), while the number of FTEs provided by this workforce has remained essentially constant (794 vs. 791). Virginia's renewing NHAs are more likely to respond to this survey (99% vs. 94%).

The percentage of all NHAs who are female has increased (60% vs. 58%), and this trend is even more pronounced among those NHAs who are under the age of 40 (61% vs. 52%). Over the same period, the diversity index of Virginia's NHA workforce has increased as well (43% vs. 21%), and this has also been the case among those NHAs who are under the age of 40 (51% vs. 25%). NHAs are more likely to have grown up in a rural area (46% vs. 42%), although NHAs who grew up in a rural area are less likely to work in a non-metro area of Virginia (26% vs. 29%). Furthermore, the percentage of all NHAs who work in a non-metro area of the state has fallen (15% vs. 18%).

While Virginia's NHAs are less likely to be employed in the profession (86% vs. 88%), they are more likely to hold one full-time job (88% vs. 87%) and work between 40 and 49 hours per week (47% vs. 42%). NHAs are more likely to start work in a new location (34% vs. 26%) and less likely to have worked at their primary work location for more than two years (46% vs. 56%). NHAs are more likely to be employed in the for-profit sector (69% vs. 61%) than in the non-profit sector (27% vs. 36%). In addition, NHAs are relatively more likely to work at an independent or stand-alone organization (30% vs. 24%) than at a facility chain organization (57% vs. 59%).

The median annual income of Virginia's NHA workforce has increased ($140k-$150k vs. $100k-$110k), and NHAs are more likely to receive at least one employer-sponsored benefit (97% vs. 94%). This includes NHAs who have access to dental insurance (80% vs. 78%) and a retirement plan (76% vs. 71%). While there has been a slight increase in the percentage of NHAs who indicated that they are satisfied with their current work situation (95% vs. 94%), the percentage of NHAs who indicated that they are "very satisfied" has declined (64% vs. 69%).

## A Closer Look:

| Licensees | | |
|---|---|---|
| **License Status** | **#** | **%** |
| **Renewing Practitioners** | 835 | 84% |
| **New Licensees** | 76 | 8% |
| **Non-Renewals** | 81 | 8% |
| **All Licensees** | **992** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*HWDC surveys tend to achieve very high response rates. Among all renewing NHAs, 99% submitted a survey. These respondents represent 88% of the 992 NHAs who held a license at some point in the past year.*

### Definitions

1. **The Survey Period:** The survey was conducted in March 2026.
2. **Target Population:** All NHAs who held a Virginia license at some point between April 2025 and March 2026.
3. **Survey Population:** The survey was available to NHAs who renewed their licenses online. It was not available to those who did not renew, including some NHAs newly licensed in the past year.

| Response Rates | | | |
|---|---|---|---|
| **Statistic** | **Non Respondents** | **Respondents** | **Response Rate** |
| **By Age** | | | |
| **Under 30** | 15 | 36 | 71% |
| **30 to 34** | 6 | 52 | 90% |
| **35 to 39** | 14 | 97 | 87% |
| **40 to 44** | 11 | 110 | 91% |
| **45 to 49** | 6 | 119 | 95% |
| **50 to 54** | 26 | 127 | 83% |
| **55 to 59** | 15 | 125 | 89% |
| **60 and Over** | 28 | 205 | 88% |
| **Total** | **121** | **871** | **88%** |
| **New Licenses** | | | |
| **Issued in Past Year** | 35 | 41 | 54% |
| **Metro Status** | | | |
| **Non-Metro** | 13 | 125 | 91% |
| **Metro** | 55 | 542 | 91% |
| **Not in Virginia** | 53 | 204 | 79% |

*Source: Va. Healthcare Workforce Data Center*

| Response Rates | |
|---|---|
| **Completed Surveys** | **871** |
| **Response Rate, All Licensees** | **88%** |
| **Response Rate, Renewals** | **99%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Licensed Administrators**

| | |
|---|---|
| Number: | 992 |
| New: | 8% |
| Not Renewed: | 8% |

**Response Rates**

| | |
|---|---|
| All Licensees: | 88% |
| Renewing Practitioners: | 99% |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Workforce**

| | |
|---|---|
| NHA Workforce: | 783 |
| FTEs: | 794 |

**Utilization Ratios**

| | |
|---|---|
| Licensees in VA Workforce: | 79% |
| Licensees per FTE: | 1.25 |
| Workers per FTE: | 0.99 |

*Source: Va. Healthcare Workforce Data Center*

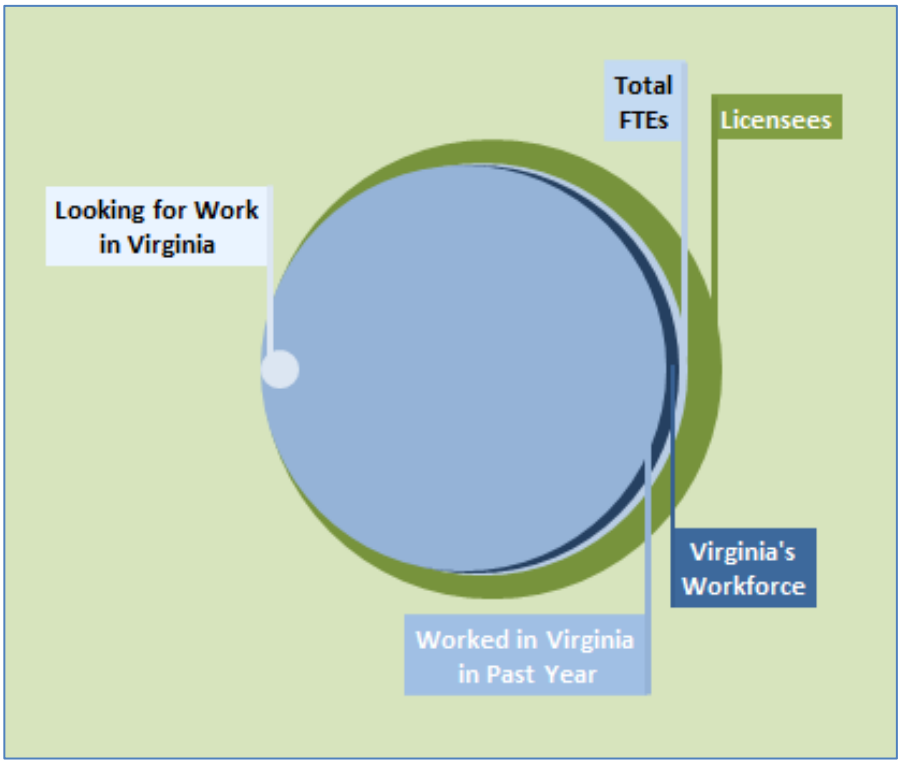
### Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

| Virginia's NHA Workforce | | |
|---|---|---|
| **Status** | **#** | **%** |
| **Worked in Virginia in Past Year** | 776 | 99% |
| **Looking for Work in Virginia** | 7 | 1% |
| **Virginia's Workforce** | **783** | **100%** |
| **Total FTEs** | **794** | |
| **Licensees** | **992** | |

*Source: Va. Healthcare Workforce Data Center*

*Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/*




*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Age & Gender | | | | | | |
|---|---|---|---|---|---|---|
| Age | Male | | Female | | Total | |
| | # | % Male | # | % Female | # | % in Age Group |
| **Under 30** | 14 | 31% | 31 | 69% | 45 | 6% |
| **30 to 34** | 21 | 47% | 24 | 53% | 45 | 6% |
| **35 to 39** | 34 | 39% | 52 | 61% | 85 | 12% |
| **40 to 44** | 38 | 42% | 54 | 58% | 92 | 13% |
| **45 to 49** | 40 | 42% | 54 | 58% | 94 | 14% |
| **50 to 54** | 31 | 29% | 75 | 71% | 106 | 15% |
| **55 to 59** | 34 | 38% | 55 | 62% | 89 | 13% |
| **60 and Over** | 67 | 49% | 71 | 52% | 139 | 20% |
| **Total** | **279** | **40%** | **416** | **60%** | **695** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| Race & Ethnicity | | | | | |
|---|---|---|---|---|---|
| Race/ Ethnicity | Virginia* | NHAs | | NHAs Under 40 | |
| | % | # | % | # | % |
| **White** | 58% | 500 | 72% | 113 | 64% |
| **Black** | 19% | 154 | 22% | 50 | 28% |
| **Asian** | 7% | 6 | 1% | 1 | 1% |
| **Other Race** | 0% | 4 | 1% | 2 | 1% |
| **Two or More Races** | 3% | 15 | 2% | 4 | 2% |
| **Hispanic** | 12% | 17 | 2% | 6 | 3% |
| **Total** | **100%** | **696** | **100%** | **176** | **100%** |

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2024.

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Gender**

| | |
|---|---|
| % Female: | 60% |
| % Under 40 Female: | 61% |

**Age**

| | |
|---|---|
| Median Age: | 49 |
| % Under 40: | 25% |
| % 55 and Over: | 33% |

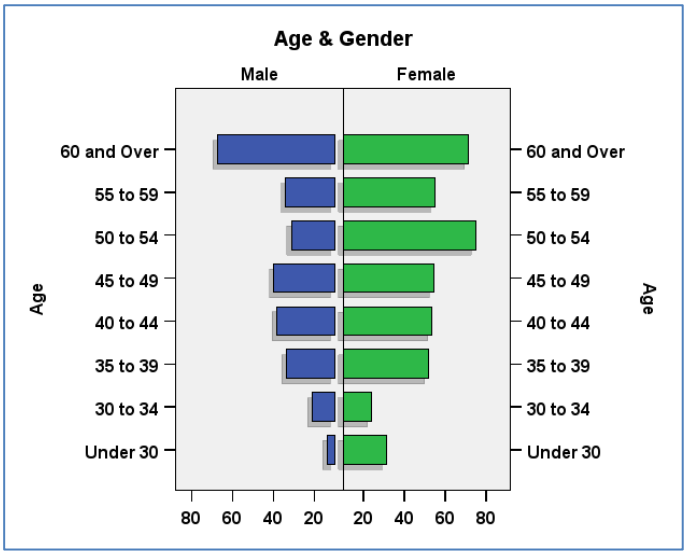
**Diversity**

| | |
|---|---|
| Diversity Index: | 43% |
| Under 40 Div. Index: | 51% |

*Source: Va. Healthcare Workforce Data Center*

*In a random encounter between two NHAs, there is a 43% chance that they would be of different races or ethnicities (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 60%.*

*One out of every four NHAs are under the age of 40, and 61% of NHAs who are under the age of 40 are female. In addition, the diversity index among NHAs who are under the age of 40 is 51%.*




*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Childhood**

| | |
|---|---|
| Urban Childhood: | 16% |
| Rural Childhood: | 46% |

**Virginia Background**

| | |
|---|---|
| HS in Virginia: | 53% |
| Prof. Edu. in VA: | 76% |
| HS or Prof. Edu. in VA: | 80% |

**Location Choice**

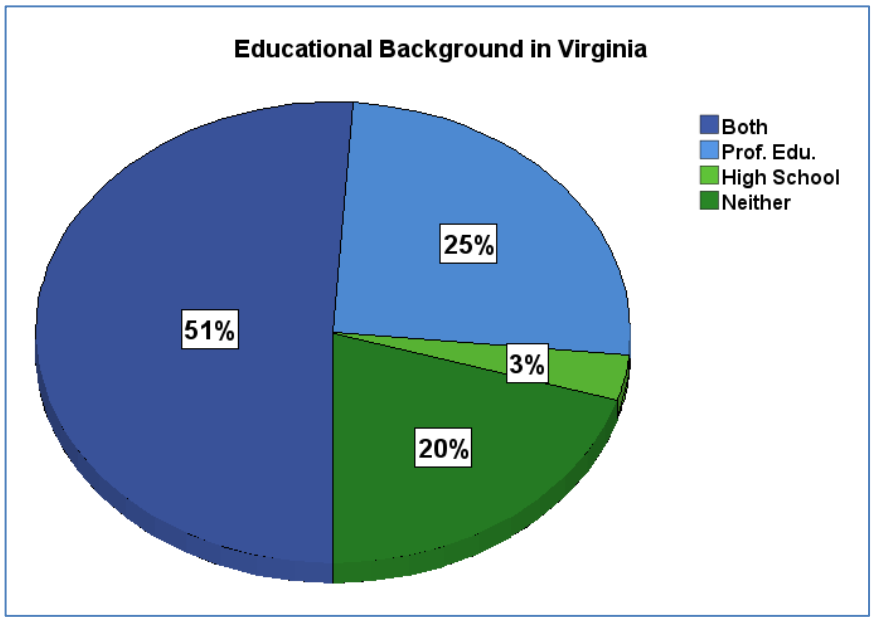
| | |
|---|---|
| % Rural to Non-Metro: | 26% |
| % Urban/Suburban to Non-Metro: | 6% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Primary Location: USDA Rural Urban Continuum | | Rural Status of Childhood Location | | |
|---|---|---|---|---|
| Code | Description | Rural | Suburban | Urban |
| | **Metro Counties** | | | |
| **1** | Metro, 1 Million+ | 32% | 46% | 22% |
| **2** | Metro, 250,000 to 1 Million | 54% | 36% | 10% |
| **3** | Metro, 250,000 or Less | 61% | 30% | 9% |
| | **Non-Metro Counties** | | | |
| **4** | Urban, Pop. 20,000+, Metro Adjacent | 63% | 31% | 6% |
| **6** | Urban, Pop. 2,500-19,999, Metro Adjacent | 75% | 17% | 8% |
| **7** | Urban, Pop. 2,500-19,999, Non-Adjacent | 81% | 10% | 10% |
| **8** | Rural, Metro Adjacent | 88% | 12% | 0% |
| **9** | Rural, Non-Adjacent | 100% | 0% | 0% |
| | **Overall** | **46%** | **38%** | **16%** |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Close to half of all NHAs grew up in a rural area, and 26% of NHAs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 15% of all NHAs currently work in a non-metro area of the state.*

## Top Ten States for Nursing Home Administrator Recruitment

| Rank | All Nursing Home Administrators | | | |
|---|---|---|---|---|
| | High School | # | Professional School | # |
| 1 | Virginia | 369 | Virginia | 481 |
| 2 | New York | 35 | Maryland | 23 |
| 3 | West Virginia | 30 | North Carolina | 18 |
| 4 | Pennsylvania | 28 | Ohio | 17 |
| 5 | Outside U.S./Canada | 27 | Tennessee | 10 |
| 6 | North Carolina | 27 | West Virginia | 8 |
| 7 | Ohio | 26 | Pennsylvania | 8 |
| 8 | Maryland | 23 | New York | 7 |
| 9 | Florida | 16 | Washington, D.C. | 6 |
| 10 | New Jersey | 14 | Minnesota | 5 |

*Source: Va. Healthcare Workforce Data Center*

*Among all NHAs, 53% received their high school degree in Virginia, and 76% received their initial professional degree in the state.*

*Among NHAs who have been licensed in the past five years, 49% received their high school degree in Virginia, and 74% received their initial professional degree in the state.*

| Rank | Licensed in the Past Five Years | | | |
|---|---|---|---|---|
| | High School | # | Professional School | # |
| 1 | Virginia | 113 | Virginia | 155 |
| 2 | North Carolina | 13 | North Carolina | 8 |
| 3 | West Virginia | 11 | Maryland | 7 |
| 4 | Outside U.S./Canada | 10 | Tennessee | 4 |
| 5 | Florida | 9 | West Virginia | 4 |
| 6 | Pennsylvania | 9 | Florida | 4 |
| 7 | Maryland | 8 | Washington, D.C. | 4 |
| 8 | New York | 8 | Ohio | 3 |
| 9 | New Jersey | 5 | Minnesota | 3 |
| 10 | Illinois | 5 | Montana | 3 |

*Source: Va. Healthcare Workforce Data Center*

*More than one out of every five licensees were not a part of Virginia's NHA workforce. Among these licensees, 91% worked at some point in the past year, including 66% who currently work as an NHA.*

## At a Glance:

**Not in VA Workforce**

| | |
|---|---|
| Total: | 209 |
| % of Licensees: | 21% |
| Federal/Military: | 1% |
| VA Border State/DC: | 15% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Highest Degree | | | | |
|---|---|---|---|---|
| Degree | Health Administration | | Degree in All Fields | |
| | # | % | # | % |
| No Specific Training | 19 | 3% | - | - |
| Admin-in-Training | 266 | 40% | - | - |
| High School/GED | - | - | 9 | 1% |
| Associate | 12 | 2% | 38 | 6% |
| Baccalaureate | 141 | 21% | 292 | 42% |
| Graduate Cert. | 13 | 2% | 13 | 2% |
| Masters | 192 | 29% | 316 | 46% |
| Doctorate | 18 | 3% | 20 | 3% |
| Other | 12 | 2% | - | - |
| **Total** | **672** | **100%** | **689** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Health Admin. Education**

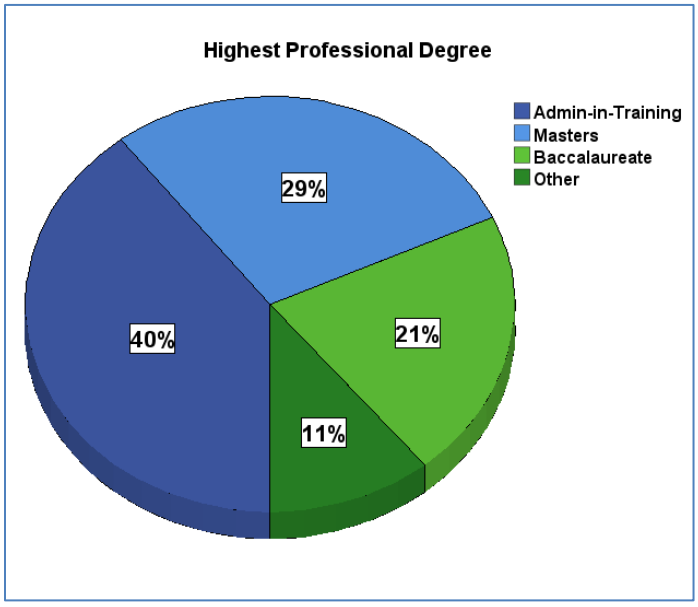
Admin-in-Training: 40%
Master's Degree: 29%
Baccalaureate Degree: 21%

**Education Debt**

Carry Debt: 43%
Under Age 40 w/ Debt: 61%
Median Debt: $50k-$60k

*Source: Va. Healthcare Workforce Data Center*

*More than two out of every five NHAs carry education debt, including 61% of NHAs who are under the age of 40. For those with education debt, the median outstanding balance is between $50,000 and $60,000.*




*Source: Va. Healthcare Workforce Data Center*

| Education Debt | | | | |
|---|---|---|---|---|
| Amount Carried | All NHAs | | NHAs Under 40 | |
| | # | % | # | % |
| None | 337 | 57% | 56 | 38% |
| Less than $10,000 | 22 | 4% | 7 | 5% |
| $10,000-$19,999 | 25 | 4% | 13 | 9% |
| $20,000-$29,999 | 23 | 4% | 7 | 5% |
| $30,000-$39,999 | 16 | 3% | 2 | 1% |
| $40,000-$49,999 | 33 | 6% | 13 | 9% |
| $50,000-$59,999 | 23 | 4% | 8 | 5% |
| $60,000-$69,999 | 19 | 3% | 6 | 4% |
| $70,000-$79,999 | 12 | 2% | 5 | 3% |
| $80,000-$89,999 | 11 | 2% | 3 | 2% |
| $90,000-$99,999 | 10 | 2% | 4 | 3% |
| $100,000 or More | 62 | 10% | 23 | 15% |
| **Total** | **594** | **100%** | **149** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Licenses/Registrations**

| | |
|---|---|
| Nurse (RN or LPN): | 11% |
| ALFA: | 5% |
| CNA: | 2% |

**Job Titles**

| | |
|---|---|
| Administrator: | 43% |
| Executive Director: | 15% |
| President/Exec. Officer: | 10% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Licenses and Registrations | | |
|---|---|---|
| **License/Registration** | **#** | **%** |
| **Nursing Home Administrator** | 682 | 87% |
| **Nurse (RN or LPN)** | 89 | 11% |
| **ALF Administrator** | 41 | 5% |
| **Certified Nursing Assistant** | 19 | 2% |
| **Registered Medication Aide** | 13 | 2% |
| **Occupational Therapist** | 5 | 1% |
| **Physical Therapist** | 4 | 1% |
| **Speech-Language Pathologist** | 2 | 0% |
| **Respiratory Therapist** | 1 | 0% |
| **Other** | 32 | 4% |
| **At Least One License** | **692** | **88%** |

*Source: Va. Healthcare Workforce Data Center*

| Job Titles | | | | |
|---|---|---|---|---|
| **Title** | **Primary** | | **Secondary** | |
| | **#** | **%** | **#** | **%** |
| **Administrator** | 337 | 43% | 29 | 4% |
| **Executive Director** | 119 | 15% | 12 | 2% |
| **President or Executive Officer** | 75 | 10% | 8 | 1% |
| **Assistant Administrator** | 27 | 3% | 2 | < 1% |
| **Owner** | 15 | 2% | 7 | 1% |
| **Other** | 111 | 14% | 21 | 3% |
| **At Least One Title** | **637** | **81%** | **73** | **9%** |

*Source: Va. Healthcare Workforce Data Center*

*Among all NHAs, 43% hold the title of administrator at their primary work location. Another 15% hold the title of executive director.*

## At a Glance:

**Employment**

| | |
|---|---|
| Employed in Profession: | 86% |
| Involuntarily Unemployed: | 1% |

**Positions Held**

| | |
|---|---|
| 1 Full-Time: | 88% |
| 2 or More Positions: | 5% |

**Weekly Hours:**

| | |
|---|---|
| 40 to 49: | 47% |
| 60 or More: | 15% |
| Less than 30: | 2% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Current Work Status | | |
|---|---|---|
| **Status** | **#** | **%** |
| **Employed, Capacity Unknown** | 1 | < 1% |
| **Employed in a Capacity Related to Long-Term Care** | 591 | 86% |
| **Employed, NOT in a Capacity Related to Long-Term Care** | 72 | 11% |
| **Not Working, Reason Unknown** | 0 | 0% |
| **Involuntarily Unemployed** | 6 | 1% |
| **Voluntarily Unemployed** | 16 | 2% |
| **Retired** | 4 | 1% |
| **Total** | **690** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*In total, 86% of all NHAs are currently employed in the profession, 88% hold one full-time job, and 47% work between 40 and 49 hours per week.*

| Current Positions | | |
|---|---|---|
| **Positions** | **#** | **%** |
| **No Positions** | 26 | 4% |
| **One Part-Time Position** | 26 | 4% |
| **Two Part-Time Positions** | 0 | 0% |
| **One Full-Time Position** | 591 | 88% |
| **One Full-Time Position & One Part-Time Position** | 27 | 4% |
| **Two Full-Time Positions** | 3 | < 1% |
| **More than Two Positions** | 2 | < 1% |
| **Total** | **675** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| Current Weekly Hours | | |
|---|---|---|
| **Hours** | **#** | **%** |
| **0 Hours** | 26 | 4% |
| **1 to 9 Hours** | 2 | < 1% |
| **10 to 19 Hours** | 6 | 1% |
| **20 to 29 Hours** | 8 | 1% |
| **30 to 39 Hours** | 22 | 3% |
| **40 to 49 Hours** | 319 | 47% |
| **50 to 59 Hours** | 187 | 28% |
| **60 to 69 Hours** | 85 | 13% |
| **70 to 79 Hours** | 11 | 2% |
| **80 or More Hours** | 8 | 1% |
| **Total** | **674** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Annual Income | | |
|---|---|---|
| **Income Level** | **#** | **%** |
| **Volunteer Work Only** | 9 | 2% |
| **Less than $60,000** | 33 | 6% |
| **$60,000-$69,999** | 11 | 2% |
| **$70,000-$79,999** | 10 | 2% |
| **$80,000-$89,999** | 12 | 2% |
| **$90,000-$99,999** | 11 | 2% |
| **$100,000-$109,999** | 32 | 6% |
| **$110,000-$119,999** | 41 | 7% |
| **$120,000-$129,999** | 57 | 10% |
| **$130,000-$139,999** | 53 | 9% |
| **$140,000-$149,999** | 51 | 9% |
| **$150,000-$159,999** | 65 | 12% |
| **$160,000-$169,999** | 42 | 8% |
| **$170,000-$179,999** | 26 | 5% |
| **$180,000-$189,999** | 21 | 4% |
| **$190,000-$199,999** | 17 | 3% |
| **$200,000 or More** | 72 | 13% |
| **Total** | **565** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Earnings**

Median Income: $140k-$150k

**Benefits**

Paid Vacation: 96%

Employer Retirement: 76%

*Source: Va. Healthcare Workforce Data Center*

*The median annual income for NHAs is between $140,000 and $150,000. In addition, 97% of NHAs receive at least one employer-sponsored benefit, including 76% who have access to a retirement plan.*

| Employer-Sponsored Benefits | | |
|---|---|---|
| **Benefit** | **#** | **%** |
| **Paid Vacation** | 566 | 96% |
| **Dental Insurance** | 472 | 80% |
| **Paid Sick Leave** | 456 | 77% |
| **Retirement** | 450 | 76% |
| **Group Life Insurance** | 423 | 72% |
| **Signing/Retention Bonus** | 94 | 16% |
| **At Least One Benefit** | **574** | **97%** |

*From any employer at time of survey.

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Satisfaction**

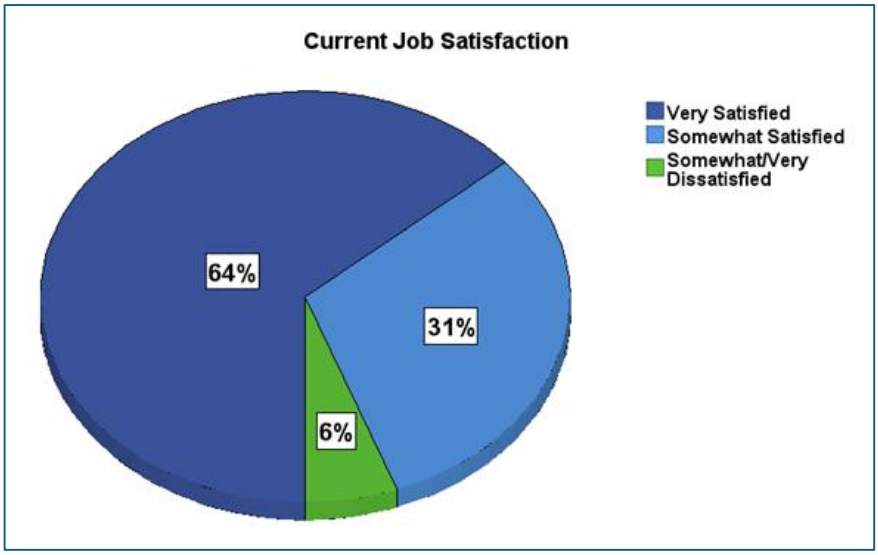
| | |
|---|---|
| Satisfied: | 94% |
| Very Satisfied: | 64% |

**Exhaustion**

| | |
|---|---|
| Burned Out: | 35% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




*Source: Va. Healthcare Workforce Data Center*

| Job Satisfaction | | |
|---|---|---|
| **Level** | **#** | **%** |
| **Very Satisfied** | 428 | 64% |
| **Somewhat Satisfied** | 207 | 31% |
| **Somewhat Dissatisfied** | 22 | 3% |
| **Very Dissatisfied** | 16 | 2% |
| **Total** | **673** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*Among all NHAs, 95% are satisfied with their current employment situation, including 64% who indicated that they are "very satisfied."*

*More than one out of every three NHAs are feeling burned out with their job. Among these NHAs, nearly two-thirds will continue to work in their current position.*

| Burned Out? | | |
|---|---|---|
| **Response** | **#** | **%** |
| **Yes** | 230 | 35% |
| **No** | 426 | 65% |
| **Total** | **656** | **100%** |
| **Experiencing Burnout** | **#** | **%** |
| **Will Continue to Work in Current Position** | 144 | 63% |
| **Planning to Leave LTC Profession within 1-2 Years** | 44 | 19% |
| **Seeking Another Position in LTC Profession** | 23 | 10% |
| **Seeking Professional Resources to Deal with Burn Out** | 19 | 8% |
| **Total** | **230** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Employment Instability in the Past Year | | |
|---|---|---|
| **In The Past Year, Did You . . .?** | **#** | **%** |
| **Experience Involuntary Unemployment?** | 27 | 3% |
| **Experience Voluntary Unemployment?** | 29 | 4% |
| **Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?** | 9 | 1% |
| **Work Two or More Positions at the Same Time?** | 57 | 7% |
| **Switch Employers or Practices?** | 90 | 11% |
| **Experience At Least One?** | **178** | **23%** |

*Source: Va. Healthcare Workforce Data Center*

*Among all NHAs, 3% experienced involuntary unemployment at some point in the past year. By comparison, Virginia's average monthly unemployment rate was 3.6% during the same time period.*[1]

### At a Glance:

**Unemployment Experience**

Involuntarily Unemployed: 3%
Underemployed: 1%

**Turnover & Tenure**

Switched Jobs: 11%
New Location: 34%
Over 2 Years: 46%
Over 2 Yrs., 2nd Location: 30%

*Source: Va. Healthcare Workforce Data Center*

| Location Tenure | | | | |
|---|---|---|---|---|
| **Tenure** | **Primary** | | **Secondary** | |
| | **#** | **%** | **#** | **%** |
| **Not Currently Working at This Location** | 13 | 2% | 7 | 9% |
| **Less than 6 Months** | 71 | 11% | 17 | 22% |
| **6 Months to 1 Year** | 114 | 17% | 21 | 27% |
| **1 to 2 Years** | 157 | 24% | 9 | 12% |
| **3 to 5 Years** | 107 | 16% | 9 | 12% |
| **6 to 10 Years** | 85 | 13% | 5 | 6% |
| **More than 10 Years** | 109 | 17% | 9 | 12% |
| **Subtotal** | **657** | **100%** | **77** | **100%** |
| **Did Not Have Location** | 13 | | 689 | |
| **Item Missing** | 113 | | 18 | |
| **Total** | **783** | | **783** | |

*Source: Va. Healthcare Workforce Data Center*

*Among all NHAs, 46% have worked at their primary location for more than two years.*

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate fluctuated between a low of 3.0% and a high of 3.9%. At the time of publication, the unemployment rate from February 2026 was still preliminary, and the unemployment rate from March 2026 had not yet been released.

## At a Glance:

**Concentration**

| | |
|---|---|
| Top Region: | 21% |
| Top 3 Regions: | 61% |
| Lowest Region: | 2% |

**Locations**

| | |
|---|---|
| 2 or More (Past Year): | 14% |
| 2 or More (Now*): | 10% |

*Source: Va. Healthcare Workforce Data Center*

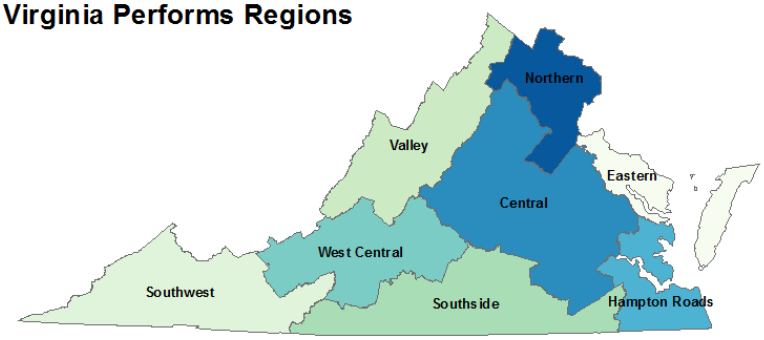
*More than three out of every five NHAs work in Central Virginia, Hampton Roads, or Northern Virginia.*

## A Closer Look:

| Regional Distribution of Work Locations | | | | |
|---|---|---|---|---|
| VA Performs Region | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **Central** | 139 | 21% | 21 | 26% |
| **Eastern** | 16 | 2% | 5 | 6% |
| **Hampton Roads** | 137 | 21% | 15 | 19% |
| **Northern** | 123 | 19% | 11 | 14% |
| **Southside** | 35 | 5% | 3 | 4% |
| **Southwest** | 35 | 5% | 4 | 5% |
| **Valley** | 61 | 9% | 10 | 12% |
| **West Central** | 106 | 16% | 7 | 9% |
| **Virginia Border State/D.C.** | 4 | 1% | 0 | 0% |
| **Other U.S. State** | 1 | 0% | 5 | 6% |
| **Outside of the U.S.** | 0 | 0% | 0 | 0% |
| **Total** | **657** | **100%** | **81** | **100%** |
| **Item Missing** | 111 | | 14 | |

*Source: Va. Healthcare Workforce Data Center*

**Virginia Performs Regions**




*Source: Va. Healthcare Workforce Data Center*

| Number of Work Locations | | | | |
|---|---|---|---|---|
| Locations | Work Locations in Past Year | | Work Locations Now* | |
| | # | % | # | % |
| **0** | 7 | 1% | 13 | 2% |
| **1** | 558 | 85% | 577 | 88% |
| **2** | 60 | 9% | 42 | 6% |
| **3** | 24 | 4% | 22 | 3% |
| **4** | 3 | 1% | 3 | 1% |
| **5** | 2 | 0% | 1 | 0% |
| **6 or More** | 3 | 1% | 0 | 0% |
| **Total** | **658** | **100%** | **658** | **100%** |

*At the time of survey completion, March 2026.

*Source: Va. Healthcare Workforce Data Center*

*While 10% of NHAs currently have multiple work locations, 14% have had multiple work locations over the past 12 months.*

## A Closer Look:

| Location Sector | | | | |
|---|---|---|---|---|
| Sector | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **For-Profit** | 442 | 69% | 49 | 72% |
| **Non-Profit** | 173 | 27% | 17 | 25% |
| **State/Local Government** | 25 | 4% | 2 | 3% |
| **Veterans Administration** | 2 | 0% | 0 | 0% |
| **U.S. Military** | 0 | 0% | 0 | 0% |
| **Other Federal Government** | 2 | 0% | 0 | 0% |
| **Total** | **644** | **100%** | **68** | **100%** |
| **Did Not Have Location** | 13 | | 689 | |
| **Item Missing** | 126 | | 25 | |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:
**(Primary Locations)**

**Sector**

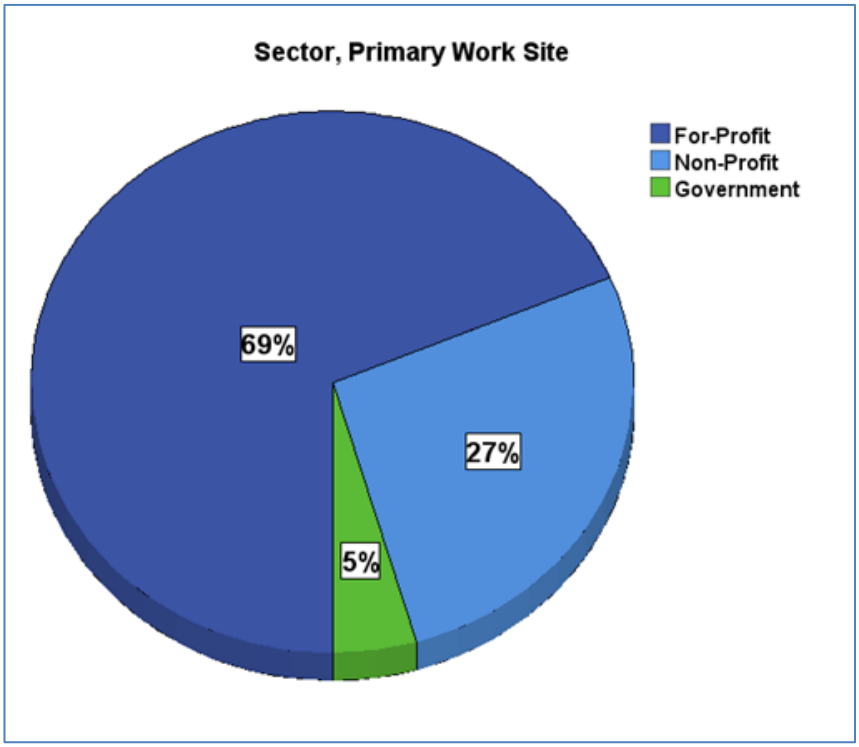
For-Profit: 69%
Federal: 1%

**Top Establishments**

Skilled Nursing Facility: 50%
Assisted Living Facility: 17%
Continuing Care Retirement Community: 15%

*Source: Va. Healthcare Workforce Data Center*

*More than two out of every three NHAs work in the for-profit sector, while another 27% work in the non-profit sector.*




*Source: Va. Healthcare Workforce Data Center*

| Location Type | | | | |
|---|---|---|---|---|
| Establishment Type | Primary Location | | Secondary Location | |
| | # | % | # | % |
| Skilled Nursing Facility | 393 | 50% | 44 | 6% |
| Assisted Living Facility | 136 | 17% | 12 | 2% |
| Continuing Care Retirement Community | 117 | 15% | 10 | 1% |
| Acute Care/Rehabilitative Facility | 32 | 4% | 4 | 1% |
| Hospice | 18 | 2% | 2 | 0% |
| Home/Community Health Care | 14 | 2% | 3 | 0% |
| Adult Day Care | 11 | 1% | 1 | 0% |
| PACE | 6 | 1% | 1 | 0% |
| Academic Institution | 2 | 0% | 4 | 1% |
| Other Practice Type | 72 | 9% | 12 | 2% |
| **At Least One Establishment** | **651** | **83%** | **78** | **10%** |

*Source: Va. Healthcare Workforce Data Center*

*Half of all NHAs are employed at a skilled nursing facility as their primary work location. Another 17% of NHAs are employed at an assisted living facility.*

*Nearly three out of every five NHAs work at a facility chain organization as their primary work location. Another 30% of NHAs are employed at an independent/stand-alone organization.*

| Location Type | | | | |
|---|---|---|---|---|
| Organization Type | Primary Location | | Secondary Location | |
| | # | % | # | % |
| Facility Chain | 346 | 57% | 39 | 59% |
| Independent/Stand Alone | 180 | 30% | 13 | 20% |
| Hospital-Based | 16 | 3% | 2 | 3% |
| Integrated Health System (Veterans Administration, Large Health System) | 15 | 2% | 1 | 2% |
| College or University | 1 | 0% | 3 | 5% |
| Other | 48 | 8% | 8 | 12% |
| **Total** | **606** | **100%** | **66** | **100%** |
| Did Not Have Location | 13 | | 689 | |
| Item Missing | 163 | | 27 | |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:
### (Primary Locations)

**Languages Offered**

| | |
|---|---|
| Spanish: | 33% |
| French: | 17% |
| Korean: | 15% |

**Means of Communication**

| | |
|---|---|
| Virtual Translation: | 70% |
| Other Staff Members: | 39% |
| Onsite Translation: | 13% |

*Source: Va. Healthcare Workforce Data Center*

*One out of every three NHAs are employed at a primary work location that offers Spanish language services for patients.*

## A Closer Look:

| Languages Offered | | |
|---|---|---|
| **Language** | **#** | **% of Workforce** |
| **Spanish** | 262 | 33% |
| **French** | 135 | 17% |
| **Korean** | 117 | 15% |
| **Chinese** | 116 | 15% |
| **Tagalog/Filipino** | 114 | 15% |
| **Arabic** | 111 | 14% |
| **Vietnamese** | 102 | 13% |
| **Hindi** | 98 | 13% |
| **Persian** | 87 | 11% |
| **Amharic, Somali, or Other Afro-Asiatic Languages** | 84 | 11% |
| **Pashto** | 83 | 11% |
| **Urdu** | 83 | 11% |
| **Others** | 65 | 8% |
| **At Least One Language** | **300** | **38%** |

*Source: Va. Healthcare Workforce Data Center*

| Means of Language Communication | | |
|---|---|---|
| **Provision** | **#** | **% of Workforce with Language Services** |
| **Virtual Translation Services** | 209 | 70% |
| **Other Staff Member is Proficient** | 116 | 39% |
| **Onsite Translation Service** | 40 | 13% |
| **Respondent is Proficient** | 19 | 6% |
| **Other** | 8 | 3% |

*Source: Va. Healthcare Workforce Data Center*

*Seven out of every ten NHAs who are employed at a primary work location that offers language services for patients provide it by means of a virtual translation service.*

## At a Glance:
### (Primary Locations)

**Typical Time Allocation**

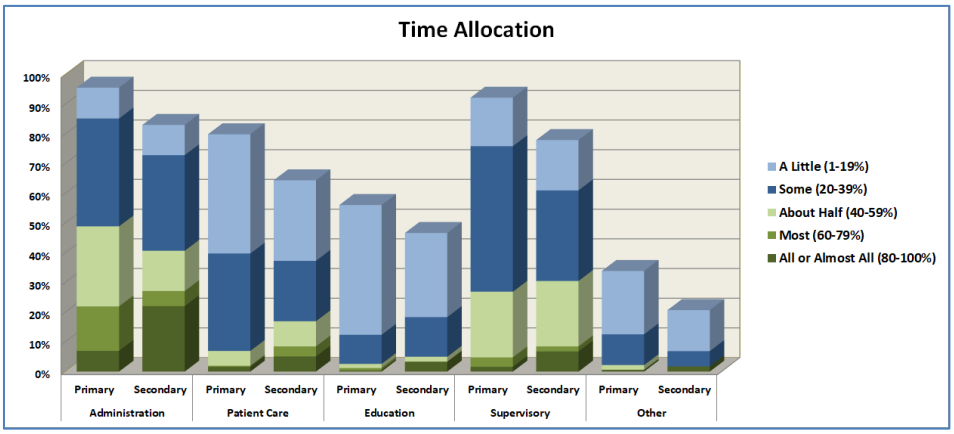
| | |
|---|---|
| Administration: | 30%-39% |
| Supervisory: | 20%-29% |
| Patient Care: | 10%-19% |
| Education: | 1%-9% |

**Roles**

| | |
|---|---|
| Administration: | 22% |
| Supervisory: | 5% |
| Patient Care: | 2% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




*Source: Va. Healthcare Workforce Data Center*

*NHAs typically spend approximately one-third of their time performing administrative tasks. In fact, 22% of NHAs fill an administrative role, defined as spending 60% or more of their time on administrative activities.*

| Time Allocation | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time Spent | Admin. | | Patient Care | | Education | | Supervisory | | Other | |
| | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site |
| **All or Almost All (80-100%)** | 7% | 22% | 2% | 5% | 0% | 3% | 2% | 7% | 1% | 2% |
| **Most (60-79%)** | 15% | 5% | 0% | 3% | 1% | 0% | 3% | 2% | 0% | 0% |
| **About Half (40-59%)** | 27% | 13% | 5% | 8% | 1% | 2% | 22% | 22% | 2% | 0% |
| **Some (20-39%)** | 36% | 32% | 33% | 20% | 10% | 13% | 49% | 30% | 10% | 5% |
| **A Little (1-19%)** | 10% | 10% | 40% | 27% | 44% | 28% | 16% | 17% | 21% | 13% |
| **None (0%)** | 4% | 17% | 20% | 35% | 44% | 53% | 8% | 22% | 66% | 77% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Patient Workload | | | | |
|---|---|---|---|---|
| # of Patients | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **None** | 70 | 13% | 21 | 27% |
| **1-24** | 13 | 2% | 7 | 9% |
| **25-49** | 19 | 3% | 1 | 1% |
| **50-74** | 63 | 12% | 10 | 13% |
| **75-99** | 72 | 13% | 6 | 8% |
| **100-124** | 117 | 21% | 13 | 17% |
| **125-149** | 33 | 6% | 2 | 3% |
| **150-174** | 39 | 7% | 4 | 5% |
| **175-199** | 24 | 4% | 3 | 4% |
| **200-224** | 22 | 4% | 3 | 4% |
| **225-249** | 4 | 1% | 0 | 0% |
| **250-274** | 8 | 1% | 1 | 1% |
| **275-299** | 3 | 1% | 1 | 1% |
| **300 or More** | 59 | 11% | 4 | 5% |
| **Total** | **546** | **100%** | **78** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Patient Workload (Median)**

Primary Location: 100-124
Secondary Location: 50-74

**Resident Capacity (Median)**

Primary Location: 100-150
Secondary Location: 50-100

*Source: Va. Healthcare Workforce Data Center*

*The median patient workload for NHAs at their primary work location is between 100 and 124 patients. In addition, the typical NHA works at a facility that contains between 100 and 150 beds for residents.*

| Resident Capacity | | | | |
|---|---|---|---|---|
| # of Beds | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **Not Applicable** | 86 | 13% | 18 | 24% |
| **10 or Less** | 5 | 1% | 1 | 1% |
| **10-25** | 7 | 1% | 0 | 0% |
| **25-50** | 27 | 4% | 2 | 3% |
| **50-100** | 156 | 24% | 22 | 29% |
| **100-150** | 190 | 29% | 20 | 26% |
| **150-250** | 112 | 17% | 8 | 11% |
| **More than 250** | 70 | 11% | 5 | 7% |
| **Total** | **653** | **100%** | **76** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Retirement Expectations | | | | |
|---|---|---|---|---|
| Expected Retirement Age | All NHAs | | NHAs 50 and Over | |
| | # | % | # | % |
| Under Age 50 | 28 | 5% | - | - |
| 50 to 54 | 27 | 4% | 4 | 1% |
| 55 to 59 | 59 | 9% | 17 | 6% |
| 60 to 64 | 126 | 20% | 54 | 18% |
| 65 to 69 | 237 | 38% | 131 | 44% |
| 70 to 74 | 88 | 14% | 61 | 21% |
| 75 to 79 | 25 | 4% | 17 | 6% |
| 80 or Over | 4 | 1% | 1 | 0% |
| I Do Not Intend to Retire | 27 | 4% | 12 | 4% |
| **Total** | **622** | **100%** | **297** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Retirement Expectations**

**All NHAs**

Under 65: 39%

Under 60: 18%

**NHAs 50 and Over**

Under 65: 25%

Under 60: 7%

**Time Until Retirement**

Within 2 Years: 9%

Within 10 Years: 30%

Half the Workforce: By 2046

*Source: Va. Healthcare Workforce Data Center*

*Among all NHAs, 39% expect to retire before the age of 65. Among NHAs who are age 50 and over, 25% expect to retire by the age of 65.*

*Within the next two years, 16% of NHAs expect to begin accepting Administrators-in-Training, and 10% of NHAs expect to pursue additional educational opportunities.*

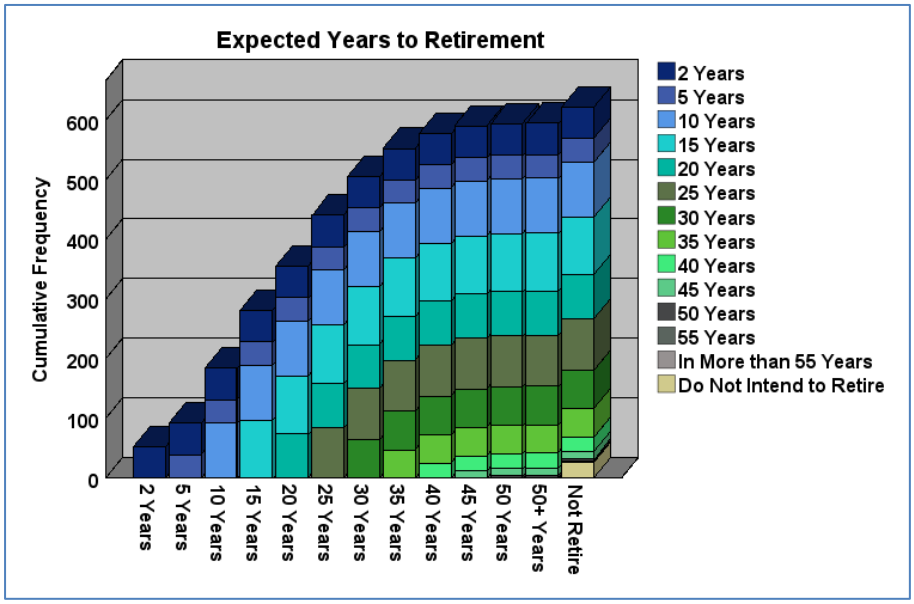
| Future Plans | | |
|---|---|---|
| Two-Year Plans: | # | % |
| **Decrease Participation** | | |
| Leave Profession | 43 | 5% |
| Leave Virginia | 64 | 8% |
| Decrease Patient Care Hours | 57 | 7% |
| Decrease Teaching Hours | 0 | 0% |
| Cease Accepting Trainees | 3 | 0% |
| **Increase Participation** | | |
| Increase Patient Care Hours | 44 | 6% |
| Increase Teaching Hours | 37 | 5% |
| Pursue Additional Education | 79 | 10% |
| Return to the Workforce | 1 | 0% |
| Begin Accepting Trainees | 126 | 16% |

*Source: Va. Healthcare Workforce Data Center*

*By comparing retirement expectation to age, we can estimate the maximum years to retirement for NHAs. While 9% of NHAs expect to retire in the next two years, 30% expect to retire within the next decade. More than half of the current NHA workforce expect to retire by 2046.*

| Time to Retirement | | | |
|---|---|---|---|
| Expect to Retire Within. . . | # | % | Cumulative % |
| 2 Years | 53 | 9% | 9% |
| 5 Years | 39 | 6% | 15% |
| 10 Years | 92 | 15% | 30% |
| 15 Years | 97 | 16% | 45% |
| 20 Years | 74 | 12% | 57% |
| 25 Years | 86 | 14% | 71% |
| 30 Years | 65 | 10% | 81% |
| 35 Years | 47 | 8% | 89% |
| 40 Years | 25 | 4% | 93% |
| 45 Years | 12 | 2% | 95% |
| 50 Years | 4 | 1% | 95% |
| 55 Years | 0 | 0% | 95% |
| In More than 55 Years | 1 | 0% | 96% |
| Do Not Intend to Retire | 27 | 4% | 100% |
| Total | 622 | 100% | |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Using these estimates, retirement will begin to reach over 10% of the current workforce every five years by 2036. Retirement will peak at 16% of the current workforce around 2041 before declining to under 10% again by 2061.*

## At a Glance:

**FTEs**

| | |
|---|---|
| Total: | 794 |
| FTEs/1,000 Residents[2]: | .090 |
| Average: | 1.03 |

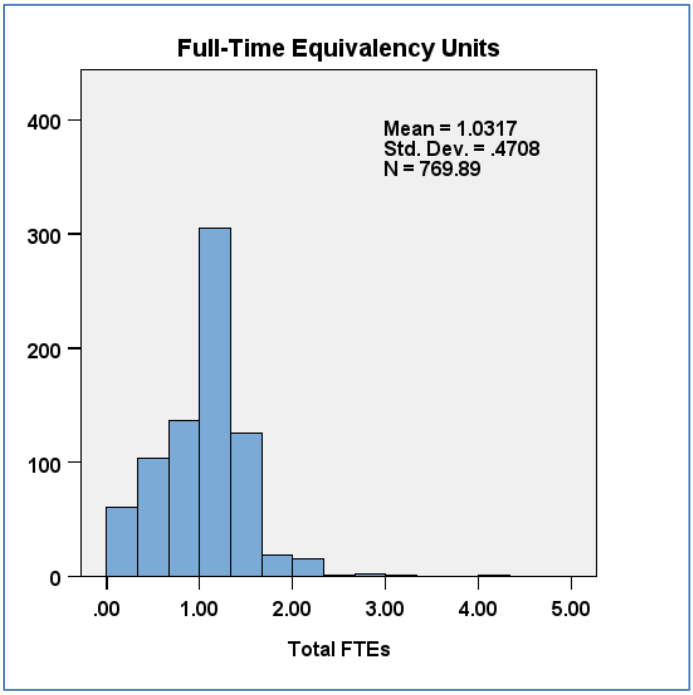
**Age & Gender Effect**

| | |
|---|---|
| Age, *Partial Eta*$^2$: | Small |
| Gender, *Partial Eta*$^2$: | None |

*Partial Eta*$^2$ *Explained:*
*Partial Eta*$^2$ is a statistical measure of effect size.

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

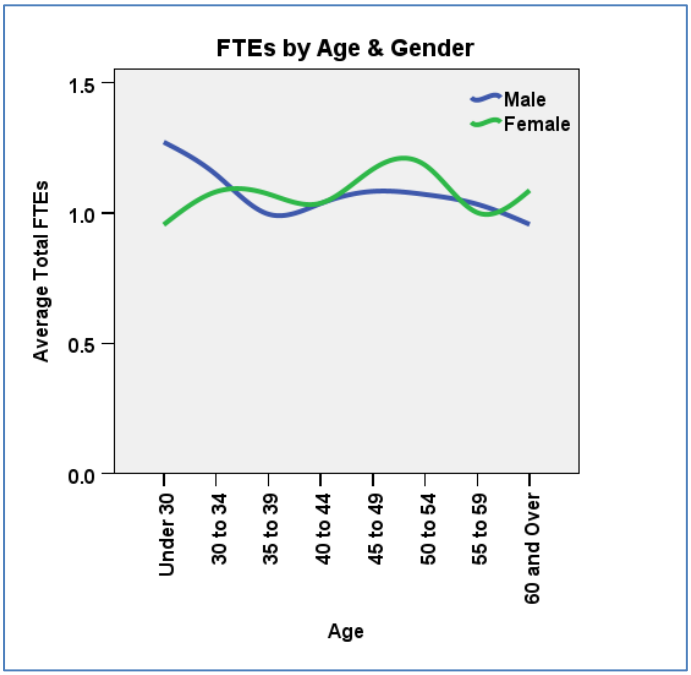



*Source: Va. Healthcare Workforce Data Center*

*The typical NHA provided 1.09 FTEs in the past year, or approximately 44 hours per week for 50 weeks. Statistical tests did not indicate that FTEs vary by either age or gender.*

| Full-Time Equivalency Units | | |
|---|---|---|
| **Age** | **Average** | **Median** |
| **Under 30** | 1.05 | 1.06 |
| **30 to 34** | 1.11 | 1.18 |
| **35 to 39** | 1.03 | 1.09 |
| **40 to 44** | 0.97 | 1.09 |
| **45 to 49** | 1.11 | 1.18 |
| **50 to 54** | 1.14 | 1.17 |
| **55 to 59** | 1.00 | 1.00 |
| **60 and Over** | 0.93 | 1.01 |
| **Gender** | | |
| **Male** | 1.04 | 1.09 |
| **Female** | 1.09 | 1.13 |

*Source: Va. Healthcare Workforce Data Center*

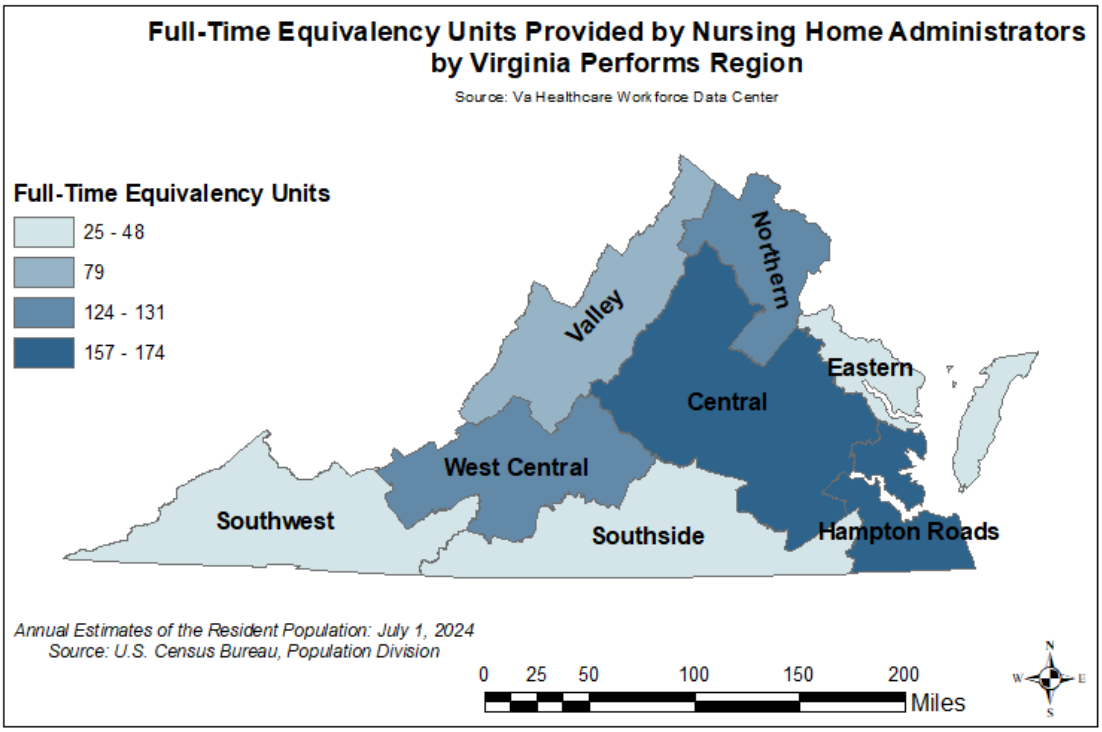


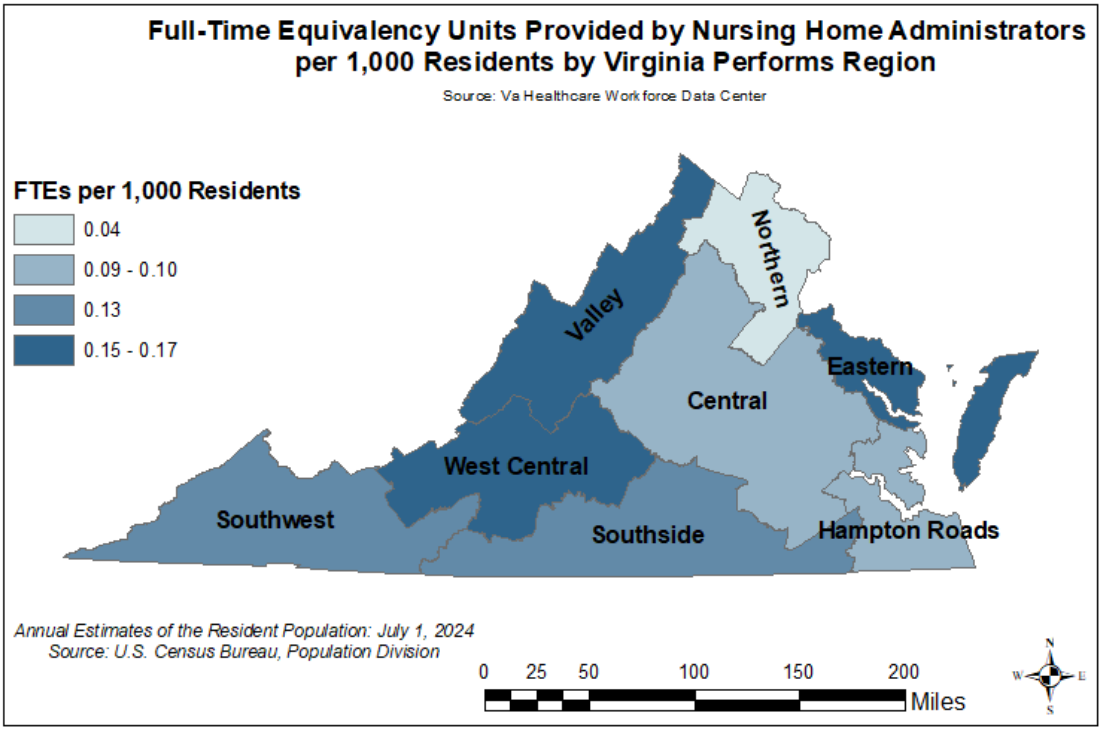

*Source: Va. Healthcare Workforce Data Center*

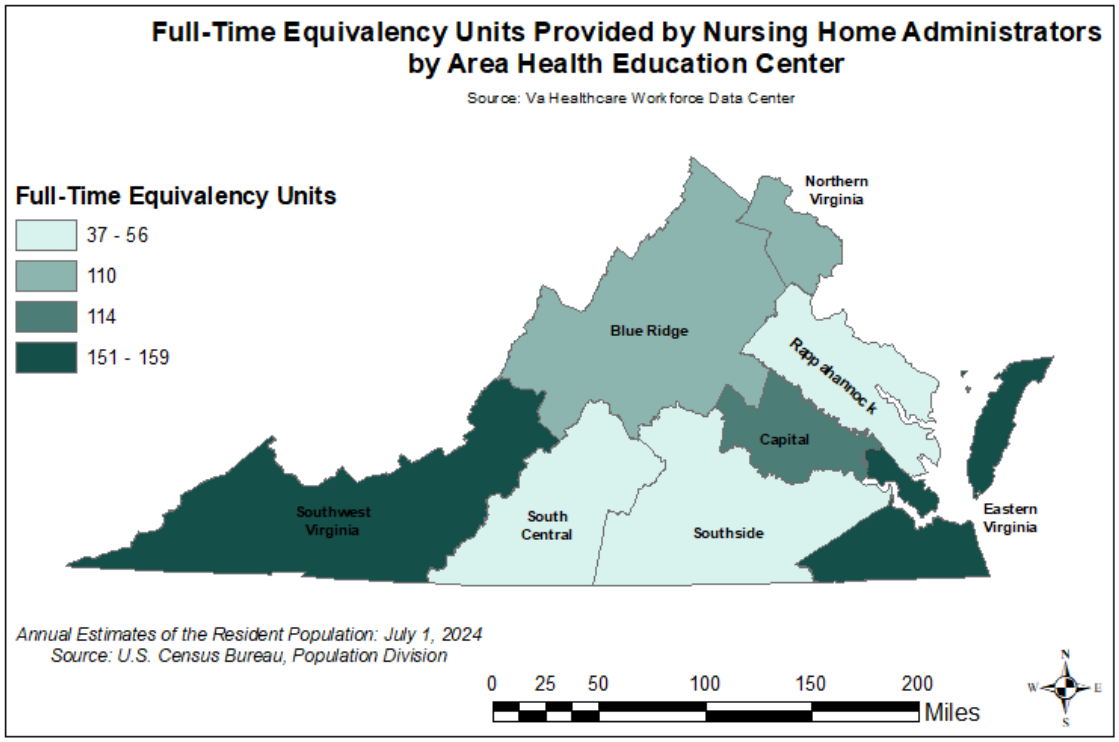
[2] Number of residents in 2024 was used as the denominator.

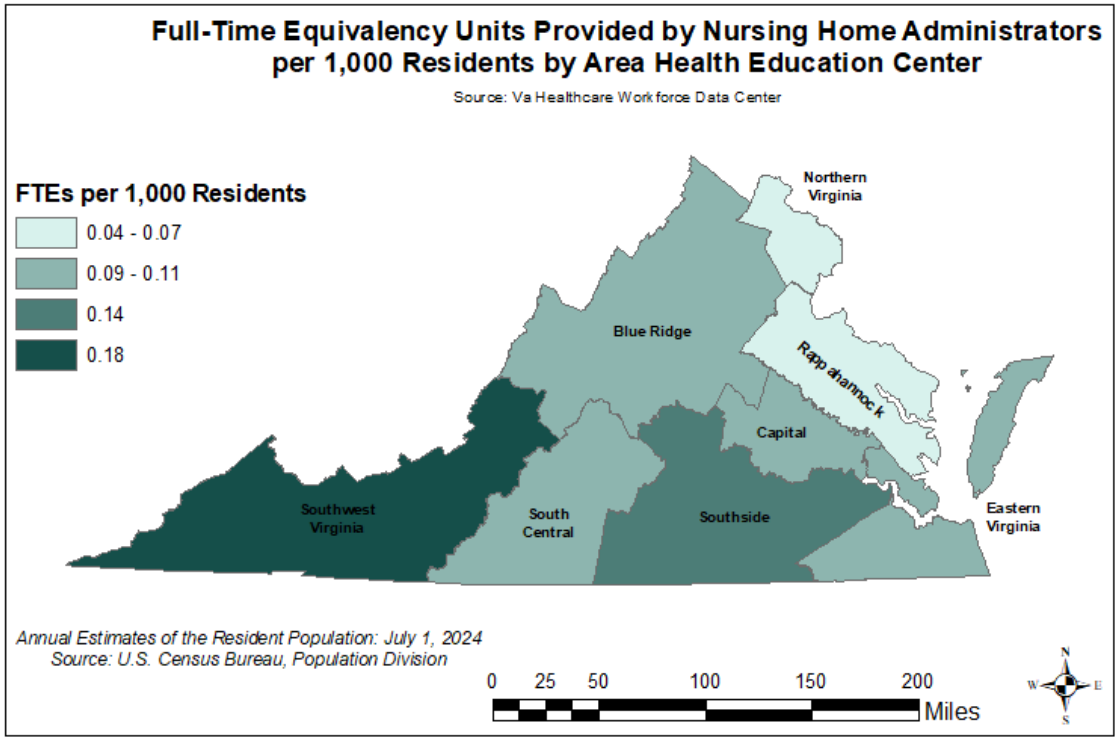
## Maps

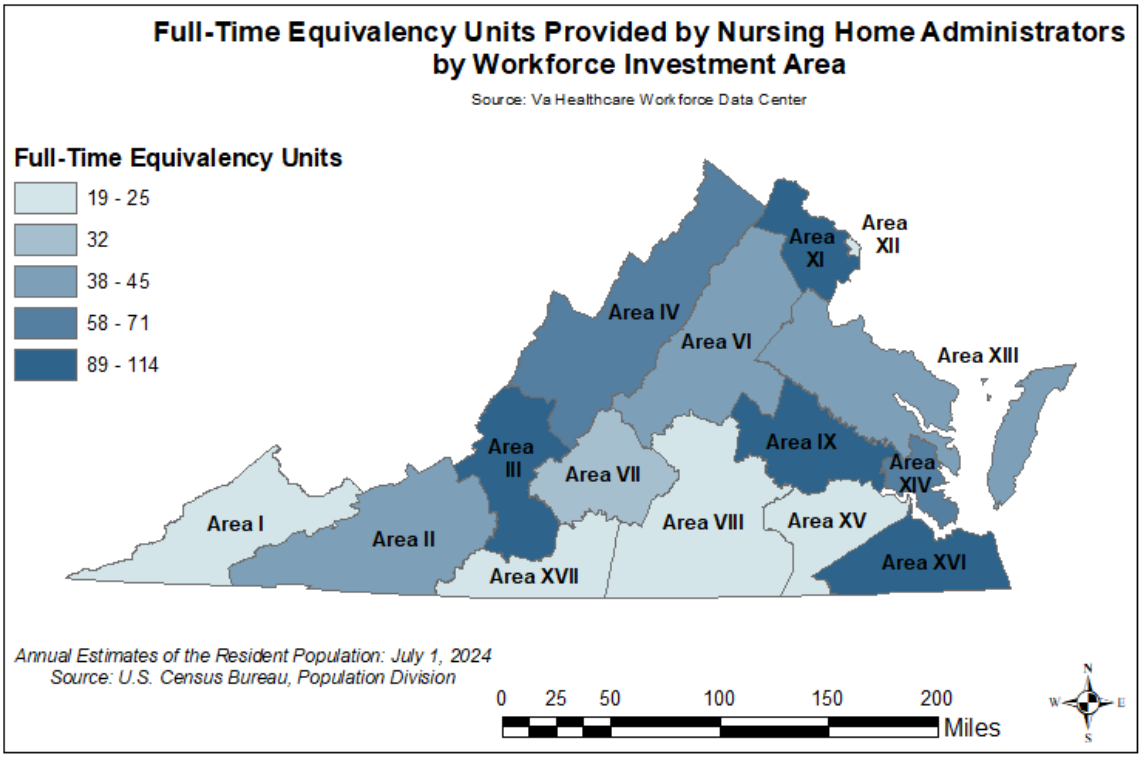
## Virginia Performs Regions

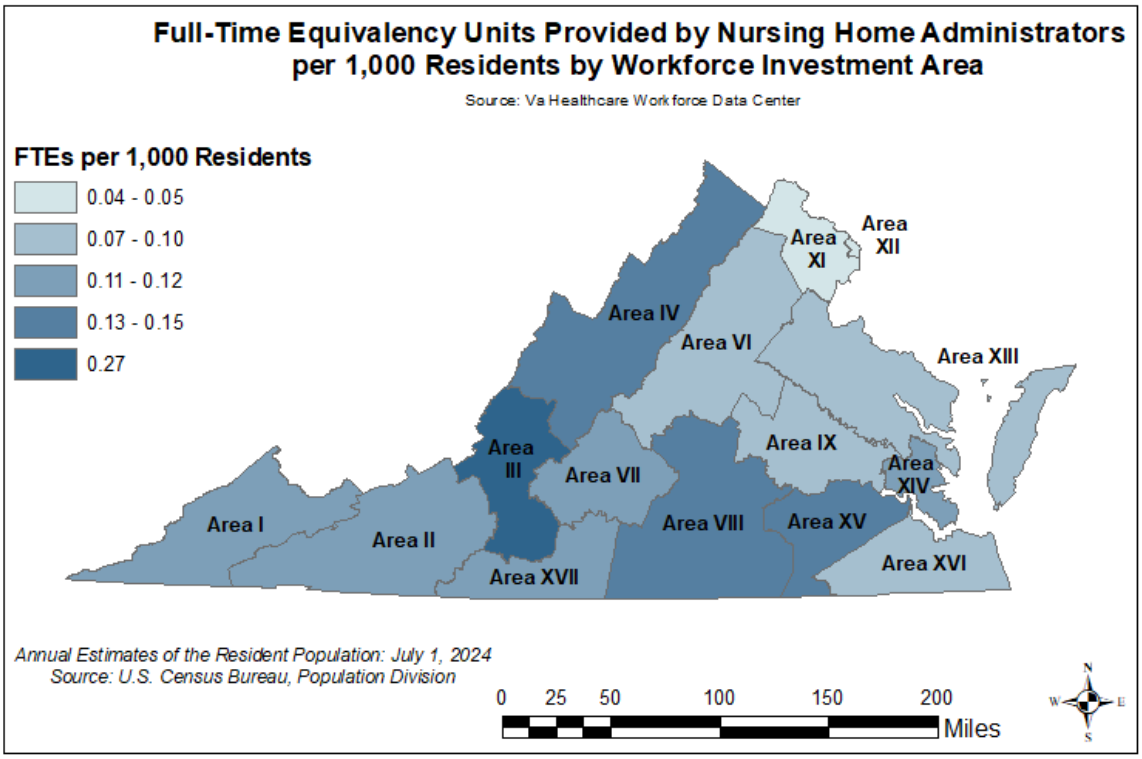


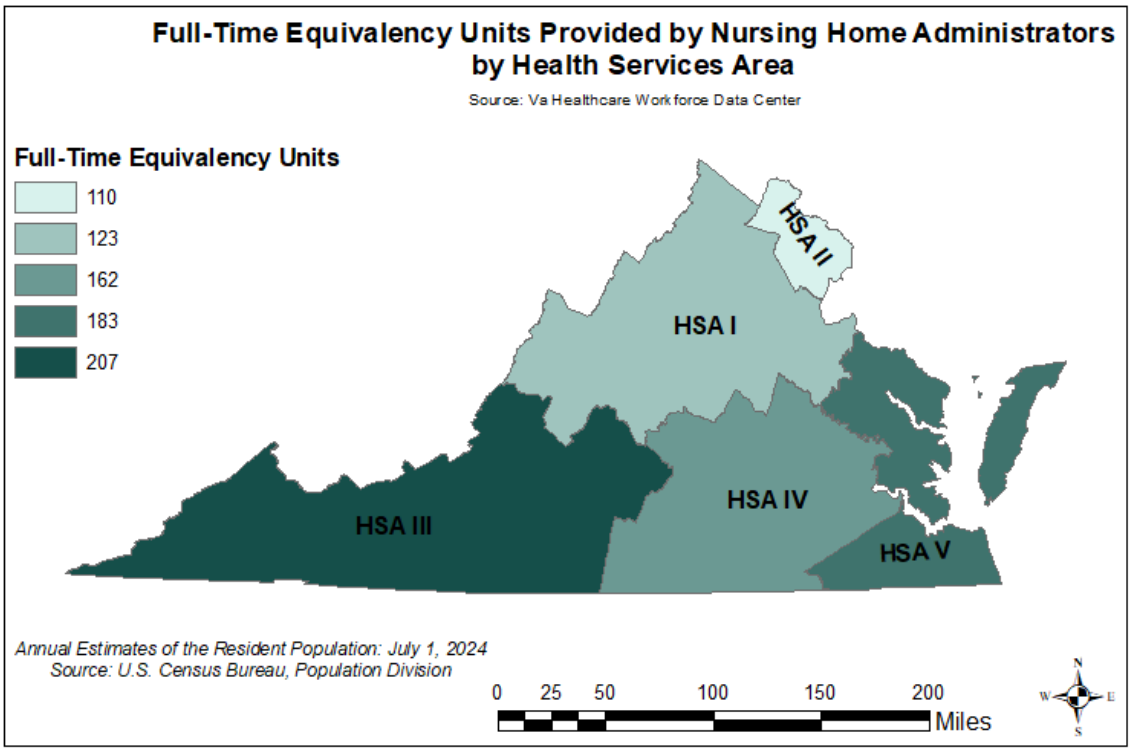



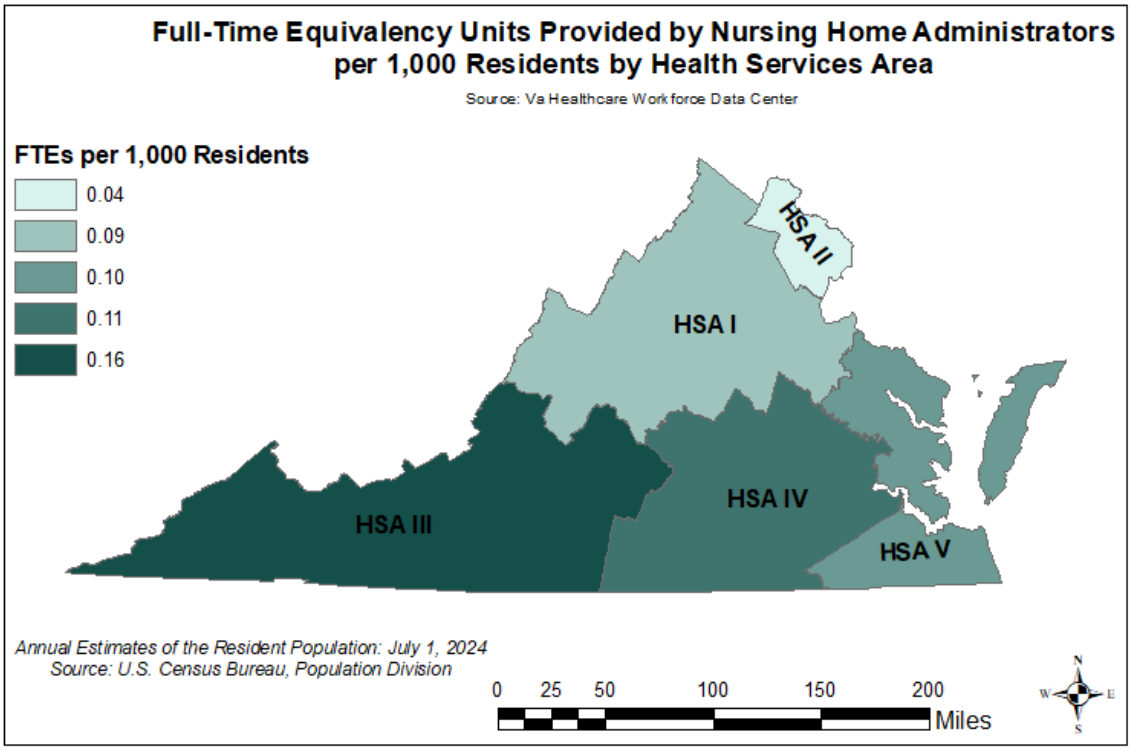

Full-Time Equivalency Units Provided by Nursing Home Administrators by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
37 - 56
110
114
151 - 159
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

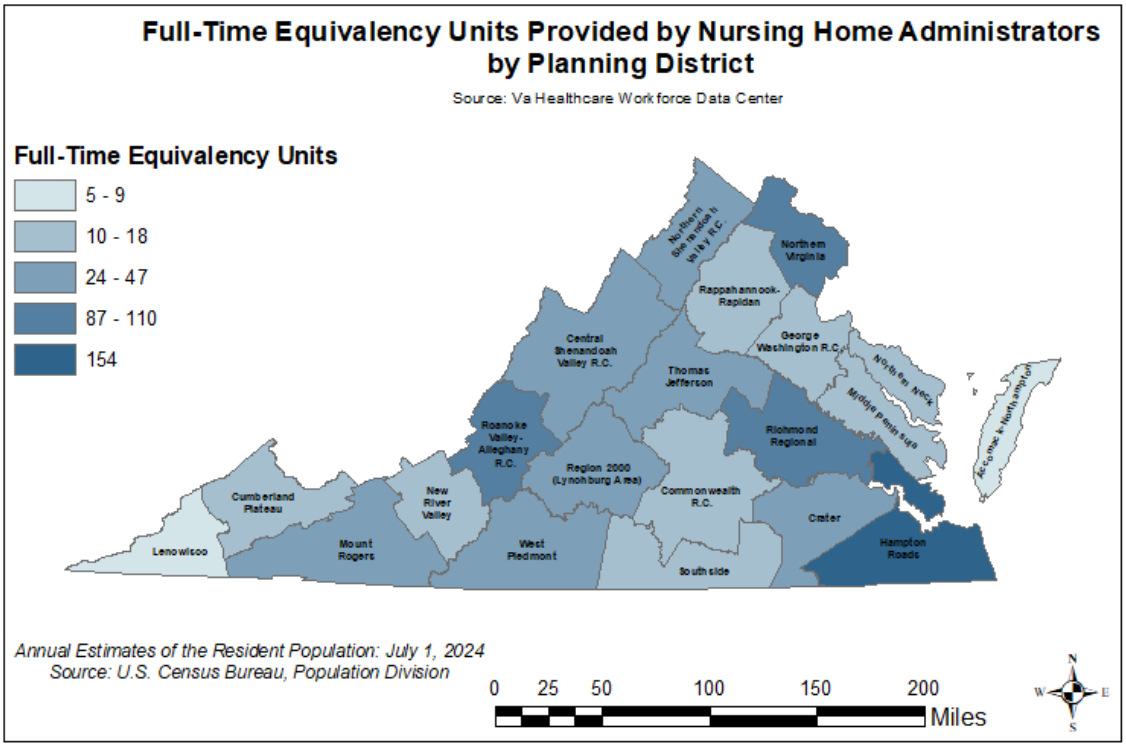

Full-Time Equivalency Units Provided by Nursing Home Administrators per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.04 - 0.07
0.09 - 0.11
0.14
0.18
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

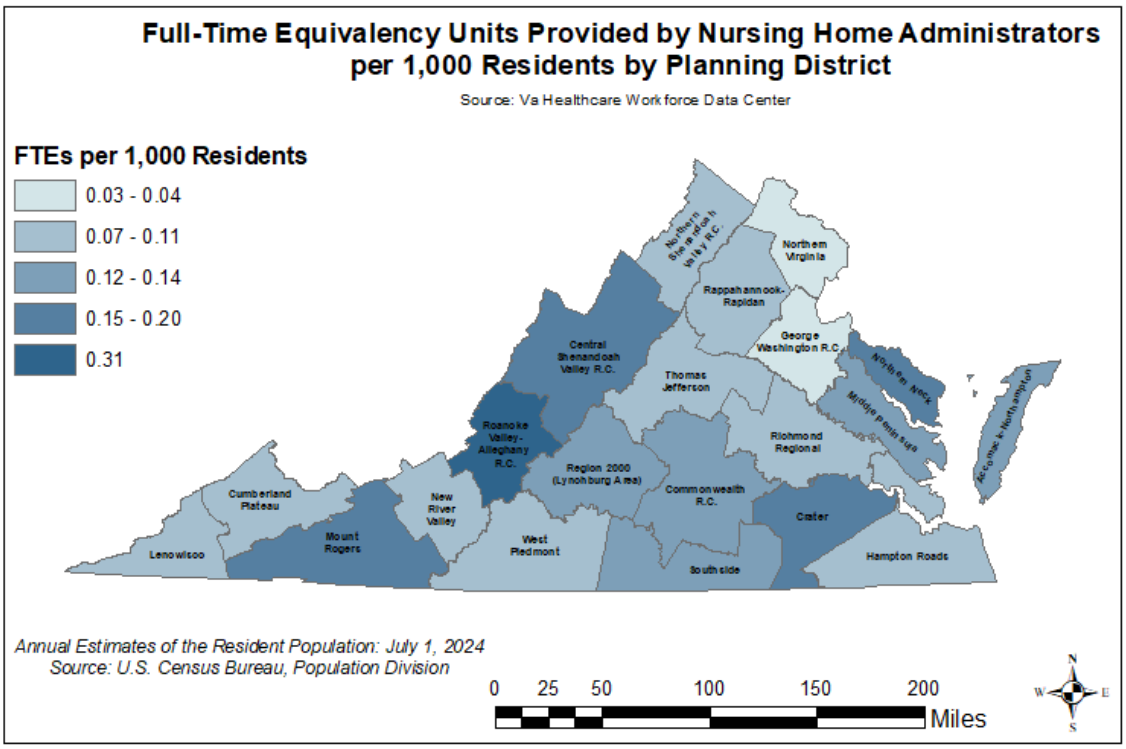

Full-Time Equivalency Units Provided by Nursing Home Administrators by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
19 - 25
32
38 - 45
58 - 71
89 - 114
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Nursing Home Administrators per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.04 - 0.05
0.07 - 0.10
0.11 - 0.12
0.13 - 0.15
0.27
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Nursing Home Administrators by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
110
123
162
183
207
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Nursing Home Administrators per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.04
0.09
0.10
0.11
0.16
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Nursing Home Administrators by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
5 - 9
10 - 18
24 - 47
87 - 110
154
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Nursing Home Administrators per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.03 - 0.04
0.07 - 0.11
0.12 - 0.14
0.15 - 0.20
0.31
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
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Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

## Appendices

### Appendix A: Weights

| Rural Status | Location Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min. | Max. |
| Metro, 1 Million+ | 399 | 90.23% | 1.108 | 1.022 | 1.379 |
| Metro, 250,000 to 1 Million | 107 | 89.72% | 1.115 | 1.028 | 1.386 |
| Metro, 250,000 or Less | 91 | 94.51% | 1.058 | 0.976 | 1.316 |
| Urban, Pop. 20,000+, Metro Adj. | 13 | 76.92% | 1.300 | 1.199 | 1.617 |
| Urban, Pop. 20,000+, Non-Adj. | 0 | NA | NA | NA | NA |
| Urban, Pop. 2,500-19,999, Metro Adj. | 60 | 88.33% | 1.132 | 1.044 | 1.408 |
| Urban, Pop. 2,500-19,999, Non-Adj. | 26 | 96.15% | 1.040 | 0.959 | 1.100 |
| Rural, Metro Adj. | 26 | 96.15% | 1.040 | 0.959 | 1.100 |
| Rural, Non-Adj. | 13 | 92.31% | 1.083 | 0.999 | 1.146 |
| Virginia Border State/D.C. | 158 | 81.65% | 1.225 | 1.130 | 1.523 |
| Other U.S. State | 99 | 75.76% | 1.320 | 1.217 | 1.642 |

*Source: Va. Healthcare Workforce Data Center*

| Age | Age Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min. | Max. |
| Under 30 | 51 | 70.59% | 1.417 | 1.316 | 1.642 |
| 30 to 34 | 58 | 89.66% | 1.115 | 1.019 | 1.293 |
| 35 to 39 | 111 | 87.39% | 1.144 | 1.045 | 1.326 |
| 40 to 44 | 121 | 90.91% | 1.100 | 1.004 | 1.275 |
| 45 to 49 | 125 | 95.20% | 1.050 | 0.959 | 1.217 |
| 50 to 54 | 153 | 83.01% | 1.205 | 1.100 | 1.396 |
| 55 to 59 | 140 | 89.29% | 1.120 | 1.023 | 1.298 |
| 60 and Over | 233 | 87.98% | 1.137 | 1.038 | 1.317 |

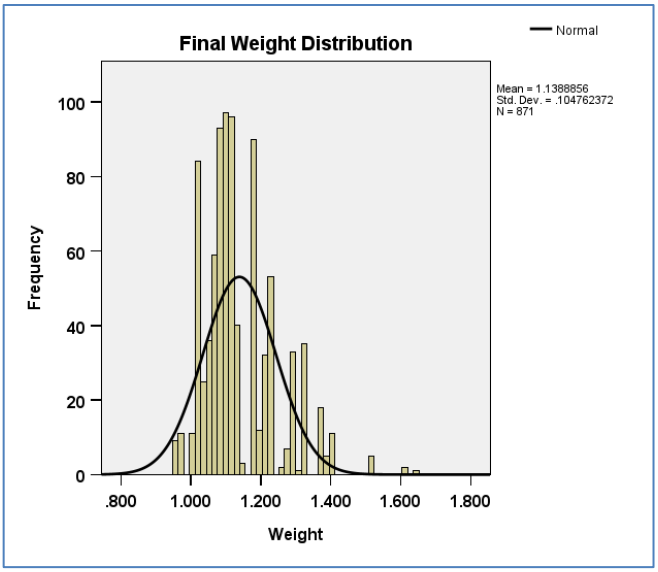
*Source: Va. Healthcare Workforce Data Center*

See the Methodology section on the HWDC website for details on HWDC methods: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

**Overall Response Rate**: **0.878024**




*Source: Va. Healthcare Workforce Data Center*

DRAFT

# *Virginia's Assisted Living Facility Administrator Workforce: 2026*

Healthcare Workforce Data Center

May 2026

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4434 (fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
***https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/***

***In total, 558 Assisted Living Facility Administrators voluntarily participated in this survey.*** *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Long-Term Care Administrators express our sincerest appreciation for their ongoing cooperation.*

# *Thank You!*

***Virginia Department of Health Professions***

**David E. Brown, DC**
*Director*

*Healthcare Workforce Data Center Staff:*

| | | | |
|---|---|---|---|
| Yetty Shobo, PhD<br>*Director* | Barbara Hodgdon, PhD<br>*Deputy Director* | Rajana Siva, MBA<br>*Data Analyst* | Christopher Coyle, BA<br>*Research Assistant* |

## Virginia Board of Long-Term Care Administrators

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*Fairfax*

***Vice-Chair***

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Latonya D. Hughes, PhD, RN, NHA
*Hampton*

Dennis Pregent, ALFA, NHA
*Powhatan*

***Executive Director***

Corie E. Tillman Wolf, JD

## Contents

# The Assisted Living Facility Administrator Workforce At a Glance:

| The Workforce | |
|---|---|
| Licensees: | 673 |
| Virginia's Workforce: | 637 |
| FTEs: | 723 |

| Background | |
|---|---|
| Rural Childhood: | 39% |
| HS Degree in VA: | 59% |
| Prof. Degree in VA: | 91% |

| Current Employment | |
|---|---|
| Employed in Prof.: | 87% |
| Hold 1 Full-Time Job: | 85% |
| Satisfied?: | 96% |

| Survey Response Rate | |
|---|---|
| All Licensees: | 83% |
| Renewing Practitioners: | 97% |

| Health Admin. Edu. | |
|---|---|
| Admin-in-Training: | 45% |
| Baccalaureate: | 15% |

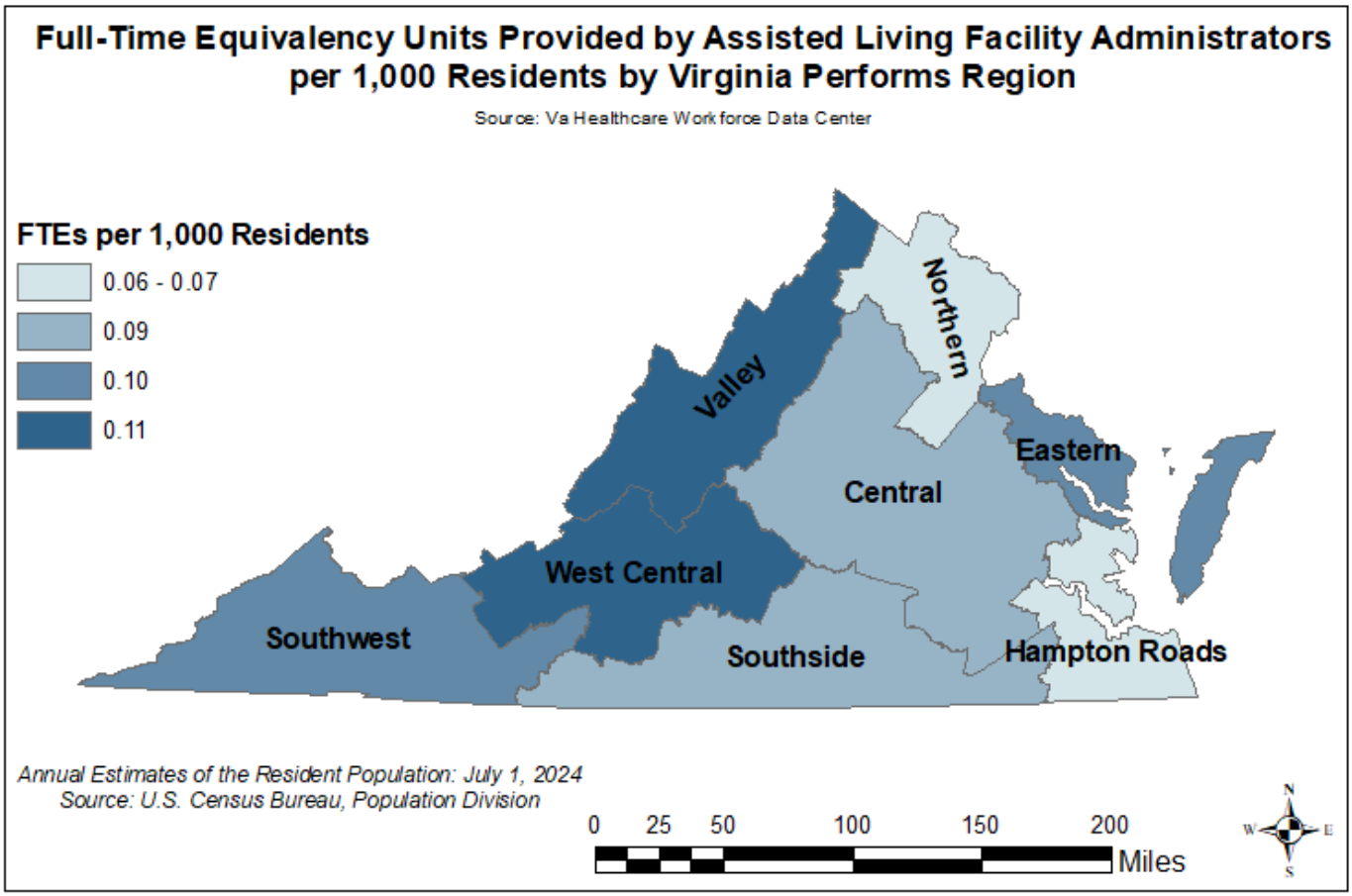
| Job Turnover | |
|---|---|
| Switched Jobs: | 8% |
| Employed Over 2 Yrs.: | 60% |

| Demographics | |
|---|---|
| Female: | 78% |
| Diversity Index: | 49% |
| Median Age: | 52 |

| Finances | |
|---|---|
| Median Inc.: | $100k-$110k |
| Retirement Benefits: | 61% |
| Under 40 w/ Ed. Debt: | 48% |

| Time Allocation | |
|---|---|
| Administration: | 40%-49% |
| Supervisory: | 20%-29% |
| Patient Care: | 10%-19% |

*Source: Va. Healthcare Workforce Data Center*



## Results in Brief

This report contains the results of the 2026 Assisted Living Facility Administrator (ALFA) Workforce Survey. In total, 558 ALFAs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every March for ALFAs. These respondents represent 83% of the 673 ALFAs licensed in the state and 97% of renewing practitioners.

The HWDC estimates that 637 ALFAs participated in Virginia's workforce during the survey time period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's ALFA workforce provided 723 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

Nearly four out of every five ALFAs are female, and the median age of the ALFA workforce is 52. In a random encounter between two ALFAs, there is a 49% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index falls to 46% among those ALFAs who are under the age of 40. The comparable diversity index for Virginia's overall population is 60%. Nearly two out of every five ALFAs grew up in a rural area, and 27% of ALFAs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 13% of all ALFAs work in a non-metro area of the state.

Among all ALFAs, 87% are currently employed in the profession, 85% hold one full-time job, and 42% work between 40 and 49 hours per week. Four out of every five ALFAs work in the for-profit sector, while another 17% work in the non-profit sector. The median annual income for ALFAs is between $100,000 and $110,000. In addition, 86% of all ALFAs receive at least one employer-sponsored benefit, including 61% who have access to a retirement plan. Among all ALFAs, 96% are satisfied with their current work situation, including 69% who indicated that they are "very satisfied."

## Summary of Trends

In this section, all statistics for the current year are compared to the 2016 ALFA workforce. The number of licensed ALFAs in Virginia has increased by 5% (673 vs. 643). In addition, the size of the ALFA workforce has increased by 4% (637 vs. 614), and the number of FTEs provided by this workforce has grown by 2% (723 vs. 712). Virginia's renewing ALFAs are more likely to respond to the survey (97% vs. 89%).

The percentage of Virginia's ALFAs who are female has declined (78% vs. 83%), and this decline has also occurred among those ALFAs who are under the age of 40 (79% vs. 86%). Over the same period, the diversity index of Virginia's ALFA workforce has increased (49% vs. 40%). In addition, the diversity index among those ALFAs who are under the age of 40 has risen as well (46% vs. 39%). This has occurred during a time in which the diversity index of the state's overall population has also increased (60% vs. 55%). ALFAs are less likely to have grown up in a rural area (39% vs. 46%), and ALFAs who grew up in a rural area are less likely to work in a non-metro area of Virginia (27% vs. 29%). In total, the percentage of all ALFAs who work in a non-metro area of the state has also declined (13% vs. 20%).

ALFAs are less likely to work in the profession (87% vs. 91%) or hold one full-time job (85% vs. 87%). In addition, ALFAs are relatively more likely to work 60 or more hours per week (19% vs. 15%) than between 40 and 49 hours per week (42% vs. 49%). At the same time, ALFAs are less likely to have worked at their primary work location for more than two years (60% vs. 67%). ALFAs have become relatively more likely to work in the non-profit sector (17% vs. 16%) than in the for-profit sector (80% vs. 83%). With respect to organization type, ALFAs are more likely to work at facility chain organizations (47% vs. 37%) than at independent or stand-alone organizations (42% vs. 56%).

The median annual income for Virginia's ALFA workforce has increased ($100k-$110k vs. $60k-$70k). In addition, ALFAs are more likely to receive at least one employer-sponsored benefit (86% vs. 82%), including those ALFAs who have access to paid vacation time (85% vs. 78%), dental insurance (68% vs. 58%) and a retirement plan (61% vs. 47%). ALFAs are slightly more likely to indicate that they are satisfied with their current employment situation (96% vs. 95%), although the opposite is true among those ALFAs who indicated that they are "very satisfied" (69% vs. 71%).

## A Closer Look:

| Licensees | | |
|---|---|---|
| **License Status** | **#** | **%** |
| **Renewing Practitioners** | 560 | 83% |
| **New Licensees** | 44 | 7% |
| **Non-Renewals** | 69 | 10% |
| **All Licensees** | **673** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*HWDC surveys tend to achieve very high response rates. Among all renewing ALFAs, 97% submitted a survey. These respondents represent 83% of the 673 ALFAs who held a license at some point in the past year.*

### Definitions

1. **The Survey Period:** The survey was conducted in March 2026.
2. **Target Population:** All ALFAs who held a Virginia license at some point between April 2025 and March 2026.
3. **Survey Population:** The survey was available to ALFAs who renewed their licenses online. It was not available to those who did not renew, including some ALFAs newly licensed in the past year.

| Response Rates | | | |
|---|---|---|---|
| **Statistic** | **Non Respondents** | **Respondents** | **Response Rate** |
| **By Age** | | | |
| **Under 30** | 8 | 9 | 53% |
| **30 to 34** | 5 | 29 | 85% |
| **35 to 39** | 10 | 59 | 86% |
| **40 to 44** | 12 | 74 | 86% |
| **45 to 49** | 21 | 65 | 76% |
| **50 to 54** | 12 | 81 | 87% |
| **55 to 59** | 17 | 94 | 85% |
| **60 and Over** | 30 | 147 | 83% |
| **Total** | **115** | **558** | **83%** |
| **New Licenses** | | | |
| **Issued in Past Year** | 28 | 16 | 36% |
| **Metro Status** | | | |
| **Non-Metro** | 23 | 95 | 81% |
| **Metro** | 75 | 419 | 85% |
| **Not in Virginia** | 17 | 44 | 72% |

*Source: Va. Healthcare Workforce Data Center*

| Response Rates | |
|---|---|
| **Completed Surveys** | **558** |
| **Response Rate, All Licensees** | **83%** |
| **Response Rate, Renewals** | **97%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Licensed Administrators**

| | |
|---|---|
| Number: | 673 |
| New: | 7% |
| Not Renewed: | 10% |

**Response Rates**

| | |
|---|---|
| All Licensees: | 83% |
| Renewing Practitioners: | 97% |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Workforce**

| | |
|---|---|
| ALFA Workforce: | 637 |
| FTEs: | 723 |

**Utilization Ratios**

| | |
|---|---|
| Licensees in VA Workforce: | 95% |
| Licensees per FTE: | 0.93 |
| Workers per FTE: | 0.88 |

*Source: Va. Healthcare Workforce Data Center*

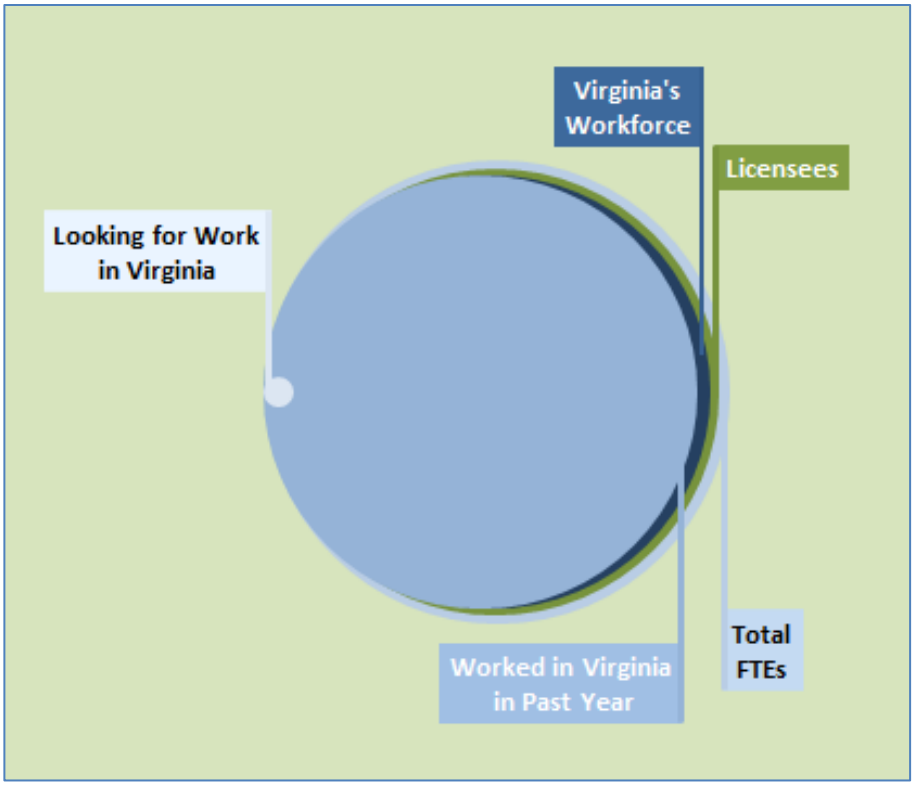
### Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

| Virginia's ALFA Workforce | | |
|---|---|---|
| **Status** | **#** | **%** |
| **Worked in Virginia in Past Year** | 634 | 100% |
| **Looking for Work in Virginia** | 3 | 0% |
| **Virginia's Workforce** | **637** | **100%** |
| **Total FTEs** | **723** | |
| **Licensees** | **673** | |

*Source: Va. Healthcare Workforce Data Center*

*Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/*




*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Age & Gender | | | | | | |
|---|---|---|---|---|---|---|
| Age | Male | | Female | | Total | |
| | # | % Male | # | % Female | # | % in Age Group |
| **Under 30** | 6 | 38% | 9 | 62% | 15 | 3% |
| **30 to 34** | 3 | 11% | 28 | 89% | 31 | 6% |
| **35 to 39** | 12 | 22% | 40 | 78% | 52 | 10% |
| **40 to 44** | 23 | 30% | 54 | 70% | 77 | 14% |
| **45 to 49** | 14 | 21% | 53 | 79% | 67 | 12% |
| **50 to 54** | 18 | 26% | 52 | 74% | 70 | 13% |
| **55 to 59** | 15 | 17% | 73 | 83% | 89 | 17% |
| **60 and Over** | 25 | 19% | 110 | 81% | 136 | 25% |
| **Total** | **117** | **22%** | **420** | **78%** | **538** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| Race & Ethnicity | | | | | |
|---|---|---|---|---|---|
| Race/ Ethnicity | Virginia* | ALFAs | | ALFAs Under 40 | |
| | % | # | % | # | % |
| **White** | 58% | 368 | 67% | 72 | 71% |
| **Black** | 19% | 122 | 22% | 15 | 15% |
| **Asian** | 7% | 29 | 5% | 8 | 8% |
| **Other Race** | 0% | 7 | 1% | 0 | 0% |
| **Two or More Races** | 3% | 5 | 1% | 1 | 1% |
| **Hispanic** | 12% | 15 | 3% | 5 | 5% |
| **Total** | **100%** | **546** | **100%** | **101** | **100%** |

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2024.

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Gender**

| | |
|---|---|
| % Female: | 78% |
| % Under 40 Female: | 79% |

**Age**

| | |
|---|---|
| Median Age: | 52 |
| % Under 40: | 18% |
| % 55 and Over: | 42% |

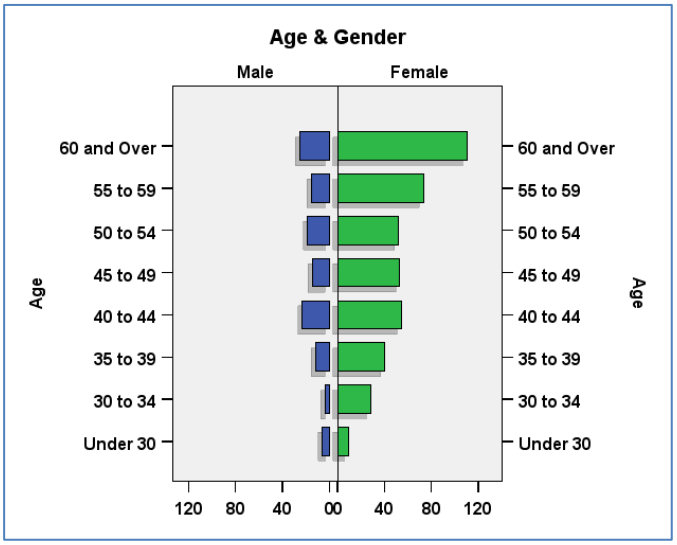
**Diversity**

| | |
|---|---|
| Diversity Index: | 49% |
| Under 40 Div. Index: | 46% |

*Source: Va. Healthcare Workforce Data Center*

*In a chance encounter between two ALFAs, there is a 49% chance that they would be of different races or ethnicities (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 60%.*

*Nearly one out of every five ALFAs are under the age of 40, and 79% of ALFAs who are under the age of 40 are female. In addition, the diversity index among ALFAs who are under the age of 40 is 46%.*




*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Childhood**

| | |
|---|---|
| Urban Childhood: | 16% |
| Rural Childhood: | 39% |

**Virginia Background**

| | |
|---|---|
| HS in Virginia: | 59% |
| Prof. Edu. in VA: | 91% |
| HS or Prof. Edu. in VA: | 92% |

**Location Choice**

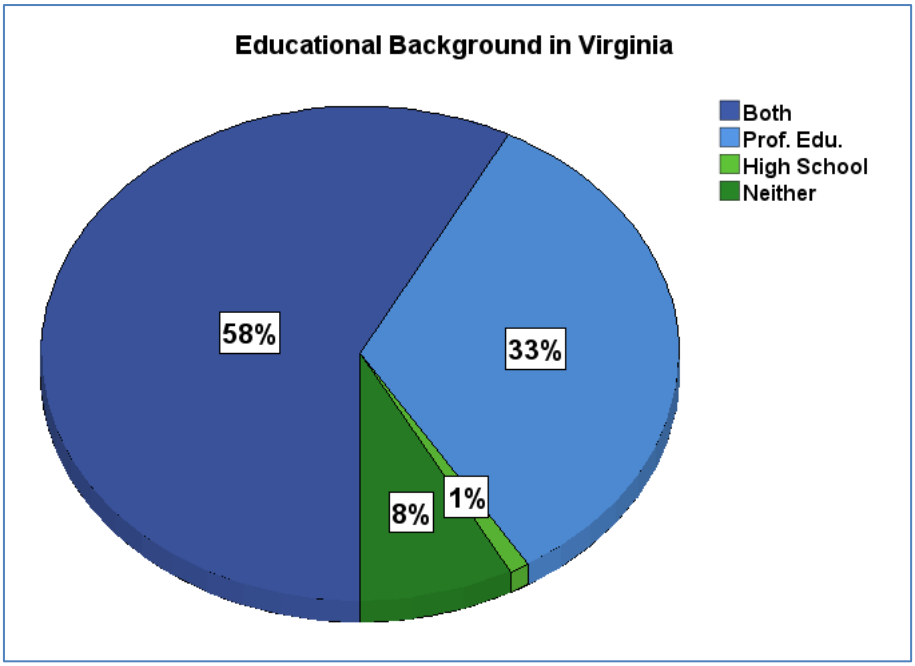
| | |
|---|---|
| % Rural to Non-Metro: | 27% |
| % Urban/Suburban to Non-Metro: | 4% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Primary Location: USDA Rural Urban Continuum | | Rural Status of Childhood Location | | |
|---|---|---|---|---|
| Code | Description | Rural | Suburban | Urban |
| | **Metro Counties** | | | |
| **1** | Metro, 1 Million+ | 26% | 55% | 19% |
| **2** | Metro, 250,000 to 1 Million | 61% | 24% | 15% |
| **3** | Metro, 250,000 or Less | 47% | 42% | 11% |
| | **Non-Metro Counties** | | | |
| **4** | Urban, Pop. 20,000+, Metro Adjacent | 89% | 0% | 11% |
| **6** | Urban, Pop. 2,500-19,999, Metro Adjacent | 93% | 3% | 3% |
| **7** | Urban, Pop. 2,500-19,999, Non-Adjacent | 59% | 29% | 12% |
| **8** | Rural, Metro Adjacent | 100% | 0% | 0% |
| **9** | Rural, Non-Adjacent | 33% | 33% | 33% |
| | **Overall** | **39%** | **44%** | **16%** |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Nearly two out of every five ALFAs grew up in a rural area, and 27% of ALFAs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 13% of all ALFAs currently work in a non-metro area of the state.*

## Top Ten States for Assisted Living Facility Administrator Recruitment

| Rank | All Assisted Living Facility Administrators | | | |
|---|---|---|---|---|
| | High School | # | Init. Prof. Degree | # |
| 1 | Virginia | 313 | Virginia | 436 |
| 2 | Outside U.S./Canada | 45 | North Carolina | 13 |
| 3 | New York | 34 | Maryland | 9 |
| 4 | North Carolina | 19 | South Carolina | 3 |
| 5 | Maryland | 16 | Florida | 2 |
| 6 | Pennsylvania | 16 | Alabama | 1 |
| 7 | Illinois | 9 | Washington, D.C. | 1 |
| 8 | California | 8 | Colorado | 1 |
| 9 | West Virginia | 7 | New York | 1 |
| 10 | Ohio | 7 | West Virginia | 1 |

*Source: Va. Healthcare Workforce Data Center*

*Among all licensed ALFAs, 59% received their high school degree in Virginia, and 91% received their initial professional degree in the state.*

*Among ALFAs who have been licensed in the past five years, 55% received their high school degree in Virginia, and 86% received their initial professional degree in the state.*

| Rank | Licensed in the Past Five Years | | | |
|---|---|---|---|---|
| | High School | # | Init. Prof. Degree | # |
| 1 | Virginia | 112 | Virginia | 156 |
| 2 | Outside U.S./Canada | 13 | Maryland | 8 |
| 3 | Pennsylvania | 10 | North Carolina | 7 |
| 4 | New York | 9 | Florida | 2 |
| 5 | Maryland | 9 | South Carolina | 2 |
| 6 | Illinois | 7 | Alabama | 1 |
| 7 | North Carolina | 5 | Indiana | 1 |
| 8 | Texas | 4 | Nebraska | 1 |
| 9 | Massachusetts | 4 | California | 1 |
| 10 | Indiana | 4 | Ohio | 1 |

*Source: Va. Healthcare Workforce Data Center*

*In total, 5% of all licensees were not a part of Virginia's ALFA workforce. Among these licensees, 94% worked at some point in the past year, including 81% who currently work as an ALFA.*

### At a Glance:

**Not in VA Workforce**

| | |
|---|---|
| Total: | 36 |
| % of Licensees: | 5% |
| Federal/Military: | 0% |
| VA Border State/DC: | 17% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Highest Degree | | | | |
|---|---|---|---|---|
| Degree | Health Administration | | Degree in All Fields | |
| | # | % | # | % |
| No Specific Training | 50 | 10% | - | - |
| Admin-in-Training | 228 | 45% | - | - |
| High School/GED | - | - | 111 | 21% |
| Associate | 42 | 8% | 95 | 18% |
| Baccalaureate | 77 | 15% | 186 | 35% |
| Graduate Cert. | 2 | 0% | 7 | 1% |
| Masters | 66 | 13% | 120 | 23% |
| Doctorate | 5 | 1% | 9 | 2% |
| Other | 41 | 8% | - | - |
| Total | 510 | 100% | 527 | 100% |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Health Admin. Education**

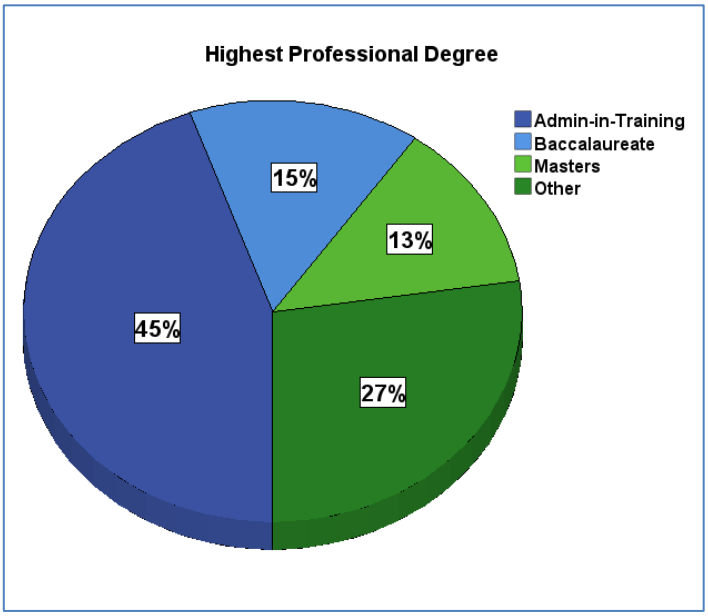
Admin-in-Training: 45%
Baccalaureate Degree: 15%
Master's Degree: 13%

**Education Debt**

Carry Debt: 34%
Under Age 40 w/ Debt: 48%
Median Debt: $40k-$50k

*Source: Va. Healthcare Workforce Data Center*

*More than one out of every three ALFAs carry education debt, including 48% of those ALFAs who are under the age of 40. For those ALFAs with education debt, the median outstanding balance is between $40,000 and $50,000.*




*Source: Va. Healthcare Workforce Data Center*

| Education Debt | | | | |
|---|---|---|---|---|
| Amount Carried | All ALFAs | | ALFAs Under 40 | |
| | # | % | # | % |
| None | 293 | 66% | 42 | 50% |
| Less than $10,000 | 23 | 5% | 5 | 6% |
| $10,000-$19,999 | 16 | 4% | 5 | 6% |
| $20,000-$29,999 | 10 | 2% | 2 | 2% |
| $30,000-$39,999 | 15 | 3% | 7 | 8% |
| $40,000-$49,999 | 13 | 3% | 0 | 0% |
| $50,000-$59,999 | 16 | 4% | 5 | 6% |
| $60,000-$69,999 | 11 | 2% | 3 | 4% |
| $70,000-$79,999 | 11 | 2% | 3 | 4% |
| $80,000-$89,999 | 3 | 1% | 0 | 0% |
| $90,000-$99,999 | 5 | 1% | 1 | 1% |
| $100,000 or More | 28 | 6% | 9 | 11% |
| Total | 444 | 100% | 84 | 100% |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Licenses/Registrations**

| | |
|---|---|
| Nurse (RN or LPN): | 18% |
| RMA: | 14% |
| CNA: | 4% |

**Job Titles**

| | |
|---|---|
| Administrator: | 34% |
| Executive Director: | 26% |
| President/Exec. Officer: | 5% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Licenses and Registrations | | |
|---|---|---|
| **License/Registration** | **#** | **%** |
| **ALF Administrator** | 525 | 82% |
| **Nurse (RN or LPN)** | 112 | 18% |
| **Registered Medication Aide** | 92 | 14% |
| **Certified Nursing Assistant** | 28 | 4% |
| **Nursing Home Administrator** | 6 | 1% |
| **Speech-Language Pathologist** | 2 | 0% |
| **Occupational Therapist** | 1 | 0% |
| **Physical Therapist** | 1 | 0% |
| **Other** | 30 | 5% |
| **At Least One License** | **527** | **83%** |

*Source: Va. Healthcare Workforce Data Center*

| Job Titles | | | | |
|---|---|---|---|---|
| **Title** | **Primary** | | **Secondary** | |
| | **#** | **%** | **#** | **%** |
| **Administrator** | 218 | 34% | 22 | 3% |
| **Executive Director** | 163 | 26% | 17 | 3% |
| **President or Executive Officer** | 30 | 5% | 8 | 1% |
| **Assistant Administrator** | 25 | 4% | 4 | 1% |
| **Owner** | 23 | 4% | 7 | 1% |
| **Other** | 102 | 16% | 15 | 2% |
| **At Least One Title** | **482** | **76%** | **57** | **9%** |

*Source: Va. Healthcare Workforce Data Center*

*More than one-third of all ALFAs hold the title of administrator at their primary work location. Another 26% hold the title of executive director.*

## At a Glance:

**Employment**

Employed in Profession: 87%
Involuntarily Unemployed: 1%

**Positions Held**

1 Full-Time: 85%
2 or More Positions: 9%

**Weekly Hours:**

40 to 49: 42%
60 or More: 19%
Less than 30: 3%

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Current Work Status | | |
|---|---|---|
| **Status** | **#** | **%** |
| **Employed, Capacity Unknown** | 0 | 0% |
| **Employed in a Capacity Related to Long-Term Care** | 459 | 87% |
| **Employed, NOT in a Capacity Related to Long-Term Care** | 57 | 11% |
| **Not Working, Reason Unknown** | 0 | 0% |
| **Involuntarily Unemployed** | 7 | 1% |
| **Voluntarily Unemployed** | 7 | 1% |
| **Retired** | 0 | 0% |
| **Total** | **530** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*Among all ALFAs, 87% are currently employed in the profession, 85% hold one full-time job, and 42% work between 40 and 49 hours per week.*

| Current Positions | | |
|---|---|---|
| **Positions** | **#** | **%** |
| **No Positions** | 14 | 3% |
| **One Part-Time Position** | 15 | 3% |
| **Two Part-Time Positions** | 4 | 1% |
| **One Full-Time Position** | 436 | 85% |
| **One Full-Time Position & One Part-Time Position** | 28 | 5% |
| **Two Full-Time Positions** | 10 | 2% |
| **More than Two Positions** | 6 | 1% |
| **Total** | **513** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| Current Weekly Hours | | |
|---|---|---|
| **Hours** | **#** | **%** |
| **0 Hours** | 14 | 3% |
| **1 to 9 Hours** | 1 | 0% |
| **10 to 19 Hours** | 8 | 2% |
| **20 to 29 Hours** | 8 | 2% |
| **30 to 39 Hours** | 20 | 4% |
| **40 to 49 Hours** | 213 | 42% |
| **50 to 59 Hours** | 150 | 29% |
| **60 to 69 Hours** | 67 | 13% |
| **70 to 79 Hours** | 17 | 3% |
| **80 or More Hours** | 12 | 2% |
| **Total** | **510** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Annual Income | | |
|---|---|---|
| **Income Level** | **#** | **%** |
| **Volunteer Work Only** | 2 | 1% |
| **Less than $30,000** | 13 | 3% |
| **$30,000-$39,999** | 5 | 1% |
| **$40,000-$49,999** | 11 | 3% |
| **$50,000-$59,999** | 11 | 3% |
| **$60,000-$69,999** | 25 | 6% |
| **$70,000-$79,999** | 30 | 7% |
| **$80,000-$89,999** | 38 | 9% |
| **$90,000-$99,999** | 38 | 9% |
| **$100,000-$109,999** | 51 | 12% |
| **$110,000-$119,999** | 34 | 8% |
| **$120,000-$129,999** | 38 | 9% |
| **$130,000-$139,999** | 26 | 6% |
| **$140,000-$149,999** | 16 | 4% |
| **$150,000 or More** | 80 | 19% |
| **Total** | **419** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Earnings**

Median Income: $100k-$110k

**Benefits**

Paid Vacation: 85%

Retirement: 61%

*Source: Va. Healthcare Workforce Data Center*

*The median annual income for ALFAs is between $100,000 and $110,000. In addition, 86% of ALFAs receive at least one employer-sponsored benefit, including 61% who have access to a retirement plan.*

| Employer-Sponsored Benefits | | |
|---|---|---|
| **Benefit** | **#** | **%** |
| **Paid Vacation** | 389 | 85% |
| **Paid Sick Leave** | 313 | 68% |
| **Dental Insurance** | 310 | 68% |
| **Retirement** | 279 | 61% |
| **Group Life Insurance** | 255 | 56% |
| **Signing/Retention Bonus** | 55 | 12% |
| **At Least One Benefit** | **397** | **86%** |

*From any employer at time of survey.

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Satisfaction**

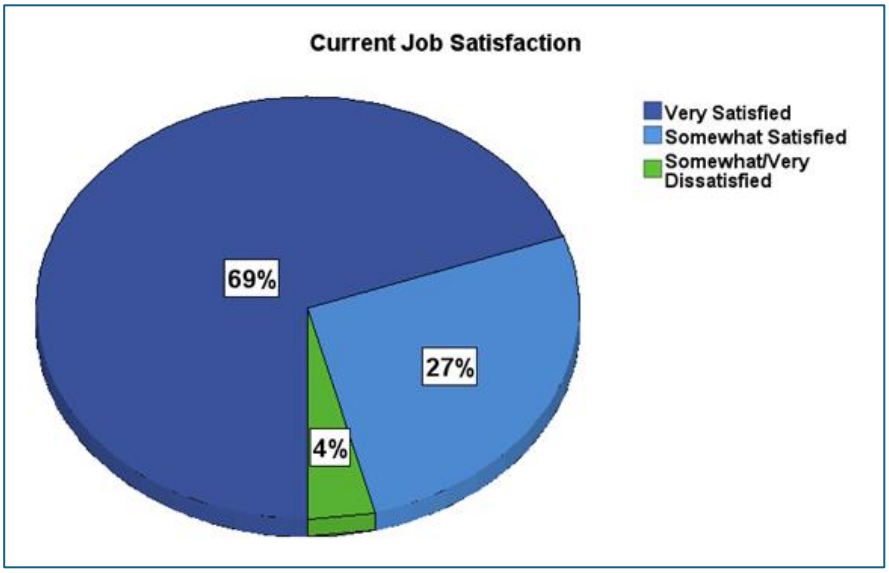
| | |
|---|---|
| Satisfied: | 96% |
| Very Satisfied: | 69% |

**Exhaustion**

| | |
|---|---|
| Burned Out: | 35% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




*Source: Va. Healthcare Workforce Data Center*

| Job Satisfaction | | |
|---|---|---|
| **Level** | **#** | **%** |
| **Very Satisfied** | 364 | 69% |
| **Somewhat Satisfied** | 139 | 27% |
| **Somewhat Dissatisfied** | 17 | 3% |
| **Very Dissatisfied** | 4 | 1% |
| **Total** | **524** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*Among all ALFAs, 96% are satisfied with their current employment situation, including 69% who indicated that they are "very satisfied."*

*More than one out of every three ALFAs are feeling burned out with their job. Among these ALFAs, 63% will continue to work in their current position.*

| Burned Out? | | |
|---|---|---|
| | **#** | **%** |
| **Yes** | 182 | 35% |
| **No** | 333 | 65% |
| **Total** | **515** | **100%** |
| **Experiencing Burnout** | **#** | **%** |
| **Will Continue to Work in Current Position** | 115 | 63% |
| **Planning to Leave LTC Profession within 1-2 Years** | 39 | 21% |
| **Seeking Another Position in LTC Profession** | 14 | 8% |
| **Seeking Professional Resources to Deal with Burn Out** | 14 | 8% |
| **Total** | **182** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Employment Instability in the Past Year | | |
|---|---|---|
| **In The Past Year, Did You . . .?** | **#** | **%** |
| **Experience Involuntary Unemployment?** | 9 | 1% |
| **Experience Voluntary Unemployment?** | 19 | 3% |
| **Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?** | 7 | 1% |
| **Work Two or More Positions at the Same Time?** | 95 | 15% |
| **Switch Employers or Practices?** | 49 | 8% |
| **Experience at Least One?** | **161** | **25%** |

*Source: Va. Healthcare Workforce Data Center*

*Among Virginia's ALFAs, 1% experienced involuntary unemployment at some point in the past year. By comparison, Virginia's average monthly unemployment rate was 3.6% during the same time period.*[1]

### At a Glance:

**Unemployment Experience**

Involuntarily Unemployed: 1%
Underemployed: 1%

**Turnover & Tenure**

Switched Jobs: 8%
New Location: 21%
Over 2 Years: 60%
Over 2 Yrs., 2nd Location: 49%

*Source: Va. Healthcare Workforce Data Center*

| Location Tenure | | | | |
|---|---|---|---|---|
| **Tenure** | **Primary** | | **Secondary** | |
| | **#** | **%** | **#** | **%** |
| **Not Currently Working at This Location** | 4 | 1% | 6 | 10% |
| **Less than 6 Months** | 39 | 8% | 5 | 8% |
| **6 Months to 1 Year** | 56 | 11% | 7 | 12% |
| **1 to 2 Years** | 99 | 20% | 12 | 20% |
| **3 to 5 Years** | 112 | 22% | 9 | 15% |
| **6 to 10 Years** | 64 | 13% | 9 | 15% |
| **More than 10 Years** | 127 | 25% | 11 | 19% |
| **Subtotal** | **501** | **100%** | **59** | **100%** |
| **Did Not Have Location** | 14 | | 565 | |
| **Item Missing** | 122 | | 13 | |
| **Total** | **637** | | **637** | |

*Source: Va. Healthcare Workforce Data Center*

*Three out of every five ALFAs have worked at their primary location for more than two years.*

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate fluctuated between a low of 3.0% and a high of 3.9%. At the time of publication, the unemployment rate from February 2026 was still preliminary, and the unemployment rate from March 2026 had not yet been released.

## At a Glance:

**Concentration**

| | |
|---|---|
| Top Region: | 28% |
| Top 3 Regions: | 69% |
| Lowest Region: | 1% |

**Locations**

| | |
|---|---|
| 2 or More (Past Year): | 14% |
| 2 or More (Now*): | 10% |

*Source: Va. Healthcare Workforce Data Center*

*More than two out of every three ALFAs in the state work in Northern Virginia, Central Virginia, or Hampton Roads.*

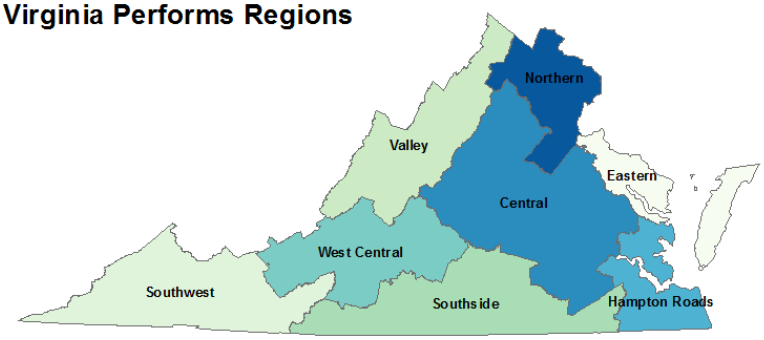
## A Closer Look:

**Regional Distribution of Work Locations**

| VA Performs Region | Primary Location | | Secondary Location | |
|---|---|---|---|---|
| | # | % | # | % |
| Central | 116 | 23% | 15 | 25% |
| Eastern | 6 | 1% | 0 | 0% |
| Hampton Roads | 92 | 18% | 10 | 17% |
| Northern | 141 | 28% | 13 | 22% |
| Southside | 24 | 5% | 2 | 3% |
| Southwest | 23 | 5% | 3 | 5% |
| Valley | 41 | 8% | 5 | 8% |
| West Central | 59 | 12% | 7 | 12% |
| Virginia Border State/D.C. | 0 | 0% | 1 | 2% |
| Other U.S. State | 1 | 0% | 4 | 7% |
| Outside of the U.S. | 0 | 0% | 0 | 0% |
| **Total** | **503** | **100%** | **60** | **100%** |
| Item Missing | 121 | | 12 | |

*Source: Va. Healthcare Workforce Data Center*

**Virginia Performs Regions**




*Source: Va. Healthcare Workforce Data Center*

**Number of Work Locations**

| Locations | Work Locations in Past Year | | Work Locations Now* | |
|---|---|---|---|---|
| | # | % | # | % |
| 0 | 3 | 1% | 8 | 2% |
| 1 | 429 | 85% | 444 | 88% |
| 2 | 56 | 11% | 38 | 7% |
| 3 | 8 | 2% | 7 | 1% |
| 4 | 1 | 0% | 1 | 0% |
| 5 | 0 | 0% | 1 | 0% |
| 6 or More | 7 | 1% | 6 | 1% |
| **Total** | **505** | **100%** | **505** | **100%** |

*At the time of survey completion, March 2026.

*Source: Va. Healthcare Workforce Data Center*

*While 10% of ALFAs currently have multiple work locations, 14% have had multiple work locations over the past 12 months.*

## A Closer Look:

| Location Sector | | | | |
|---|---|---|---|---|
| Sector | Primary Location | | Secondary Location | |
| | # | % | # | % |
| For-Profit | 392 | 80% | 45 | 83% |
| Non-Profit | 84 | 17% | 7 | 13% |
| State/Local Government | 11 | 2% | 1 | 2% |
| Veterans Administration | 0 | 0% | 0 | 0% |
| U.S. Military | 0 | 0% | 0 | 0% |
| Other Federal Government | 1 | 0% | 1 | 2% |
| **Total** | **488** | **100%** | **54** | **100%** |
| Did Not Have Location | 14 | | 565 | |
| Item Missing | 136 | | 18 | |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:
**(Primary Locations)**

**Sector**

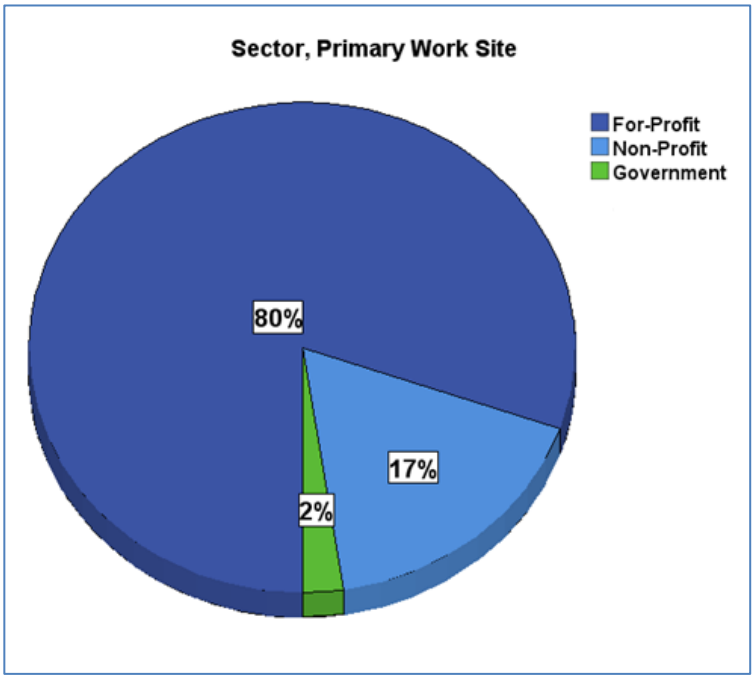
For-Profit: 80%
Federal: <1%

**Top Establishments**

Assisted Living Facility: 67%
Continuing Care Retirement Community: 4%
Home/Community Health: 2%

*Source: Va. Healthcare Workforce Data Center*

*Among all ALFAs, 80% work in the for-profit sector, while another 17% work in the non-profit sector.*




*Source: Va. Healthcare Workforce Data Center*

| Location Type | | | | |
|---|---|---|---|---|
| Establishment Type | Primary Location | | Secondary Location | |
| | # | % | # | % |
| Assisted Living Facility | 427 | 67% | 47 | 7% |
| Continuing Care Retirement Community | 25 | 4% | 3 | 0% |
| Home/Community Health Care | 15 | 2% | 1 | 0% |
| Skilled Nursing Facility | 14 | 2% | 0 | 0% |
| Adult Day Care | 9 | 1% | 0 | 0% |
| Hospice | 5 | 1% | 1 | 0% |
| Acute Care/Rehabilitative Facility | 4 | 1% | 0 | 0% |
| Academic Institution | 3 | 0% | 0 | 0% |
| PACE | 3 | 0% | 0 | 0% |
| Other Practice Type | 48 | 8% | 8 | 1% |
| **At Least One Establishment** | **493** | **77%** | **59** | **9%** |

*Source: Va. Healthcare Workforce Data Center*

*Two out of every three ALFAs are employed at an assisted living facility as their primary work location.*

*Among all ALFAs, 47% are employed at a facility chain organization as their primary work location. Another 42% of ALFAs are employed at an independent/stand-alone organization.*

| Location Type | | | | |
|---|---|---|---|---|
| Organization Type | Primary Location | | Secondary Location | |
| | # | % | # | % |
| Facility Chain | 213 | 47% | 15 | 32% |
| Independent/Stand Alone | 193 | 42% | 29 | 62% |
| Hospital-Based | 8 | 2% | 1 | 2% |
| College or University | 5 | 1% | 0 | 0% |
| Integrated Health System (Veterans Administration, Large Health System) | 1 | 0% | 0 | 0% |
| Other | 37 | 8% | 2 | 4% |
| **Total** | **457** | **100%** | **47** | **100%** |
| Did Not Have Location | 14 | | 565 | |
| Item Missing | 165 | | 25 | |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:
### (Primary Locations)

**Languages Offered**

| | |
|---|---|
| Spanish: | 16% |
| Tagalog/Filipino: | 5% |
| French: | 3% |

**Means of Communication**

| | |
|---|---|
| Other Staff Members: | 65% |
| Respondent: | 29% |
| Virtual Translation: | 25% |

*Source: Va. Healthcare Workforce Data Center*

*Among all ALFAs, 16% are employed at a primary work location that offers Spanish language services for patients.*

## A Closer Look:

| Languages Offered | | |
|---|---|---|
| **Language** | **#** | **% of Workforce** |
| **Spanish** | 103 | 16% |
| **Tagalog/Filipino** | 35 | 5% |
| **French** | 21 | 3% |
| **Hindi** | 15 | 2% |
| **Amharic, Somali, or Other Afro-Asiatic Languages** | 13 | 2% |
| **Korean** | 12 | 2% |
| **Chinese** | 10 | 2% |
| **Arabic** | 8 | 1% |
| **Urdu** | 7 | 1% |
| **Vietnamese** | 6 | 1% |
| **Persian** | 4 | 1% |
| **Pashto** | 2 | 0% |
| **Others** | 17 | 3% |
| **At Least One Language** | **145** | **23%** |

*Source: Va. Healthcare Workforce Data Center*

| Means of Language Communication | | |
|---|---|---|
| **Provision** | **#** | **% of Workforce with Language Services** |
| **Other Staff Member is Proficient** | 94 | 65% |
| **Respondent is Proficient** | 42 | 29% |
| **Virtual Translation Services** | 36 | 25% |
| **Onsite Translation Service** | 9 | 6% |
| **Other** | 1 | 1% |

*Source: Va. Healthcare Workforce Data Center*

*Nearly two out of every three ALFAs who are employed at a primary work location that offers language services for patients provide it by means of a staff member who is proficient.*

## At a Glance:
### (Primary Locations)

**Typical Time Allocation**

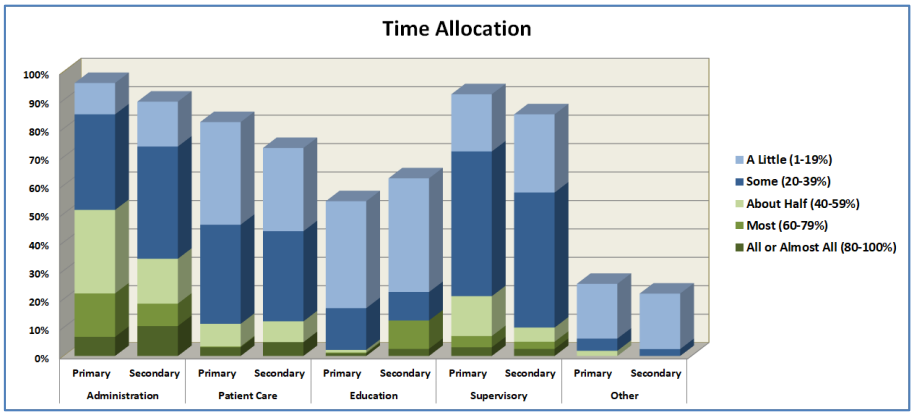
| | |
|---|---|
| Administration: | 40%-49% |
| Supervisory: | 20%-29% |
| Patient Care: | 10%-19% |
| Education: | 1%-9% |

**Roles**

| | |
|---|---|
| Administration: | 22% |
| Supervisory: | 7% |
| Patient Care: | 3% |
| Education: | 1% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




*Source: Va. Healthcare Workforce Data Center*

*ALFAs spend close to half of their time performing administrative tasks. In fact, 22% of ALFAs fill an administrative role, defined as spending 60% or more of their time on administrative activities.*

| Time Allocation | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time Spent | Admin. | | Patient Care | | Education | | Supervisory | | Other | |
| | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site |
| All or Almost All (80-100%) | 7% | 10% | 3% | 5% | 1% | 2% | 3% | 2% | 0% | 0% |
| Most (60-79%) | 15% | 7% | 0% | 0% | 0% | 10% | 4% | 2% | 0% | 0% |
| About Half (40-59%) | 29% | 15% | 8% | 7% | 1% | 0% | 14% | 5% | 2% | 0% |
| Some (20-39%) | 34% | 37% | 35% | 32% | 15% | 10% | 51% | 46% | 4% | 2% |
| A Little (1-19%) | 11% | 15% | 36% | 29% | 38% | 39% | 20% | 27% | 19% | 20% |
| None (0%) | 4% | 10% | 18% | 27% | 45% | 37% | 8% | 15% | 74% | 78% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Patient Workload | | | | |
|---|---|---|---|---|
| # of Patients | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **None** | 41 | 10% | 6 | 12% |
| **1-24** | 64 | 16% | 14 | 27% |
| **25-49** | 51 | 13% | 10 | 20% |
| **50-74** | 74 | 18% | 5 | 10% |
| **75-99** | 75 | 18% | 5 | 10% |
| **100-124** | 60 | 15% | 3 | 6% |
| **125-149** | 8 | 2% | 0 | 0% |
| **150-174** | 2 | 0% | 2 | 4% |
| **175-199** | 4 | 1% | 1 | 2% |
| **200 or More** | 27 | 7% | 4 | 8% |
| **Total** | **408** | **100%** | **51** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Patient Workload (Median)**

Primary Location: 50-74
Secondary Location: 25-49

**Resident Capacity (Median)**

Primary Location: 50-100
Secondary Location: 50-100

*Source: Va. Healthcare Workforce Data Center*

*The median patient workload for ALFAs at their primary work location is between 50 and 74 patients. In addition, the typical ALFA works at a facility that contains between 50 and 100 beds for residents.*

| Resident Capacity | | | | |
|---|---|---|---|---|
| # of Beds | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **Not Applicable** | 46 | 9% | 10 | 18% |
| **10 or Less** | 31 | 6% | 6 | 11% |
| **10-25** | 38 | 8% | 4 | 7% |
| **25-50** | 55 | 11% | 7 | 12% |
| **50-100** | 177 | 36% | 16 | 28% |
| **100-150** | 93 | 19% | 11 | 19% |
| **150-250** | 30 | 6% | 2 | 4% |
| **More than 250** | 21 | 4% | 1 | 2% |
| **Total** | **491** | **100%** | **57** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Retirement Expectations | | | | |
|---|---|---|---|---|
| Expected Retirement Age | All ALFAs | | ALFAs 50 and Over | |
| | # | % | # | % |
| Under Age 50 | 8 | 2% | - | - |
| 50 to 54 | 14 | 3% | 2 | 1% |
| 55 to 59 | 24 | 5% | 3 | 1% |
| 60 to 64 | 90 | 20% | 55 | 21% |
| 65 to 69 | 177 | 38% | 92 | 36% |
| 70 to 74 | 78 | 17% | 54 | 21% |
| 75 to 79 | 27 | 6% | 23 | 9% |
| 80 or Over | 10 | 2% | 7 | 3% |
| I Do Not Intend to Retire | 34 | 7% | 22 | 9% |
| Total | 461 | 100% | 258 | 100% |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Retirement Expectations**

**All ALFAs**

Under 65: 30%

Under 60: 10%

**ALFAs 50 and Over**

Under 65: 23%

Under 60: 2%

**Time Until Retirement**

Within 2 Years: 10%

Within 10 Years: 33%

Half the Workforce: By 2046

*Source: Va. Healthcare Workforce Data Center*

*Three out of every ten ALFAs expect to retire before the age of 65. Among ALFAs who are age 50 and over, 23% expect to retire before the age of 65.*

*Within the next two years, 13% of ALFAs expect to begin accepting Administrators-in-Training, and 12% of ALFAs expect to pursue additional educational opportunities.*

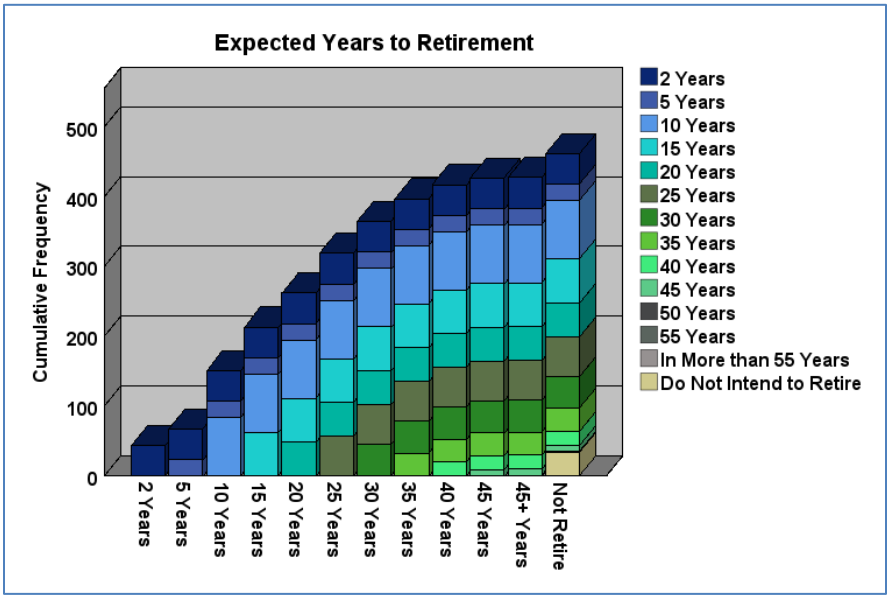
| Future Plans | | |
|---|---|---|
| Two-Year Plans: | # | % |
| **Decrease Participation** | | |
| Leave Profession | 18 | 3% |
| Leave Virginia | 34 | 5% |
| Decrease Patient Care Hours | 53 | 8% |
| Decrease Teaching Hours | 3 | 0% |
| Cease Accepting Trainees | 5 | 1% |
| **Increase Participation** | | |
| Increase Patient Care Hours | 37 | 6% |
| Increase Teaching Hours | 18 | 3% |
| Pursue Additional Education | 76 | 12% |
| Return to the Workforce | 1 | 0% |
| Begin Accepting Trainees | 80 | 13% |

*Source: Va. Healthcare Workforce Data Center*

*By comparing retirement expectation to age, we can estimate the maximum years to retirement for ALFAs. While 10% of ALFAs expect to retire in the next two years, 33% expect to retire within the next decade. More than half of the current ALFA workforce expect to retire by 2046.*

| Time to Retirement | | | |
|---|---|---|---|
| Expect to Retire Within. . . | # | % | Cumulative % |
| **2 Years** | 44 | 10% | 10% |
| **5 Years** | 23 | 5% | 15% |
| **10 Years** | 84 | 18% | 33% |
| **15 Years** | 62 | 13% | 46% |
| **20 Years** | 49 | 11% | 57% |
| **25 Years** | 57 | 12% | 69% |
| **30 Years** | 46 | 10% | 79% |
| **35 Years** | 33 | 7% | 86% |
| **40 Years** | 20 | 4% | 91% |
| **45 Years** | 9 | 2% | 93% |
| **50 Years** | 1 | 0% | 93% |
| **55 Years** | 0 | 0% | 93% |
| **In More than 55 Years** | 0 | 0% | 93% |
| **Do Not Intend to Retire** | 34 | 7% | 100% |
| **Total** | **461** | **100%** | |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Using these estimates, retirement will begin to reach over 10% of the current workforce every five years by 2036. Retirement will peak at 18% of the current workforce around the same time before declining to under 10% again by 2061.*

## At a Glance:

**FTEs**

| | |
|---|---|
| Total: | 723 |
| FTEs/1,000 Residents[2]: | .082 |
| Average: | 1.16 |

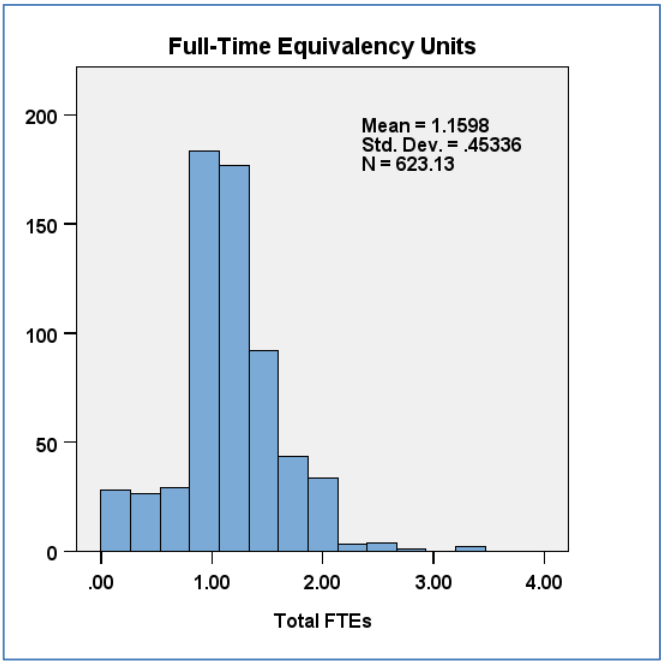
**Age & Gender Effect**

| | |
|---|---|
| Age, *Partial Eta*$^2$: | Small |
| Gender, *Partial Eta*$^2$: | None |

*Partial Eta*$^2$ *Explained:*
*Partial Eta*$^2$ is a statistical measure of effect size.

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

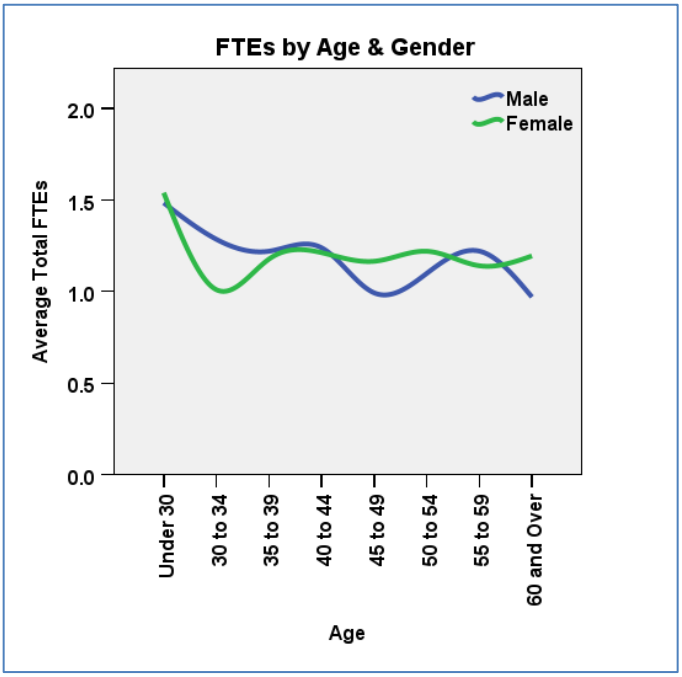



*Source: Va. Healthcare Workforce Data Center*

*The typical ALFA provided 1.09 FTEs in the past year, or approximately 44 hours per week for 50 weeks. Statistical tests did not indicate that FTEs vary by either age or gender.*

| Full-Time Equivalency Units | | |
|---|---|---|
| **Age** | **Average** | **Median** |
| **Under 30** | 1.44 | 1.13 |
| **30 to 34** | 1.04 | 1.09 |
| **35 to 39** | 1.16 | 1.12 |
| **40 to 44** | 1.29 | 1.18 |
| **45 to 49** | 1.11 | 1.09 |
| **50 to 54** | 1.16 | 1.07 |
| **55 to 59** | 1.15 | 1.18 |
| **60 and Over** | 1.12 | 1.09 |
| **Gender** | | |
| **Male** | 1.14 | 1.09 |
| **Female** | 1.18 | 1.18 |

*Source: Va. Healthcare Workforce Data Center*

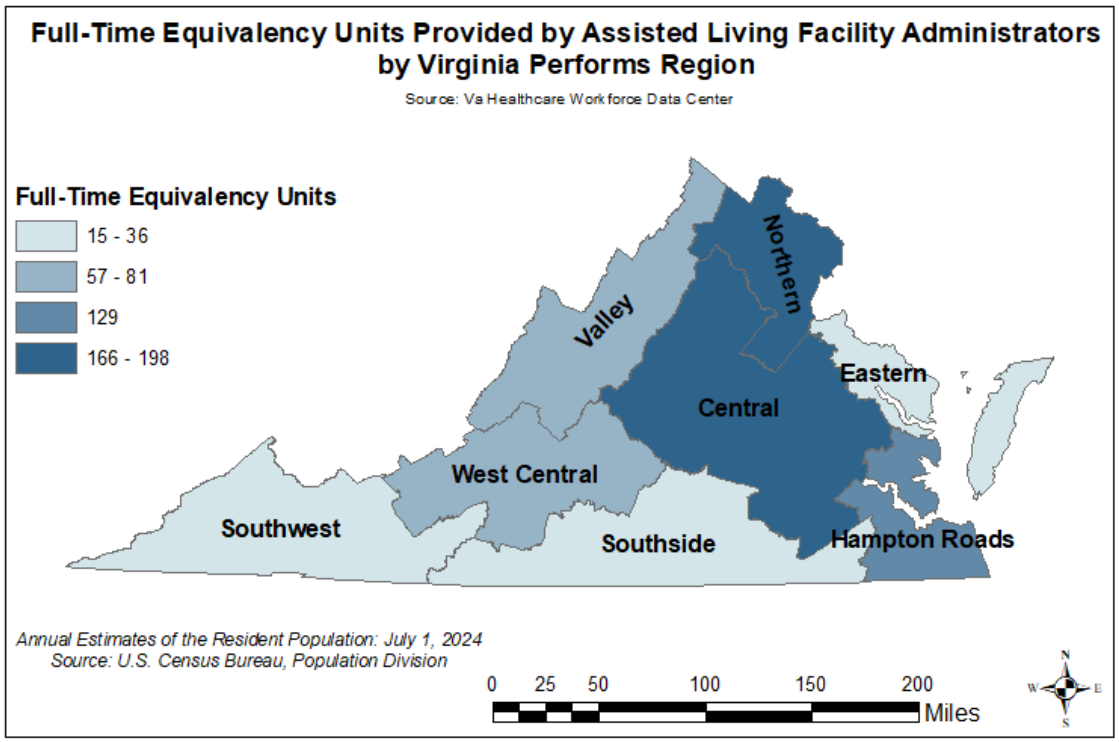


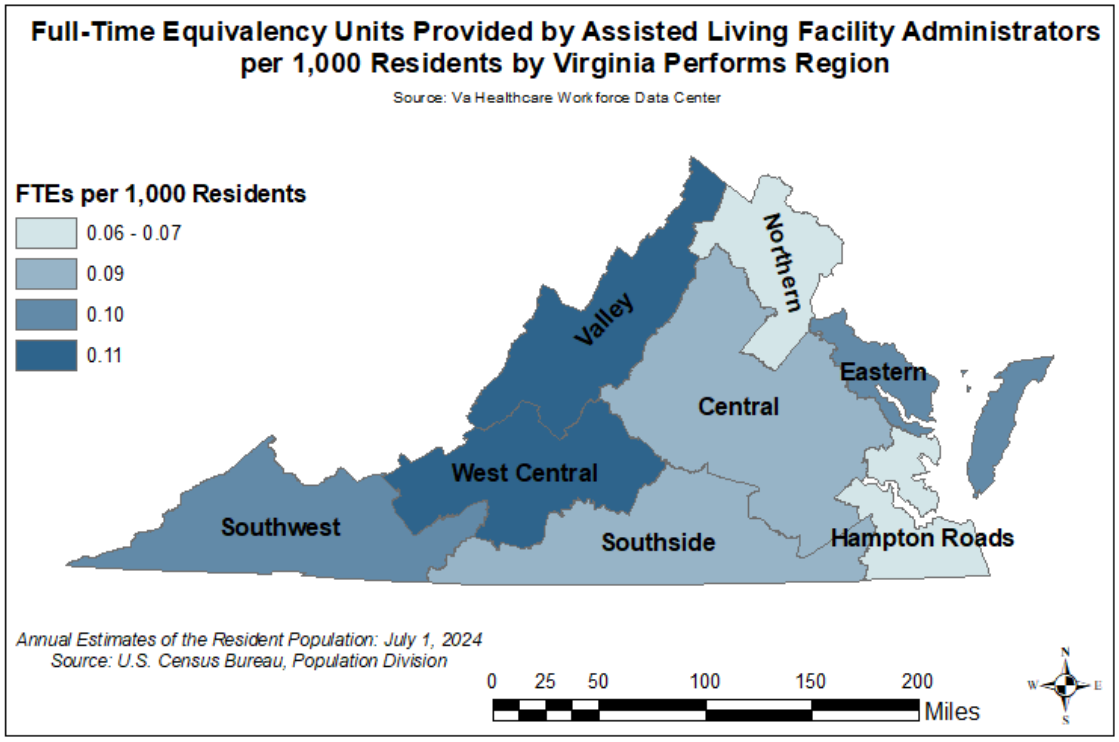

*Source: Va. Healthcare Workforce Data Center*

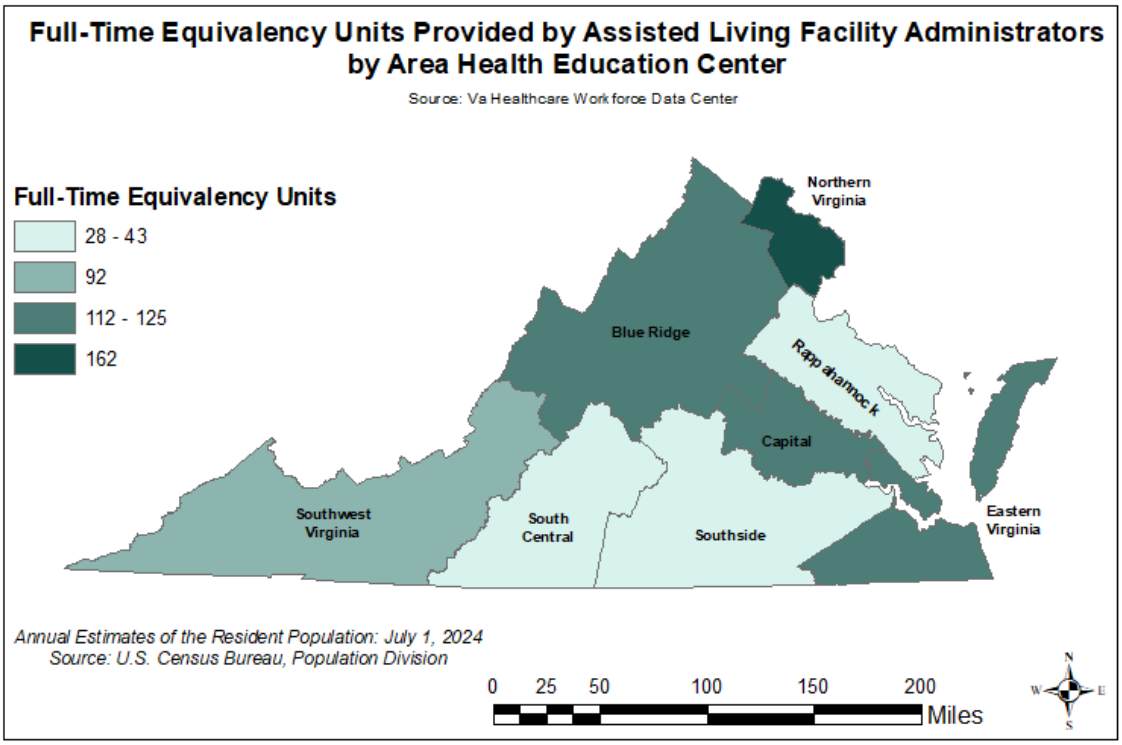
[2] Number of residents in 2024 was used as the denominator.

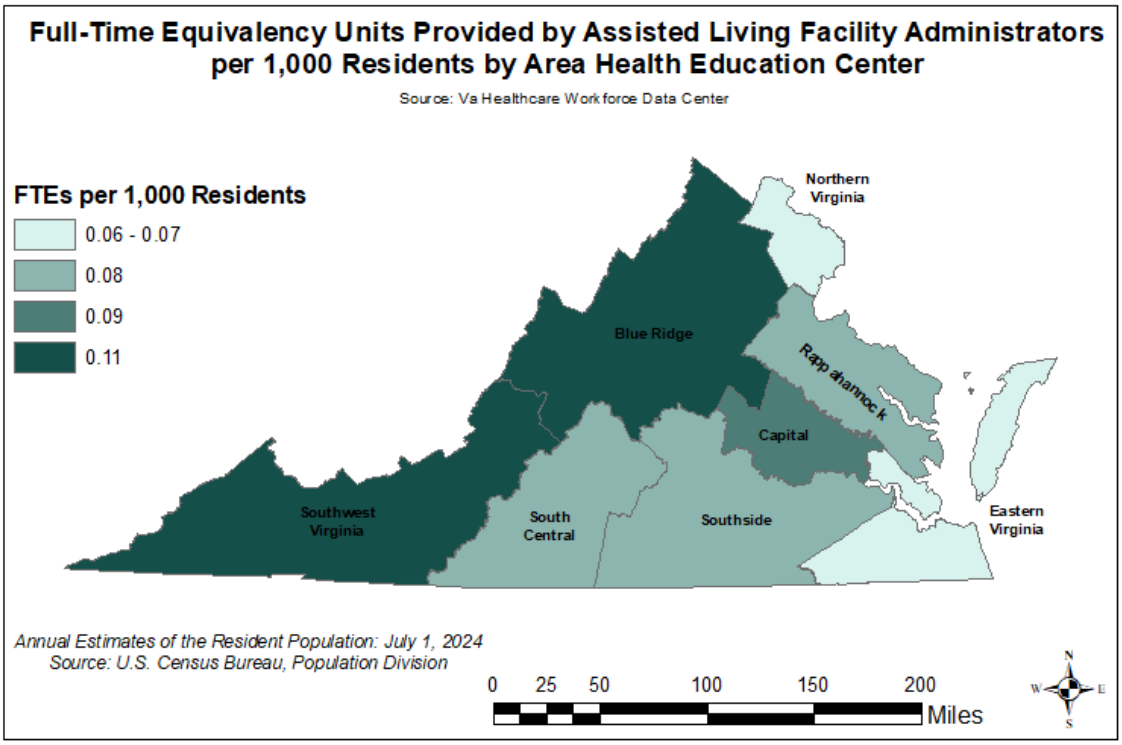
## Maps

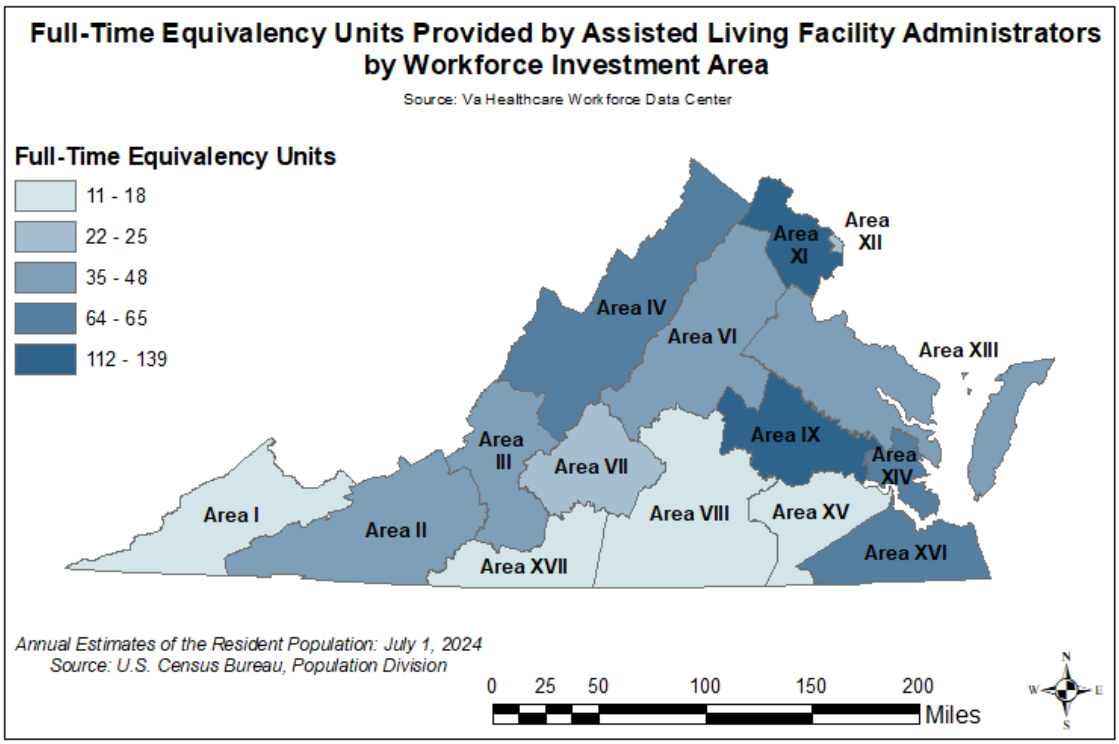
### Virginia Performs Regions

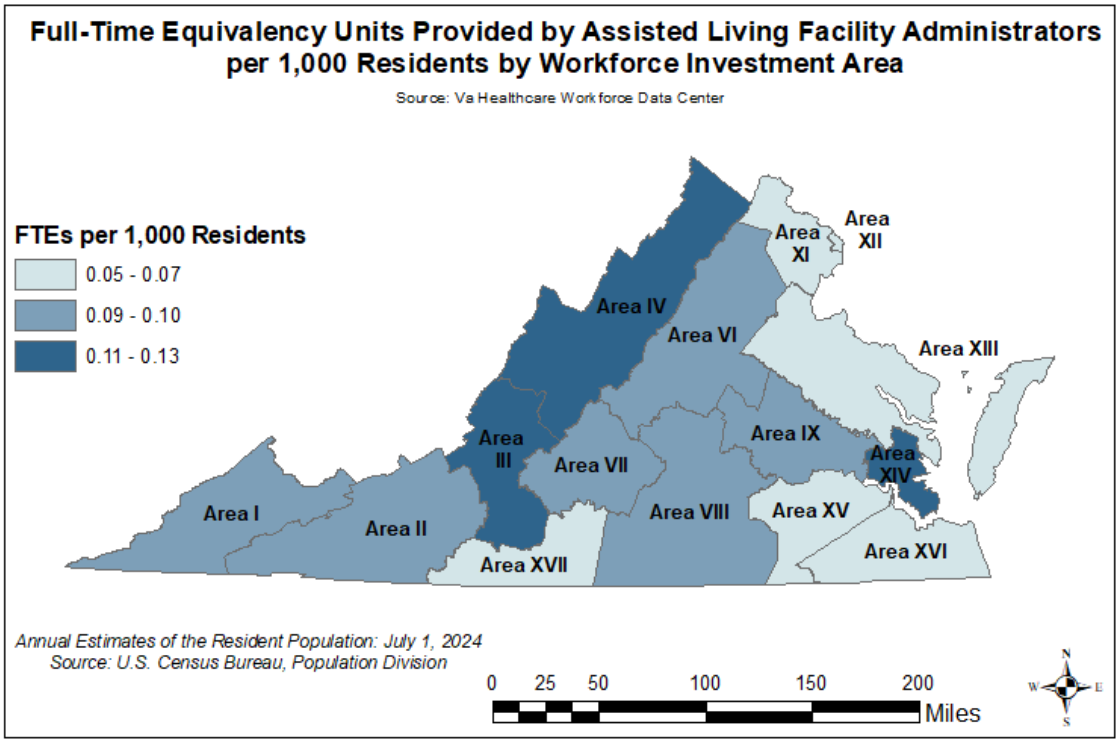


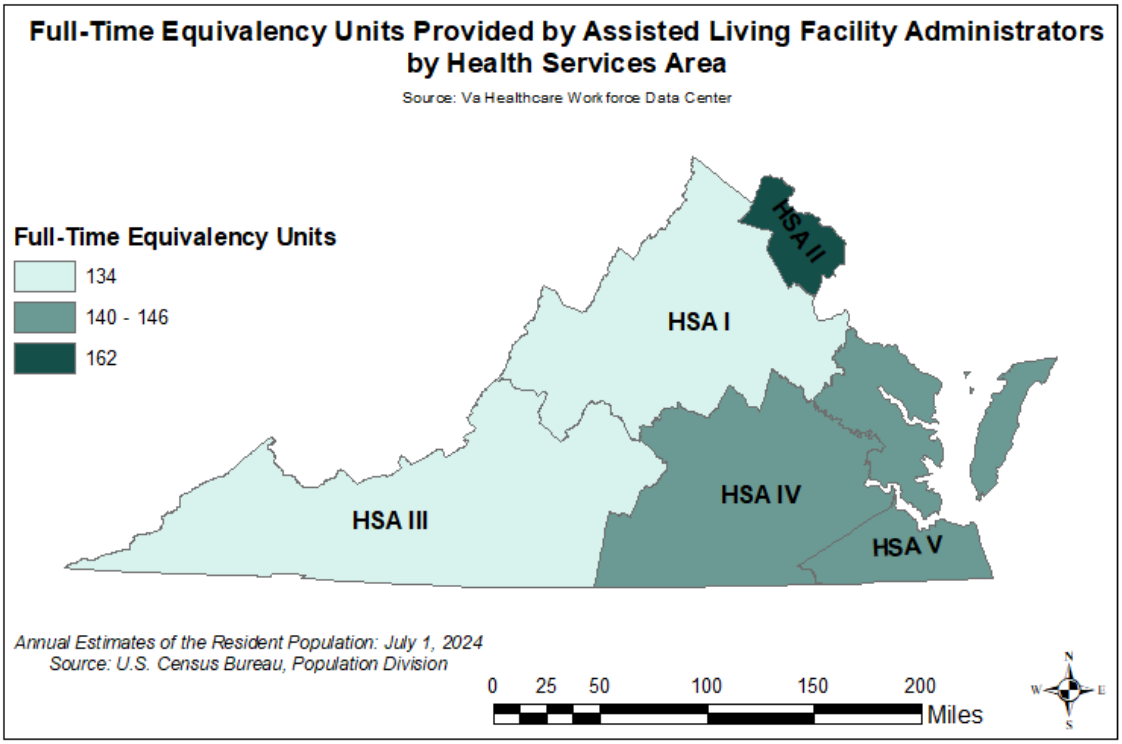



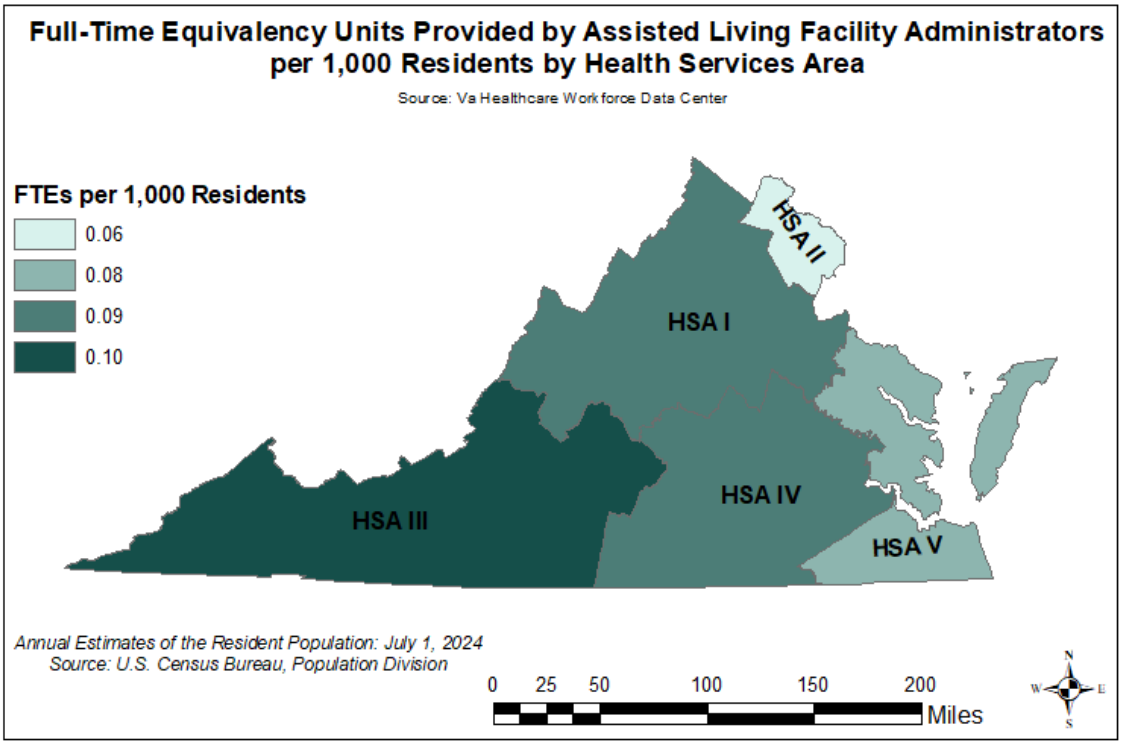

Full-Time Equivalency Units Provided by Assisted Living Facility Administrators by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
28 - 43
92
112 - 125
162
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

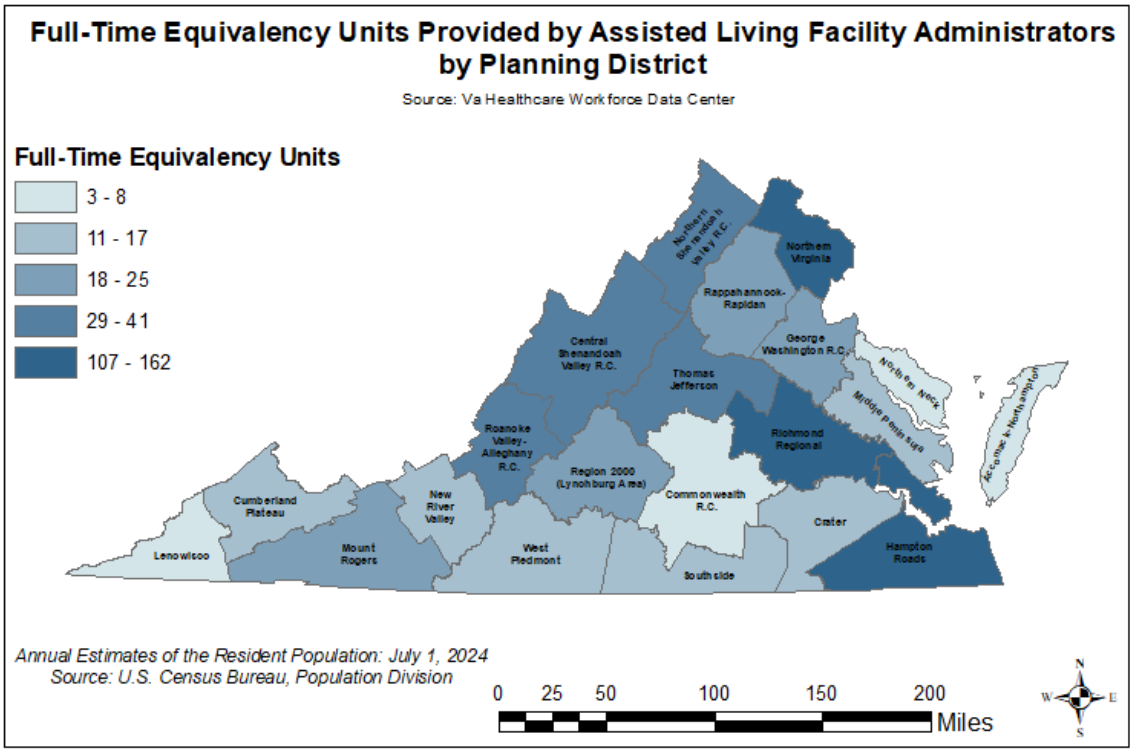

Full-Time Equivalency Units Provided by Assisted Living Facility Administrators per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.06 - 0.07
0.08
0.09
0.11
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

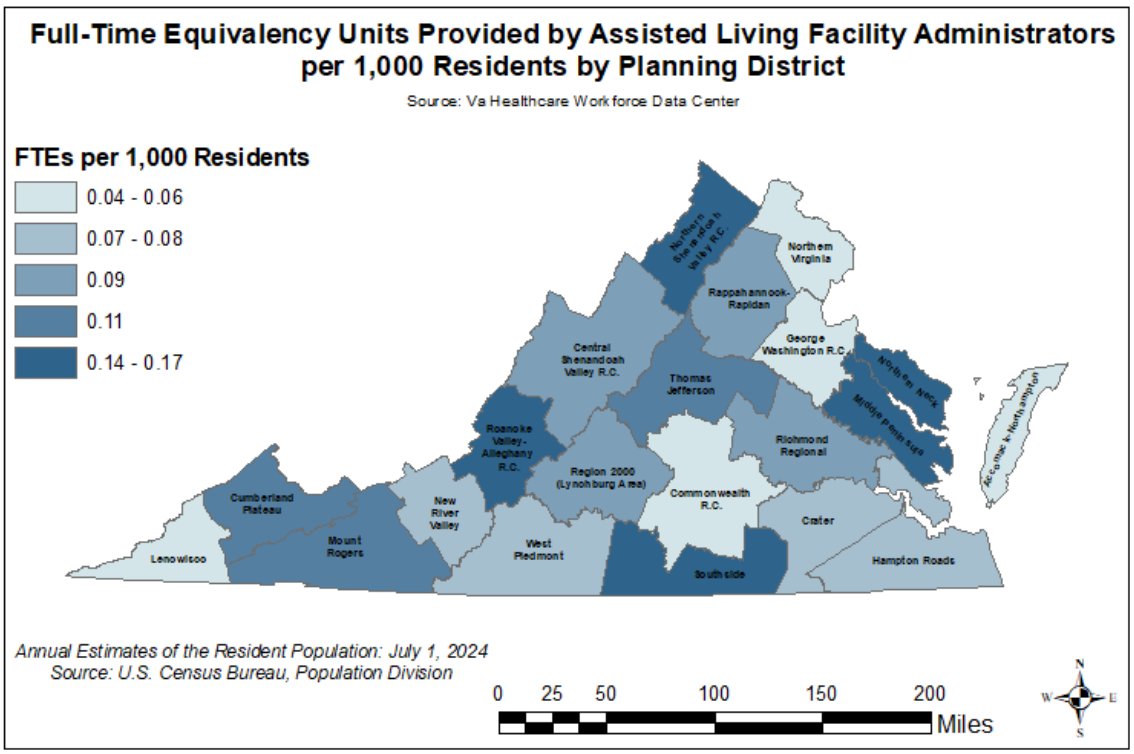

Full-Time Equivalency Units Provided by Assisted Living Facility Administrators by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
11 - 18
22 - 25
35 - 48
64 - 65
112 - 139
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Assisted Living Facility Administrators per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.05 - 0.07
0.09 - 0.10
0.11 - 0.13
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Assisted Living Facility Administrators by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
134
140 - 146
162
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Assisted Living Facility Administrators per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.06
0.08
0.09
0.10
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Assisted Living Facility Administrators by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
3 - 8
11 - 17
18 - 25
29 - 41
107 - 162
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Assisted Living Facility Administrators per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.04 - 0.06
0.07 - 0.08
0.09
0.11
0.14 - 0.17
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2024
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

## Appendix A: Weights

| Rural Status | Location Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min. | Max. |
| Metro, 1 Million+ | 387 | 86.05% | 1.162 | 1.106 | 1.820 |
| Metro, 250,000 to 1 Million | 61 | 81.97% | 1.220 | 1.161 | 1.911 |
| Metro, 250,000 or Less | 46 | 78.26% | 1.278 | 1.216 | 2.001 |
| Urban, Pop. 20,000+, Metro Adj. | 12 | 75.00% | 1.333 | 1.285 | 1.331 |
| Urban, Pop. 20,000+, Non-Adj. | 0 | NA | NA | NA | NA |
| Urban, Pop. 2,500-19,999, Metro Adj. | 51 | 78.43% | 1.275 | 1.214 | 1.399 |
| Urban, Pop. 2,500-19,999, Non-Adj. | 27 | 85.19% | 1.174 | 1.118 | 1.288 |
| Rural, Metro Adj. | 15 | 93.33% | 1.071 | 1.020 | 1.175 |
| Rural, Non-Adj. | 13 | 69.23% | 1.444 | 1.375 | 1.585 |
| Virginia Border State/D.C. | 44 | 75.00% | 1.333 | 1.269 | 1.463 |
| Other U.S. State | 17 | 64.71% | 1.545 | 1.471 | 1.543 |

*Source: Va. Healthcare Workforce Data Center*

| Age | Age Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min. | Max. |
| Under 30 | 17 | 52.94% | 1.889 | 1.820 | 2.001 |
| 30 to 34 | 34 | 85.29% | 1.172 | 1.130 | 1.296 |
| 35 to 39 | 69 | 85.51% | 1.169 | 1.039 | 1.401 |
| 40 to 44 | 86 | 86.05% | 1.162 | 1.032 | 1.489 |
| 45 to 49 | 86 | 75.58% | 1.323 | 1.175 | 1.585 |
| 50 to 54 | 93 | 87.10% | 1.148 | 1.020 | 1.471 |
| 55 to 59 | 111 | 84.68% | 1.181 | 1.049 | 1.513 |
| 60 and Over | 177 | 83.05% | 1.204 | 1.070 | 1.543 |

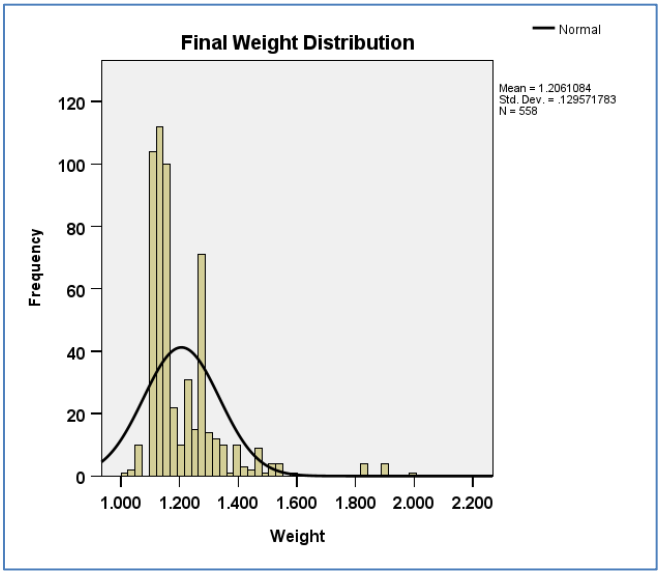
*Source: Va. Healthcare Workforce Data Center*

See the Methodology section on the HWDC website for details on HWDC methods: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

**Overall Response Rate**: **0.829123**




*Source: Va. Healthcare Workforce Data Center*