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The next decade will be defined by rising acuity, tightening labor, and a decisive shift toward tech-enabled aging in place across skilled nursing, assisted living, home care, and home- and community-based services (HCBS).

Demographic and market forces reshaping the continuum

In 2026, the "silver tsunami" is no longer a metaphor; the oldest baby boomers are moving firmly into the ages where functional decline, chronic illness, and dementia drive higher service utilization. Senior housing occupancy in primary and secondary markets climbed from 87.4% at the end of 2024 to 89.4% in Q4 2025 and is projected to reach a new cyclical high in 2026 as demand accelerates. At the same time, construction of new senior housing has slowed sharply–completions have fallen by roughly 73% since 2021–creating a supply-demand imbalance for existing providers. This is encouraging mergers and acquisitions, as pandemic-weary investors look for exits, and future-focused capital funds seek to take advantage.

Even though it is a much more mixed story, skilled nursing facility (SNF) occupancies have experienced a parallel recovery, with national occupancy rising from a pandemic low near 67% in 2021 to about 79% by mid-2025, approaching pre-2015 levels. This rebound is being fueled by growth in hospital discharges to post acute settings and persistent clinical complexity in the Medicare population. For managers, these structural trends mean that the time of "waiting out" volatility is over; the organizations that will thrive are those that reposition their service mix and physical plant around emerging consumer and payer expectations.


Irving L. Stackpole

Skilled nursing: Higher acuity, tech-enabled care, and margin pressure

The skilled nursing sector in 2026 is characterized by recovering occupancy, volatile reimbursement, and ongoing pressure to manage higher-acuity patients in a constrained labor market. CMS's 2026 final rule provides an approximate 3.2% net rate increase for the SNF prospective payment system–positive, but below the prior year's 4.2%. This is keeping operators in a narrow margin band even as wages and other cost inputs are elevated. Publicly traded SNF operators report strong year over year revenue growth, signaling that payor mix optimization, length-of-stay management, and clinical program development are now core strategic levers rather than peripheral initiatives.

Technology adoption is no longer optional. Sector leaders are deploying advanced electronic medical records, AI-supported monitoring, and predictive analytics to track vital signs, hydration, gait, and wound trajectories in real time, reducing hospital transfers and adverse events. These capabilities support earlier intervention for pressure injuries, sepsis, and falls, aligning SNFs with hospital value based purchasing and readmission penalties. At the same time, SNFs are under pressure from health systems' "hospital at home" programs, which increasingly siphon off lower acuity Medicare episodes that once defaulted to residential post-acute care. Administrators who wish to remain preferred partners will need to double down on subspecialty programs (e.g., complex wound care, ventilator weaning, cardiac and neuro rehabilitation) and seamless data exchange with referring hospital and health system EMRs.

From a capital perspective, investment flows have resumed, but lenders and REITs are increasingly selective, favoring operators who demonstrate robust clinical quality metrics, occupancy recovery, and credible workforce strategies. As policy proposals aimed at constraining Medicare and Medicaid growth advance in Washington, the SNF sector will see heightened scrutiny of staffing ratios, antipsychotic use, and infection control, all requiring disciplined, data-driven management.

Assisted living: Lifestyle-driven demand meets rising acuity

Assisted living and other senior living models are being reshaped by boomers who view residential communities as lifestyle choices rather than end-of-life necessities. The market is tilting toward independent and "active adult plus" configurations that emphasize privacy, hospitality, and wellness, while preserving the capacity to layer in home health and supportive services as residents age in place. Research is finding that many boomers, even though delaying entry, are seeking amenities and social engagement, not basic custodial care, which pushes initial acuity slightly lower but accelerates acuity growth once residents are on campus.

In 2026, amenities such as multiple dining venues, demonstration kitchens, a fitness and wellness culture, and curated social programming are increasingly viewed as standard rather than premium. Communities are replacing traditional therapy gyms with holistic wellness hubs that include yoga studios,

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Challenges for the oldest state

by Richard A. Gamache, FACHCA

Here's a trivia question: What state is the "oldest" in the country?

You might guess that it's Delaware, the first state to adopt the U.S. Constitution in December 1787, but that's not the answer. Perhaps your guess is Virginia. After all, it was the first colony to be settled, back in 1607. Again, not the correct answer.

Here's a hint: It is in New England, and what makes it "oldest" is that 1 in 5 of its residents are over the age of 65, qualifying it as America 's "oldest" state.

If your guess is Maine, congratulations, you win the prize: A lifetime subscription to New England Administrator!

A combination of lower birth rates and increased longevity of older adults in Maine are the two factors often cited as the causes of the increase in average age. Nonetheless, this circumstance has far-reaching implications for health care, especially long-term services and support, affordable housing options, and state funding assistance.

Thirty years ago, Maine legislators sounded the alarm to reduce Medicaid spending even before the demographics began to shift. They strategized as to how to decrease nursing home utilization. Through a variety of tactics, including increased certificate of need regulations and budget cuts, Maine now has about 4,000 fewer nursing home beds. This is due to the closure of 50 homes in a ten-year period, with most of those (29) occurring since the Covid pandemic.

According to longtime owner/operator John Orestis, Covid "crushed" homes. Decreased census and the exorbitant costs of temporary "traveler" staff to fill holes caused by an unprecedented labor shortage drove the already challenged nursing home sector to the brink financially.

The closures impacted rural areas especially hard. Some counties in northern Maine have no nursing homes at all, while many older homes remain open, for now, at least. In Maine, certain nursing home buildings are over 100 years old. They date back before the Great Depression and were likely designed by people who were born in the 1800s.

The need for increased capital, supported by government sources, couldn't be more critical.

Today, because of the immediate needs of its aging population, Maine's reliance on Medicaid for nursing home residents remains 5 percentage points higher than the 63% U.S. average.

At the same time as nursing homes have closed, assisted living has expanded by over 4,000 apartments, which may seem a bit like a shell game, except that most assisted living residents are paying privately. Maine Medicaid, called Maine Care, pays for certain assisted living services, but not for room and board. Senior advocates point out that many Maine Care recipients end up in nursing homes at a much higher cost to the state because they cannot afford assisted living.

Currently, 30% of all Maine residents are enrolled in Maine Care. That number is poised to continue increasing as the population ages, and it will eventually be unsustainable. Elected officials need to work with those in the senior care sector to find effective solutions to the increasing demand for service and support, rather than use shortsighted budget cuts to force a shift in the costs of care.

Like most of the surrounding New England states, Maine nursing homes have undergone dramatic changes in ownership recently. What were once family-owned enterprises are now businesses operated by for-profit corporations. Many remain devoted to high-quality care and compliance, while a few, especially those from out-of-state, seem focused primarily on the bottom line.

"Many of the families that operated nursing homes have sold and retired," Orestis remembers. He recalls that the nursing homes business was not sophisticated when he first pondered a career in the field.

"I was considering the purchase of a family-run home. In most of those situations, it was a husband and wife who served as administrator and nursing director. In one case, the wife would go grocery shopping, and whatever she purchased would be used to make up the menus and meals for that week."

In some ways, we are trying to recapture some of the "home-ness" of that era, while existing within a regulatory framework that tends to discourage innovation in favor of compliance.

There are unique challenges within the state of Maine that must be met with a collaborative approach from providers, advocates, consumers, and elected officials. As the "oldest" state in America, Maine is, in some ways, the "canary in the coal mine" for the rest of the U.S. It needs to serve as a valuable testing ground to bring long-term care from the past into the future. Perhaps being the "oldest" provides the best opportunity to get it right.

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The future of long-term care: Is assisted living the solution?

by K.R. Kaffenberger, PhD

For several years Irving Stackpole has been expressing concern for the future of long-term care for the old and disabled. He has published many articles that touch on this topic in the New England Administrator. In the December 2019 edition he talked about the physical plant issues in his piece, "Marketing Healthcare in times of trouble." Stackpole pointed out that the inventory of skilled nursing facilities (SNFs) was old by then with little renovation or new construction since the early 1990s. He questioned if anyone would choose to stay in a hotel which had not undergone a serious renovation in 30 years but highlighted the difficulty of financing such upgrades for most facilities.

In his article "The trifecta of pain for SNFs" (September 2022), Stackpole highlighted the problems caused by ever-more stringent regulations of the industry. He said, "…now there is not a more heavily regulated segment in the healthcare system" than SNFs. He goes on to talk about a White House fact sheet that detailed 21 suggestions for regulatory change–all of which were more demanding and restrictive. Meanwhile, he addressed the financial side of the equation saying that the US "spends less than other developed economies on long term care." There is high regulatory control by government together with limited expenditure, Stackpole noted. In the December 2022 issue Seth Wilson wrote "Trends in New England Senior Care," which also highlighted the fiscal plight nursing homes, which are largely dependent on Medicaid, face.

Stackpole again addressed the problems that nursing homes are facing in "Notes from an Optimist? Now I'm not so sure" (April 2024). He highlighted census problems as a key source of the financial quagmire in which so many of us find our facilities. Medicare at the time was a boon for facilities but entirely too few (he said 10%) had the Medicare and private census they needed for financial stability and health.

A year later I reported on the work of my colleagues at UMass Boston in "Payment for and Quality of Medicaid Services." Ed Miller, Marc Cohen, and others carefully analyzed and reported on Medicaid payments in 44 states. As suspected, they found out that Medicaid is vastly underfunded and routinely fails to pay the cost of care for its residents in most states. Diminished quality is a likely result. This simple fact explains a lot of what is wrong in long term care right now.

I am not alone in thinking that underpayment by Medicaid is a root cause of many of the problems in nursing homes. The lack of capital improvement, the underpayment of staff, and the failure to explore change are largely related to facility underpayment. For those thoughtful and daring enough to want to try to change in a risky environment, the awful burden of excessive and ever-increasing regulations stymies them.

There is literature on the financial problems of long-term services and supports (LTSS) which includes long-term care as we know it. The emphasis in much of this literature is on home- and community-based services (HCBS). There is little contradictory evidence to be found there. The Bipartisan Policy Council published a couple of pieces from Investopedia that talked about the One Big Beautiful Bill Act cutting $1 trillion from Medicaid. In an earlier piece the author indicated that about 80% of nursing home and HCBS is paid by Medicaid and that the burden of that care would shift entirely to the states beyond the limited federal contribution. The Kaiser Family Foundation piece on OBBBA focuses mostly on HCBS other than to point out that the Biden era staffing standards were negated by the new law.

Despite the affection that academics and the press have for HCBS, it is not doing any better financially or in terms of labor dynamics than residential long-term care. So, the long-held view that the answer for those in nursing homes is HCBS is not really functional without substantially more funding by recipients, insurers, and/or governments.

So, what is the answer for the future of what we have called nursing homes or SNFs? On the financial side, if insurance would adequately cover costs, that would solve one important problem. Marc Cohen and others have spent years of research effort looking at the possibilities that may exist. As this article demonstrates, something will almost certainly have to be done to address this.

However, even a successful effort to give individuals and families choices may not really solve things for nursing homes. The industry would still face the enormous and expensive burden of regulation. More importantly, fewer members of the public look at SNFs as the answer when they or their loved ones need care resulting from old age or disability. While users of nursing homes may be grateful, potential users fear the necessity of having to enter the Medicaid-supported long-term care system. While the expense is excessive for most individuals, the reputation of nursing homes is a marketing disaster.

A more acceptable form of care for some people is assisted living. What's more, assisted living facilities are licensed by states but are not paid or overseen by the federal government. This frees them from federal oversight and reliance on federal funds. The assisted living model may offer a path to survival and even success for nursing homes and most SNFs.

Looking at other states can be informative as we consider assisted living licenses. New England states have fairly restrictive rules around assisted living. But Maryland (and other states) offers an interesting contrast. A website (https://alfboss.com/) presents a summary of the Code of Maryland Regulations (COMAR) for assisted living. Because assisted living is state li-

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NAB today: Resources, mobility, and professional growth

by Elizabeth Lollis

Many nursing home administrators first learn about the National Association of Long Term Care Administrator Boards (NAB) when they are preparing for licensure. For some, that may have been years ago, when NAB was most familiar as the organization behind the national licensing examinations. That role is still important, but NAB's work has grown. Today, the organization supports state licensing boards and long-term care administrators through examinations, continuing education resources, licensure portability efforts, the HSE qualification, and academic standards, all with a focus on public protection, professional competency, and the changing needs of the long-term care profession.

One resource administrators may find especially helpful is NAB's Continuing Education (CE) Registry. The registry gives administrators a centralized place to track continuing education needed for licensure renewal. NAB also reviews and approves CE programs through the National Continuing Education Review Service (NCERS), and those NAB-approved CEs are accepted by nearly all states for renewal. Administrators can search NAB's Approved CE Database to find programs and state licensing boards can use the CE Registry to verify that state CE requirements have been met.

NAB is also paying close attention to licensure mobility, an issue that continues to affect healthcare professionals across the country. Many administrators work for organizations that operate in more than one state, or they may consider opportunities outside the state where they were first licensed. When that happens, obtaining another state license can be complicated and time-consuming.

NAB NATIONAL ASSOCIATION OF LONG TERM CARE ADMINISTRATOR BOARDS

The Health Services Executive (HSE) qualification was developed to help with that challenge. The HSE is nationally recognized and reflects an individual's education, experience, and examination achievements across the continuum of long-term services and support. It does not replace an NHA license, but it can provide another pathway to obtain a state-issued NHA license. For administrators, that can make the process of seeking licensure in another state more manageable. For states, it gives licensing boards another way to evaluate qualified applicants while still maintaining professional standards.

NAB also supports students who are preparing to enter the profession. Through its Academic Accreditation program, NAB accredits college/university programs that offer a baccalaureate or graduate degree in long-term care administration and meet NAB's standards for quality education and training, including a 1,000-hour administrator residency/AIT. Graduates of NAB HSE accredited programs are eligible to seek the HSE qualification directly after graduation, giving them a clear starting point as they begin their careers as nursing home administrators.

NAB's work matters because it helps keep administrators,

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It probably didn't start in your building

by Mikhail Novikov, MD

Most of the pressure ulcers that show up in a nursing home began somewhere else–usually upstream, in the hospital. But your official numbers won't show it unless your team documents the wound the day the resident arrives. Here is why that one habit protects your survey, your legal exposure, your hospital relationships, and your bottom line.

Picture a typical weekend admission. A resident arrives from the hospital after a long stay–medically complex, weeks of barely moving. Three weeks later, a stage 3 pressure ulcer surfaces on the heel. On paper, it is now your building's wound. It will be counted that way, surveyed that way, and–if things go badly–sued that way.

Here is the part most people outside the clinical world never hear: That wound almost certainly did not start in your building.

Pay attention to the skin assessment

Pressure ulcers travel with patients. By some estimates, as many as 70% of the pressure injuries that appear in post-acute care began upstream during the acute hospital stay, where long surgeries, sedation, malnutrition, and days of immobility do their damage. You won't see that in the official documentation. The records make it look like the wounds started with your facility.

The reason is documentation, specifically the nursing assessment on admission.

A pressure ulcer only counts as "present on admission" if someone finds it and writes it down, correctly, in the short window after the resident arrives. Miss it– because the skin assessment was rushed, because the wound was early and subtle, because staging is genuinely difficult–and the official record quietly reclassifies it as facility-acquired. The wound the hospital handed you becomes, on paper, a wound you caused. Mismatched timelines make it worse: Facility quality measures and clinician assessments don't always line up, so a wound a physician clearly documents as present on admission can still land in your facility-acquired column.

The single most valuable thirty minutes in a resident's entire stay may be the skin assessment performed on day one.

This lands on three desks you care about

A missed admission wound is not a clinical footnote. It shows up in the three places that keep administrators awake, starting with your survey.

F-686, the federal pressure-injury tag at §483.25(b), turns on one word: avoidable. The regulation accepts that some wounds can't be prevented in sick, immobile people. What it doesn't forgive is a wound that looks facility-acquired and preventable. An undocumented present-on-admission wound looks exactly like that. Document it on arrival, and you're simply managing the hospital's outcome; miss it and it's your deficiency.

Your legal exposure. Pressure ulcers are one of the most common and most expensive claims in long-term care. Serious cases can result in substantial settlements and verdicts, particularly when advanced pressure ulcers contribute to infection, hospitalization, or death.

The first thing a plaintiff's attorney looks for is whether the wound was present on admission, and whether you can prove it. A clear admission record is the line between "this arrived with the resident" and "this appeared in our care." One is a defense. The other is a check.

And documentation can do more than separate the hospital's wounds from yours. Not every facility-acquired wound is a failure of care. The regulation itself concedes that some pressure ulcers develop even when a facility does everything right. The resident is too ill, too immobile, too malnourished, or declines the very interventions that would have protected the skin. But "unavoidable" is not a label you apply after the fact. It is a case you build in real time, and building it takes a highly trained wound care team.

That is because unavoidable-wound documentation cannot be templated. It requires an individualized record–the specific risk factors identified, the interventions attempted and adjusted, the refusals and contraindications noted as they happened–written by clinicians with the knowledge and experience to anticipate what legal scrutiny will look for. Boilerplate phrases repeated across charts are the first thing a plaintiff's attorney highlights. A genuinely individualized record of a wound that could not be prevented is one of the strongest protections a facility can hold.

Your reputation and your referring hospitals. Families read your Care Compare numbers before they ever tour. Discharge planners track whether the residents they send you come back worse. When a wound deteriorates into a hospital transfer, you don't just lose a resident for a few days; you tell the hospital that feeds your census that you couldn't manage what you accepted. Referrals are a relationship, and a bounce-back is a withdrawal from that account.

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This summary was developed in collaboration with the American Society of Consultant Pharmacists

According to National Institute of Neurological Disorders and Stroke, Parkinson's disease (PD) is the **second-most common** neurodegenerative disorder and majority of people diagnosed with PD are **60 years of age or older**.[1]

In the United States, roughly **90,000 people** are diagnosed with PD each year.[2]

A study has shown that patients with Parkinson's disease psychosis have **increased** odds of death compared to PD patients.[3]

A 2024 retrospective analysis was conducted on data from a 100% Medicare sample (parts A, B, and D claims) in long-term care/nursing home (LTC/NH) settings.[4] Outcomes included three measures: risks of falls only, fractures only, and falls/fractures.[4] This analysis examined Parkinson's disease psychosis (PDP) residents on continuous monotherapy with **pimavanserin (PIM)** versus **other atypical antipsychotics (AAPs)** (quetiapine, risperidone, olanzapine, aripiprazole), and **quetiapine (QUE)**.[4]

After propensity score matched (PSM) comparative cohort of **PIM** (n = 1005) **versus other AAPs cohort** (n = 1005) **results**.[4]

- **Risk of falls only:** For PIM was 4.58% (*n* = 46) compared with 7.66% (*n* = 77) for other AAPs [RR = 0.60 (0.42, 0.85), $p < 0.05$].[4]
- **Risk of fractures only:** For PIM was 1.39% (*n* = 14) compared with 2.09% (*n* = 21) for other AAPs (RR = 0.67 (0.34, 1.30), p-value: not significant (NS)).[4]
- **Risk of falls or fractures:** For PIM was 5.67% (*n* = 57) compared with 9.05% (*n* = 91) for other AAPs [RR = 0.63 (0.46, 0.86), $p < 0.05$].[4]

The analysis showed that LTC/NH residents with PDP, on pimavanserin had **37% lower risk** of all-cause falls/fractures compared to other atypical antipsychotics.[4]

After PSM secondary analysis on **PIM cohort** (n = 1005) **compared to QUE cohort** (n = 1005) **results**.[4]

- **Risk of falls only:** For PIM was 4.6% (n = 46) compared with 8.26% (n = 83) for QUE [RR = 0.55 (0.39, 0.79), $p < 0.05$].[4]
- **Risk of fractures only:** For PIM was 1.39% (n = 14) compared with 1.89% (n = 19) for QUE (RR = 0.74 (0.37, 1.46), *p*-value: ns).[4]
- **Risk of falls or fractures:** For PIM was 5.67% (n = 57) compared with 9.55% (n = 96) for QUE [RR = 0.59 (0.43, 0.81), $p < 0.05$].[4]

The analysis showed that LTC/NH residents with PDP, on pimavanserin had **41% lower risk** of all-cause falls/fractures compared to quetiapine.[4]

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Created April 8, 2025

Do happy employees make better employees? It's a question we hear all the time.

And if you've spent any time in senior care, you've probably heard this one too: "No one wants to work anymore."

But after more than 20 years in this field, I came to a realization that changed everything. It wasn't that no one wanted to work; it was that no one wanted to work for me. That was a hard truth. But it was also the moment leadership began.

There's a well-known study where two groups of doctors were observed. One group was greeted each morning with a simple question: "Would you like a piece of candy?" The other group received a standard "Good morning."

After just two weeks, the doctors who were offered candy were more patient, more engaged, more approachable–and their patients had better outcomes. So, what changed? Not the systems, not the staffing, not the workload. Just the emotional starting point of the day.

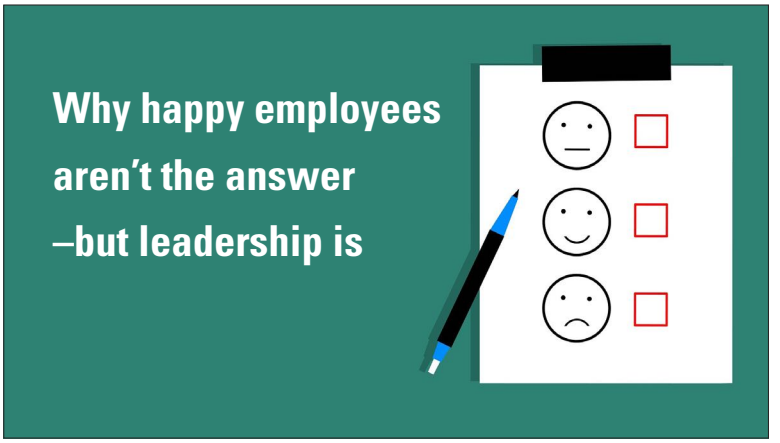
That small moment–getting someone to smile–is what researchers call pre-framing. It means you intentionally shape someone's emotional state before the work begins. And that matters more than most leaders realize, because staff members don't show up as blank slates. They bring stress, fatigue, frustration, and life with them. Leadership sets the tone for what happens next.

The moment you change how someone feels, you change how they perform. But let's be clear: This is not about candy. If it were, we'd all have perfect buildings. This is about something deeper: intentional leadership, designed experiences, and emotional awareness. Because even something as simple as the temperature of a room, the tone of a voice, or the first interaction of the day can shift outcomes in measurable ways.

Which brings us to belief. The Titanic didn't sink because it hit an iceberg. Ships hit obstacles all the time. The Titanic sank because of a belief that the ship was unsinkable. That belief led to fewer lifeboats, overconfidence, and delayed response.

In leadership, we have our own version of that belief. Too many managers operate as if their staff will always be there. As if people need the job more than the organization needs them. As if, if someone leaves, they can just be replaced.

That belief shows up in behavior–lack of urgency, poor communication, tolerance of dysfunction, minimal follow-up. And over time, people leave.



The reality is this: People don't have to work for you anymore. They have options–more than ever before. Which means you are not managing employees. You are leading volunteers.

Think about volunteers. They don't have to be there. They can leave at any time. They choose environments where they feel valued.

Now imagine what would change if you treated your staff the same way. You would communicate differently. You would show appreciation more often. You would be more intentional. You would design better experiences.

Because what we call a staffing crisis is often something else entirely. It's a leadership crisis. When leaders avoid accountability, do everything themselves, or fail to design systems that work, they create environments where people don't want to stay.

I see this all the time in what I call "whale leadership." A whale has no natural predators, but it still dies. Because eventually, it takes on too much.

Leaders do the same thing. "I'll just do it myself." "It's easier this way." "I don't want to bother them." And before long, they're burned out, overwhelmed, and leading disengaged teams.

After years of observing organizations, one principle continues to hold true: Every problem is either a process issue or a behavior issue. If it's a process issue, the system is broken. If it's a behavior issue, leadership isn't reinforcing expectations. Either way, it's a leadership responsibility.

And this is where many organizations get stuck. They try to solve problems instead of designing systems. They react instead of preventing. They fix symptoms instead of addressing root causes.

People don't leave because the work is hard, or the hours are long. They leave because the system doesn't work, the environment drains them, and leadership doesn't support them.

So if you want better outcomes, you must stop asking, "How do I fix this?" and start asking, "What system allowed this to happen?" "What belief led to this behavior?" "What experience are we creating every day?"

Because leadership is not about reacting to problems. It's about designing environments where people can succeed.

It's easy to say, "No one wants to work." But better leaders ask a different question: What would make someone want to work here? Because in today's world, you don't get commitment by default. You earn it by design.

It's not that no one wants to work. It's that no one wants to work in a system that doesn't work for them. And that system? It is designed–and led–by you.

As always, I hope I made you think and smile.

Ralph Peterson, of Ralph Peterson Management Services works with senior care organizations on leadership training, Quality Awards and QAPI programs. To learn more call or text Ralph directly: (914) 656-0190

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EDITORIAL

Deceptive "community fees"

by Bruce Glass

Anyone who travels has likely been hit with "resort fees," the unwelcome charge tacked on to many hotel bills. It doesn't matter whether guests actually use any of the amenities, they still must pay the fee. Airlines and others in the hospitality and service sectors have similar hidden fees.

Assisted living facilities have a related add-on that they label "community fees." Really, it's nothing more than an increase in the basic rate, but under a different name. Why not just adjust the rate? Keeping it as a separate line item gives the appearance of a less expensive rate. Are we fooled by this? Not likely.

Community fees at assisted living facilities are not illegal. But they are deceptive.

SEEKING YOUR CONTENT

New England Administrator
seeks your wisdom and expertise.

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The Marketing Guru on trends and dynamics

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strength-training zones, hydrotherapy, and outdoor meditation and walking spaces. Physical design is evolving toward "micro campuses" embedded in walkable urban and suburban nodes, with ready access to restaurants, arts and cultural institutions, parks, and retail. These integrated locations support intergenerational engagement and mirror the mixed use environments many boomers enjoyed in midlife.

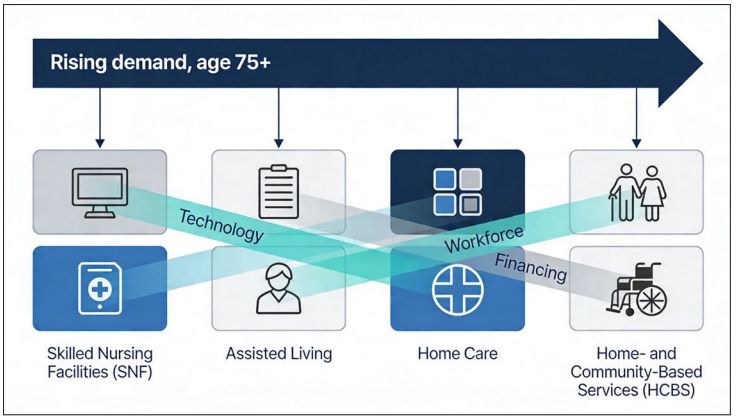
Behind the front-of-house transformation lies a quieter revolution in data and capital allocation. Providers are returning to rigorous market studies to reassess their competitive position and figure out whether to renovate, expand, or fully redevelop aging properties. With higher interest rates and construction costs, renovation now outpaces ground up development, but token "refreshes" are no longer sufficient; residents expect reconfigured units, flexible spaces, and built in smart home features. Consolidation is accelerating as single site nonprofits pursue affiliations with regional systems to gain the capital and operational scale necessary to modernize plant and technology.

Home care and HCBS: Aging in place is the default

As skilled nursing and assisted living modernize, home care and HCBS are expanding their footprints even more dramatically. Aging in place is now the default aspiration for older adults and their families, and public and private payers are increasingly willing to finance non residential options to avoid higher-cost facility-based care. The home health and personal care sectors in 2026 are integrating telehealth, remote patient monitoring, and AI-powered safety tools to manage chronic illness, detect early deterioration, and coordinate care across fragmented provider networks.

"Hospital at home" models illustrate how far this shift has progressed. Health systems are now deploying home based acute care episodes that include IV therapy, complex wound care, post surgical monitoring, and frequent virtual physician visits, supported by interdisciplinary home care teams. Evidence from early adopters suggests that these programs reduce infection risk, lower costs, and preserve patient satisfaction and functional outcomes, particularly for older adults. For home health agencies, alignment with these programs presents both opportunities and risks: Participation can drive volume and specialization, but it also demands robust clinical governance, interoperable technology, and 24/7 response capabilities.

HCBS is emerging as a strategic pillar for senior living organizations as well. Operators that historically focused solely on brick and mortar campuses are building service lines that reach into the surrounding community, offering personal care, care management, adult day services, respite, transportation, and social engagement programming. This diversification helps maintain relationships with older adults earlier in their aging journey and creates feeder streams into higher-acuity settings when needed. Public funding streams, including Medicaid waivers and state HCBS initiatives, are expanding in many jurisdictions, but providers must navigate complex regulations, documentation standards, and labor rules to participate effectively.



Cross-cutting themes: Workforce, technology, and data

Across all settings, workforce dynamics remain the central operational constraint. The long-term care sector was the hardest hit by pandemic-era turnover, and even as occupancy and revenue recover, recruiting and retaining licensed nurses, aides, and therapists remains challenging. Research has shown that retention depends on internal and external factors, such as organizational culture and community-level employment availability and turnover. Forward-looking providers are also using design itself as a workforce tool, adding ergonomic workspaces, efficient floor plans to reduce walking distances, and staff lounges with natural light and outdoor access. Some are exploring on site childcare and dedicated staff wellness spaces to differentiate themselves in competitive labor markets.

Technology serves as both an expectation and a force multiplier. Boomers entering senior living are digitally fluent and expect seamless connectivity; high-speed Wi Fi has become table stakes rather than a luxury. Communities are layering in unobtrusive technologies such as AI-based fall detection, ambient health monitoring, circadian lighting, and smart-home controls that are designed to enhance safety and independence without making environments feel institutional. In the home care and HCBS segments, smart medication dispensers, voice assistants, and sensor platforms support adherence and provide early warnings, while enabling caregivers to safely manage larger populations.

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The Marketing Guru

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Underpinning these efforts is a renewed emphasis on data-driven decision-making. Senior living and post acute organizations are commissioning more granular market analyses and using occupancy, margin, and clinical performance data to prioritize capital projects. On the clinical side, predictive analytics and data-rich tools, such as dashboards, are increasingly used to track rehospitalization rates, falls, antipsychotic use, and functional outcomes at the unit level, enabling targeted interventions that align care quality with value-based payment incentives. Capital markets are rewarding these capabilities: REITs and lenders have ramped up investment volumes as they see sustained occupancy gains, rising net operating income, and operational sophistication in senior housing and skilled nursing portfolios.

Strategic implications for New England administrators

For administrators in New England, where aging demographics, high labor costs, and regulatory intensity converge, these trends carry specific strategic implications.

- First, organizations should revisit their position along the continuum and explore partnerships or service-line expansions that allow them to follow patients across settings, particularly into home- and community-based care.
- Second, boards should expect and support a multi year capital agenda focused on modernizing existing infrastructure rather than relying solely on new construction, aligning projects with market data and consumer research.
- Third, workforce strategy must move beyond incremental wage increases to encompass culture, scheduling flexibility, career ladders, and built environment improvements that signal respect for frontline staff, especially Gen Z.
- Fourth, technology planning must be proactive and integrated, with clear roadmaps for broad-scale interoperability, remote monitoring, AI enabled risk stratification, and resident facing digital amenities.
- Finally, administrators will need to keep a close eye on federal and state policy–including efforts to constrain Medicare and Medicaid outlays and to tighten quality standards, to ensure that strategic plans remain financially viable under various reimbursement scenarios.

The common denominator across skilled nursing, assisted living, home care, and HCBS is that older adults and their families are demanding not only safety, but autonomy, connection, and purpose. Providers who can integrate clinical excellence, hospitality, technology, and workforce sustainability into coherent models of care will not simply endure the coming demographic wave; they will shape the lived experience of aging in New England and create models for the country.

Is assisted living the answer?

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censed, inspections are designed and carried out by the states, and only state regulations apply to these licensees. Any residential care facility may be granted an assisted living license that meets the COMAR standards.

There are three levels of assisted living in Maryland ranging from level 1, the least intense level of care, to level 3, the most intense. At level 3, a facility must meet the needs of residents by assessing a broad range of care needs and provide a range of services for physical and mental wellbeing. This includes the administration of medications to those who may not be able to self-medicate and other services in which assisted living in other states may not be permitted to engage.

Maryland's licensure of assisted living includes many of the services typically provided by nursing homes, which stands in contrast to New England's rules. It may be instructive to look at each of the New England states' rules to think about what might need to change so that a SNF or nursing home could be licensed only as an assisted living facility but still offer services for residents who would need substantial care.

At present Connecticut and Massachusetts rules include statements that specifically exclude assisted living licensees from providing the services that nursing homes are licensed to provide. Maine's rules also seem to be a substantial barrier to providing nursing home services with an assisted living license. New Hampshire seems to leave the door open to some level of change. But its requirements would not seem to make assisted living a viable alternative to replace nursing homes.

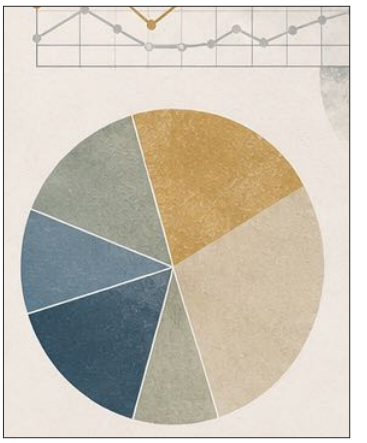
Rhode Island and Vermont seem to be the New England states that offer some opportunity for assisted living to provide a choice for seriously sick patients who would today be nursing home residents. In Vermont the Department of Disabilities, Aging, and Independent Living regulates assisted living. Some nursing overview and medication management are specifically listed as requirements. The rules generally are not too different from lower-level nursing homes.

Rhode Island's Department of Health regulates assisted living. The Rhode Island rules specifically mention assisted living as a place to support activities of daily living. As a practical matter this is much of the work that is done in nursing facilities of all kinds. What's more, there is a structure for special licenses within these regulations.

One of the important things about Vermont and Rhode Island is their record of changing rules and legislation suggests that they are more flexible than the other New England states. They both have legislatures that passed new legislation in 2025, and Vermont typically has specified a review or required new legislation be enacted within a known time frame.

There may be other places for our states to turn to extend the financial viability of providing care for the old and disabled. But to me, the prospect of providing a more acceptable and fiscally viable form of care through assisted living licensing seems the most likely alternative.

KR Kaffenberger, Ph.D., M.P.H., is a fellow of the Gerontology Institute at UMass Boston and a former nursing home administrator.



Taking the pressure off wound care

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Good wound care is good business

Now the encouraging part, because this isn't only about avoiding disasters. Wound care is one of the few clinical programs that improves both sides of the ledger.

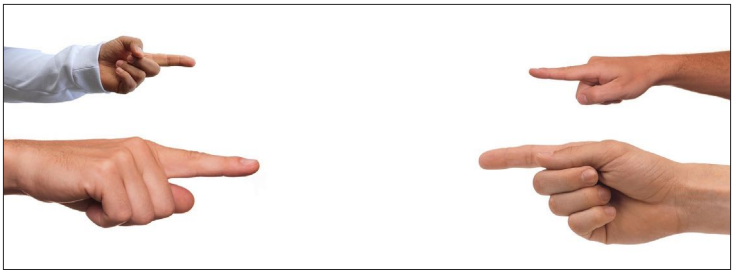
On the bottom line, healing is cheaper than managing. A wound that closes in weeks instead of lingering for months consumes fewer nursing hours, fewer supplies, and fewer physician visits. And a wound that never deteriorates never becomes a transfer, a readmission, a citation, or a lawsuit. The Agency for Healthcare Research and Quality puts the cost of a single pressure injury between roughly $21,000 and $152,000. Multiply that by the wounds in your building and the figure gets your attention. Peer-reviewed data from skilled nursing facilities shows that a structured wound program can cut average time-to-heal by about a third, with the biggest gains in the deepest, most dangerous wounds.

On the top line–the part too few administrators connect–strong wound outcomes are a growth strategy. Hospitals send their hardest, highest-acuity cases to the buildings that can heal them and not send them back. The ability to safely admit a medically complex patient with multiple wounds is the ability to accept a higher-reimbursing resident and a steadier referral stream. Excellent wound care fills beds. It is a marketing asset that happens to live in the treatment room.

What successful facilities do differently

The good news is that strong wound outcomes are not limited to low-acuity buildings.

Some of the most successful wound programs operate in facilities caring for residents with tracheostomies, ventilators,



traumatic brain injuries, severe mobility limitations, and multiple chronic conditions — the very populations most vulnerable to pressure injuries.

What separates these facilities is not a miracle product or a single clinical intervention. It is a system.

The admission skin assessment is treated as a priority rather than a paperwork exercise. New and worsening wounds are evaluated quickly by clinicians with the expertise and authority to adjust the treatment plan. Nutrition, nursing, rehabilitation, and providers communicate consistently. Progress is measured not by whether wounds remain stable, but by whether they are moving toward closure.

In these environments, even complex wounds that might otherwise linger for months often heal more quickly than expected. The lesson for administrators is simple: Acuity alone does not determine outcomes. Systems do.

Buildings that consistently identify wounds early, document them accurately, and respond promptly place themselves in a stronger position clinically, operationally, and financially.

The bottom line

Pressure ulcers will continue to arrive at nursing homes because nursing homes care for some of the most medically fragile people in the healthcare system.

The question is not whether wounds will enter your building. The question is whether your team will recognize them, document them, and respond to them quickly enough to protect the resident–and the organization.

The most effective wound-care programs are not defined by the dressings they use. They are defined by the systems behind them: accurate admission assessments, documentation that stands up to scrutiny, timely intervention, multidisciplinary communication, and consistent follow-through.

Get those pieces right, and wound care becomes more than a clinical responsibility. It becomes a competitive advantage.

Mikhail Novikov, MD, is a surgeon with more than 38 years of experience and the founder and medical director of Dr. Novikov Wellness and Skin Care in Northborough, Massachusetts, a physician-led wound care and surgical dermatology practice serving skilled nursing and long-term care facilities across Massachusetts, New Hampshire, and Connecticut. He is the co-author of Practical Wound Dressings for Long-Term Care and Healing Matters, and a national and international speaker on wound healing and skin cancer prevention.

NAB today

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state licensing boards, educators, and continuing education providers connected to the same goals: strong leadership, competent practice, and public protection. Whether you are renewing your license, tracking continuing education, considering a future career move, or preparing the next generation of leaders, NAB offers resources that support both individual administrators and the state agencies that license them. If your last interaction with NAB was when you sat for the national licensing examination, it may be worth taking another look.

Elizabeth Lollis is NAB program manager

New Englanders receive awards

The 2026 ACHCA Convention in Orlando was a special event for the New Englanders who received recognition from the national organization, especially new ACHCA Hall of Fame inductee, Lonnie Brisbano, FACHCA, of Rhode Island. With calm determination and good humor, Brisbano guided the organization during one its most difficult periods. He was presented with his gold jacket at the New England Alliance Spring Conclave in Newport.

Bob Oriol, of Holden, Massachusetts, president of The New England Alliance, received a special Distinguished Service Award from ACHCA Board Chair Mark Prefogle, while Lori

Pomelow, FACHCA, of Maine was recognized as Outstanding Member. (Pomelow also serves as treasurer of New England Administrator.)

Other honorees included: Cailin Gallego of Massachusetts as AIT Preceptor and Kerry Hart of NOA in Cromwell, Connecticut as Business Partner. In addition, two chapters were recognized: Massachusetts for Group Membership and Maine for Continuing Education.

Long-time New England icon Lonnie Brisbano (center) is inducted into the ACHCA Hall of Fame at the 2026 New England Alliance Conference in Newport, Rhode Island. Flanking him are Julian Rich (L) and Bruce Glass.

The NEW ENGLAND ALLIANCE

ACHCA

UPCOMING EVENTS

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