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Juliet Madubata

has been found to be complete and satisfactory in all respects,
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Abstract

By 2040, 79.7 million older adults will live in the US, and nearly 40% will need nursing home services that are primarily funded by Medicare and Medicaid. Researchers have underscored the importance of leadership in quality healthcare care delivery, suggesting that nursing home administrator turnover could influence resident quality of life, causing ill-health for the residents and preventable medical costs for taxpayers. In spite of the suggested association, little research has specifically examined the role of administrator turnover on resident quality of life. As such, the purpose and central research questions of this case study were designed specifically to address the relationship between nursing home administrator turnover and resident quality of life. The Donabedian health services quality model was the framework for the study. Data were collected from 14 nursing homes, and included semistructured interview data with 7 nursing home administrators, and a review of other documents related to quality of care including site visit reports and surveys. An iterative process of coding and constant comparison was used to identify themes and categories from the data. The findings indicate that turnover likely caused an adverse impact on the nursing home overall, which was expected. The study also determined, however, that high turnover itself was not perceived to be associated to low resident quality of life. The implication for social change is that nursing home stakeholders may develop processes to retain competent administrators which in turn could reduce absent leadership presence in nursing homes. Consistent leadership presence may lead to improvement in quality of life regulatory compliance and reduction in unnecessary Medicare and Medicaid spending by nursing home residents.

The Influence of Nursing Home Administrator Turnover on Resident Quality of Life

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Doctor of Philosophy

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Dedication

This research is dedicated to my family. To my dad Rowland Eke Mbajunwa, who was a Retired Police Inspector. Thank you for telling me that the sky was my limit. This degree is for you. I wish you were here today to cheer me on in life. To my husband wonderful Dr. Christian D. Madubata and my seven great children Chiduzie, Nnaemeka, Ugochi, Chioma, Chinwe, Ijeoma, and Chukwunyere, you are my rock. Thank you for your love, patience, guidance and sustenance throughout this process. To my mom Dorathy Ihuarula Mbajunwa, thank you for everything. To my brothers Henry, Stanley, Martin, Noel, Lawson, and Franklin, and my sisters Edna and Adline, thank you for your unshakeable belief in me. Thank you for your support and being my cheerleaders. To my Nigerian, American and Walden extended family thank you for your support.

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Chapter 1: Introduction to the Study

The services provided to nursing home (NH) residents are mostly funded by Medicare and Medicaid. Siegel, Young, Leo, and Santillan (2012) suggested that NH sponsors base the payment for the services rendered by nursing homes on the quality and cost-effectiveness of the services. Nursing home administrator (NHA) turnover and resident quality of life (QOL) have been areas of concern for nursing home stakeholders for many years. Some scholars noted that frequent administrator changes resulted in other employee changes, which adversely impacted nursing home services and outcomes (Castle, 2008; Donoghue, 2009; Donoghue & Castle, 2009). Other researchers stated that resident QOL was affected by disease conditions (Halvorsrud et al., 2010; Luleci et al., 2008; Zanocchi et al., 2008).

Administrator turnover has also been associated with negative resident QOC (QOC; Castle, 2001; Hyer et al., 2011). Resident QOC is different from resident QOL according to the online Centers for Medicare & Medicaid Services' (CMS) States Operations Manual (SOM) for long-term care facilities. Due to the scarcity of researchers who studied the association between nursing home administrator (NHA) turnover with resident QOL, I explored the influence of NHA turnover on nursing home resident QOL and endeavored to address the gap of knowledge.

In accordance to federal and states regulations, nursing home owners must recruit licensed NHAs to manage their nursing homes and also preserve and sustain residents' QOL in order to comply with Medicare and Medicaid payment for services requirements. It is important for public administrators to understand the direct connection between

NHA turnover and poor QOC, which could result in frequent transfer of residents to hospitals. The recurring transfer of residents to hospitals could impact their QOL and increase medical cost for the residents and/or the taxpayers. Siegel et al. (2012) stated that since a significant amount of federal and state funds pay for the care provided to nursing home residents, there is a need to ensure that services rendered are cost-effective and beneficial to the residents (p. 222).

The study may affect positive social change by providing data to enable policy makers and nursing home stakeholders to implement nursing home initiatives which will address the retention of NHAs, and to generate continuous quality improvement measures to ensure that residents achieve and preserve high QOL. Public issue such as NHA turnover impact on the QOL of nursing home residents should be of interest to public policy regulators, because of its possible medical and financial implications.

Background of the Study

NHs are healthcare institutions that provide care and services to the adults in need of help with activities of daily living, NHAs are the individuals licensed by each state's board of NHAs to manage nursing homes. According to longtermcare.gov of U.S. Department of Health and Human Services' website, 70% of persons who are 65 years or older would use long term care services in their life time. About 40% of older adults would use the services provided by nursing homes (Williams, 2013). U.S. federal and states regulation requires that nursing home owners must recruit licensed NHAs (LNHAs) to operate their nursing homes. Employee turnover has been a problem in the nursing home industry for several years.

At the beginning of the 21st century, 81% of NHAs resigned within 3 years of employment while 75% of NHAs were terminated by nursing home owners by the end of 3 years of employment (Singh & Schwab, 2000). Nine years later, 53% of NHAs turned over yearly and 160% of NHAs turned over within 3 years (Donoghue & Castle, 2009). Recently, there was a 300% NHA departure noted during a case study (Hunt, Corazzini, & Anderson, 2012).

Worker turnover has an adverse impact on organizational effectiveness, finance, and performance (Eldridge, 2008). There is a connection between administrator turnover and the number of regulatory deficiencies received by nursing homes (Geletta & Sparks, 2013). Nursing homes with stable employees provide high quality of services, reduce recruitment and training cost, and have employees with organizational based experiences (Donoghue, 2010). American Health Care Association (AHCA; DATE) stated on its website that nursing home staff stability is good for the residents or patients. According to AHCA, stable employees are familiar with the residents and environment, and respond appropriately to residents' needs that lead to positive outcomes for the nursing homes. Due to the high turnover rate in nursing homes, studies that relate turnover to quality are needed (Castle, 2001; Hyer et al., 2011; Thomas, Mor, Tyler, & Hyer, 2012).

It is estimated that, by the year 2030, there will be 71 million older adults, and that older adults will make up 17% to 20% of America's population (Centers for Disease Control and Prevention [CDC] and The Merck Company Foundation, 2007; Eliopoulos, 2010). About 40% of older adults will spend the end of their lives in nursing homes (Williams, 2013). Advancement in age often leads to decrease in QOL, in regards to

autonomy, social participation, and activities (Figueira, Figueira, Mello, & Dantas, 2008). Several scholars have given suggestions on older adult's QOL in their studies. The recommendations were that QOL issues should be addressed during regulatory survey visits, healthcare organizations should include older adult QOL preservation and enhancement as one of its goals, and organizational outcome should be based on the achievement of QOL by residents and not on the clinical QOC provided to residents (Castle, Ferguson, & Hughes, 2009; Netuveli & Blane, 2008; Sloane et al., 2005). According to the online Centers for Medicare & Medicaid Services' (CMS) States Operations Manual (SOM) for long-term care facilities, regulation F240, §483.15, in order for nursing homes to achieve high residents' QOL, nursing homes are expected to care for their residents in a custom and in an environment that supports, maintains, or/and enhances each resident's QOL. Due to the anticipated increase in the number of older adults entering nursing homes and the converted focus of regulators on residents' QOL during regulatory visits, studies that address the influence of nursing home top management turnover on resident QOL is very important.

NHAs should ensure that residents receive quality care from nursing home employees in order for them to achieve and preserve high QOL. Some of the previous researchers on NHA turnover focused on the impact of turnover on resident QOC instead of resident QOL (Castle, 2011; Castle & Decker; 2011; Hyer et al., 2011), while several of the QOL researchers focused on the influence of disease conditions such as pain, urinary incontinence, stroke, dementia, and cognitive impairment on resident QOL (Abrahamson, Clark, Perkins, & Arling, 2012; Dugger, 2010; Willemse, Smit, De Lange,

& Pot 2011). The turnover of NHAs has been associated with staff turnover, deficiency citations, and negative organizational outcomes (Castle & Lin, 2010; Holecek, Dellmann-Jenkins, & Curry, 2008). Since the turnover of NHAs has been associated with negative resident QOC, there is a possibility that the turnover of NHAs could influence resident QOL.

Residents, family members, and nursing homes direct caregivers were the participants of previous studies on resident QOL concerning disease conditions (Crespo, Quiros, Gomez, & Hornillos, 2012; Willemse et al., 2011; Zanocchi et al., 2008). Qualitative studies on the influence of NHA turnover on resident QOL are rare. The limited data is why I explored how NHAs connect their departure to resident QOL. The availability of data that connects NHA turnover with resident QOL might assist NHAs and NH owners with future turnover decisions. A detailed discussion of the study's literature review will be found in Chapter 2.

For the purpose of clarity, according to CMS SOM for long-term care facilities, the identified areas of QOC is different from the areas of QOL in the federal government regulations for nursing homes, and the specific regulations are addressed below.

Resident Quality of Care

CMS use regulation F309, §483.25 found in the SOM for long-term care facilities to evaluate the QOC provided by nursing homes. According to the online CMS SOM for long-term care facilities, nursing homes are expected to provide care to each resident according to his/her comprehensive assessment and plan of care, to enable him/her "to attain and maintain the highest practical physical, mental and psychosocial well-being"

(F309, §483.25, para 1). The specific regulatory areas of focus relative to QOC are as followed: Activities of daily living, vision and hearing, pressures sores, urinary incontinence, range of motion, mental and psychosocial functioning, naso-gastric tubes, accidents, nutrition, hydration, special needs, unnecessary drugs, medication errors, influenza and pneumococcal immunizations and nursing services.

Resident Quality of Life

QOL has varying levels, and researchers have stated how it has been difficult for scholars to produce a definitive model or framework of QOL that is acceptable to all research communities (Brajkovic, Godan, & Godan, 2009; Keefe, Stadnyk, White, & Fancey, 2009; Solans et al., 2008). There are also knowledge gaps in the definition of health-related QOL (HRQOL; Zubritsky et al., 2012). This is the reason why several of the research literatures on QOL focused on a specific aspect of QOL relative to disease conditions, such as dementia, cognitive impairment, urinary incontinence, restraint use, stroke, prevalence of pressure ulcer, and chronic pain in sick older adults (Abrahamson et al., 2012; Dugger, 2010; Luleci, Hey, & Subasi, 2008).

According to the online CMS SOM for long-term care facilities, in order for nursing homes to achieve high residents' QOL, nursing homes are expected to care for their residents in a custom and in an environment that supports, maintains, or/and enhances each resident's QOL. The areas of focus based on this guideline are as followed: dignity, self-determination and participation, social services, participation in resident and family groups, accommodation of needs, activities, participation in other activities, and environment. CMS also stated that "the intention of the QOL requirements

is to specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident" (F240, §483.15, para 2).

The constant departure of NHAs could make it difficult to achieve high QOL for residents, due to changeable leaders and frontline employees. In order for nursing homes administrators to address residents' QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-determination and participation), residents' relationships (participation in resident and family groups), and residents' meaningful activities (activities), NHAs must stay for long duration at the nursing homes and be dedicated to the job. This is why I focused on how NHA connect their turnover to resident QOL. If NHAs understand the adverse impact of their turnover on resident QOL, maybe NHAs would not change jobs often. Retention of organizational employees (top management and staff) creates a culture of organization-specific knowledge and experience, which leads to quality improvement (Thomas, Mor, Tyler, & Hyer, 2012).

Understanding how NHAs associate their turnover to the QOL of nursing home residents is crucial since administrators direct the care that is provided by frontline employees, and older adults' QOL could be affected by changes in their environment (Eliopoulos, 2010; Halvorsrud, Kirkevold, Diseth, & Kalfoss, 2010). The participants of previous QOL studies were residents, residents' family members and nursing home frontline employees (Kaasalainen et al., 2010; Luleci et al., 2008; Zubritsky et al., 2012). Crespo et al. (2012) stated that during recent QOL surveys, regulators used QOL measures to evaluate the programs and processes that nursing homes use to improve resident QOL (p. 64-65). The turnover of NHAs has affected the QOC received by the

residents for many years. Donoghue and Castle (2009) found that NHA turnover resulted in an increase in certified nursing assistant (direct caregiver) turnover (p. 170). When direct caregivers leave nursing homes, there is no consistency of care.

While it is true administrators care about the residents' QOL, it is questionable if they understand the impact their departure has on the resident QOL. NHAs play a crucial role in the QOC and services received by the residents from the direct caregivers. I explored how NHA turnover influences resident QOL, from administrators' perspective. Nursing home owners might implement processes to support the retention of NHAs If owners are aware of the association of NHA turnover with resident QOL and residents' QOL might improve. The study illustrated the gap of knowledge by providing data to assist nursing home stakeholders with nursing home initiatives.

According to the CDC and The Merck Company Foundation (2007), by 2030, there will be 71 million older adults in American, and 80% of older adults will have at least one chronic disease condition which could cause pain, loss of independence, disability, and loss of function. Older adults who are unable to meet their QOL needs due to limited functioning capacity and disability from the aging process, chronic disease conditions, and infirmities need assistance from healthcare professionals to meet the needs, and older adults in need of institutional care live in the long-term care nursing homes. When organizations assess residents' QOL needs, they are able to meet resident's needs (Crespo et al., 2012; Costanza et al., 2007; Castle Ferguson, & Hughes, 2009).

I explored the influence of NHA turnover on nursing home resident QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-

determination and participation), residents' relationships (participation in resident and family groups), and residents' meaningful activities (activities), which are not QOC but QOL issues. Residents in nursing homes are the individuals who need assistance with activities of daily living. In order for residents to achieve and/or preserve high QOL, the residents must receive dependable care from employees of nursing homes. Castle and Engberg (2008) revealed that organizational practice of care should be coordinated, consistent, and of high quality (p. 474). Persistent leadership changes often result in organization's inability to achieve organizational expected outcomes (Tellis-Nayak, 2007).

Newly hired NHAs are focused on immediate needs of nursing homes, such as regulatory citations, finances, staffing issues, and complaints that they do not adequately pay attention to planning and coordination of services (Castle el al., 2009). Hunt, Corazzini, and Anderson (2012) stated that NHs with continuing staff departures lack the ability to sustain ongoing quality improvement measures (p. 18). NHAs are accountable for their nursing homes' operation, and they should stay long enough in the nursing homes to determine the outcome of implemented processes.

Stakeholders expect organizations to be reliable and to produce quality services or products. Nursing homes with recurring leadership changes frequently receive substandard citations (Castle, 2008; Castle & Lin, 2010; Holecek et al., 2008). Nursing homes with high turnover of NHAs also have poor care systems, negative quality indicators, and deficiency citations that increase in scope and severity (Tellis-Nayak, 2007, p. 20). According to ACHA (2014) Quality Report, nursing home

administrative staff turnover rate was 21.8% in 2008, 21.1% in 2009, 17.7% in 2010 and 26.7% in 2011 (p. 13). There is a possibility that the poor QOC may adversely influence resident QOL because resident's dignity and self-determination and participation might be ignored by nursing home employees. As evidenced by the citations that the nursing homes' in the study received from the surveyors. In regard to the evaluation of the outcome of care provided to nursing home residents, Sloane et al. (2005) suggested that the focus should be on the QOL achieved by residents, instead of the QOC provided to the residents (p. 37).

Statement of the Problem

NHA turnover has been negatively associated with the QOC provided to nursing homes residents (Castle, 2001; Castle & Lin, 2010). Accomplishing and preserving resident QOL might be a problem in nursing homes with frequent leadership changes. Despite the ongoing nursing home initiative on quality improvement and competent leadership retention by the Centers for Medicare and Medicaid Services' Quality Improvement Organizations, deficient citation on QOC measures is occurring (Holecek et al., 2008; Hunt et al., 2012). This problem has negatively impacted nursing home residents because of their dependency on nursing home staff for their care and services. A possible cause of the problem is NHA turnover. Nursing home top management departure adversely affected QOC measures such as pain, physical restraint, and pressure sores (Decker & Castle, 2011). The specific problem addressed in this study was that the nursing home resident QOL seemed to be influenced by NHA turnover.

Resident QOL has become a more significant issue to nursing home stakeholders in recent years; but, the problem is unsolved (Costanza et al., 2007; Crespo et al., 2012; Sloane et al., 2005) Previously, regulators based resident outcome on QOC provided to resident instead of QOL achieved by residents (Sloane et al., 2005). Costanza et al. (2007) recommended that social policy emphasize the need for sustainable QOL measures (p. 274) while Crespo et al. (2012) suggested that assessment of nursing home residents' QOL is significant, in order to meet their needs (p. 56). In order to address resident QOL, it is necessary to understand about the influence of NHA departure on resident QOL from an administrator perspective. A study that used qualitative case study method helped to address in the gap of knowledge.

Castle and Decker (2011), Castle et al. (2007), and Hunt et al. (2012) demonstrated that NHA turnover has become a crucial issue in recent years. NHA turnover could be voluntary or involuntary. Since 81% of NHA turnover was voluntary (Singh & Schwab, 2000), the knowledge of the influence of NHA turnover on resident QOL might reduce the rate of NHA voluntary departure. In order to address NHA turnover, it is necessary to understand about its influence on resident QOL, and the understanding NHAs have on the role their departure played in the resident QOL. I used Donabedian's health services quality model 1988 helped to understand how NHA turnover influences resident QOL.

Purpose of the Study

The high turnover of NHAs adversely affected nursing homes quality measures relative to pressure sores, physical restraint, and pain, which are QOC issues (Decker &

Castle, 2011). The purpose of this qualitative case study was to explore how NHAs connect their departure with resident QOL. The frequent voluntary turnover of NHAs often leads to the revolving door of new, inexperienced, and overworked administrators. Some of the departed NHAs successors have different leadership styles and are unfamiliar with the nursing homes' culture, which, leads to vulnerable systems (Castle et al., 2009; Hunt et al., 2012). Top management turnover often results in facility-wide staff turnover, which leads to service deficiencies in nursing home organizations (Castle, 2008; Hunt et al., 2012).

Castle and Lin (2010) used structural equation modeling methods to study nursing home top management turnover direct and indirect effects on nursing home QOC measures such as pain, daily activities, pressure sores, restraints, and so forth. The authors found that NHA and director of nursing (DON) turnover had direct effects on quality measures and indirect effects on staffing levels and use of agency staffing (p. 172). Due to limited or nonexistence of empirical research specifically focused on the influence of NHA turnover on resident QOL, from NHAs' perspective, this exploratory study about NHA turnover and its influence on residents' QOL addresses the gap in the literature. I addressed four residents' QOL areas (accommodation of needs, self-determination and participation, participation in resident and family groups, and activities).

Significance of the Study

The CMS pays for most of the services provided to residents in the nursing homes in the US. More than 40% of older adults will need the services provided by the nursing

homes (Williams, 2013). Previous researchers found that 42% of older adults experienced a decrease in functional abilities due to systemic changes, chronic disease conditions, and ailments which affected their abilities to perform activities of daily living (ADL), which resulted in an increased stay in nursing homes in 2007 from 28 per 1,000 to 81 per 1000 (Administration on Aging [AOA] U.S. Department of Health and Human Services, 2011; Federal Interagency Forum on Aging-Related Statistics, 2010). According to CMS' website, a nursing home provides things like a living space, meals, and help with activities of daily living and recreation for individuals with physical and mental problems. CMS also defined a nursing facility as a facility that provides nursing and related care and services from a skilled staff meant to rehabilitate the injured, disabled or sick. This care is custodial and consistent. I focused on nursing homes administrators and residents.

The results of the research may affect positive social change by providing data that illuminates the quality of residents' life issues in nursing homes. The study also provided data to assist nursing home stakeholders with nursing home initiatives. This qualitative study could be relevant to nursing home stakeholders, such as the researchers, NHAs, nursing home owners, long-term care residents and family members, long-term care employees, and other related healthcare professionals.

Understanding NHA turnover and the influence of turnover on the residents is also important. Frequent nursing home leadership turnovers often lead to employees' poor performance, which adversely impacts the quality of services provided to nursing home residents. Some of the employees at the nursing homes practiced performance

without rationale. The findings of the study showed that NHA turnover leads absent leadership presence and facility-wide connection break. Improving resident QOL could reduce medical cost and positively impact the federal budget by reducing Medicare and Medicaid expenditures.

Significance to Leadership

The data from this study illuminate NHA turnover impact on resident QOL to public administrators. NHAs are the top leaders of the nursing homes. Donoghue (2009) found that the turnover of NHAs creates unpredictable environments resulting in nurses' turnover (process; p. 93). Hunt et al. (2012) found that frequent turnover in nursing homes leads to lack of teamwork, coordination, and supervision needed to improve quality outcomes (p. 18). I confirmed that NHA turnover leads to absent leadership presence and facility-wide connection break. This study provided data to enable nursing home stakeholders to implement nursing home initiatives which will address the retention of NHAs, and to generate continuous quality improvement measures to ensure that residents achieve and preserve high QOL.

Nature of the Study

The choice of research design for the study was the case study. Case study design enables a researcher to conduct an in-depth study of a single phenomenon at a given time with the use of multiple sources (Babbie, 2008; Creswell, 2007; Yin, 2009). The data sources for this study were interviews and observations, plan of correction, and Online Survey Certification and Reporting (OSCAR) file NHAs current nursing homes and previous nursing homes. In the research, NHAs were asked to describe their turnover

experiences and their understanding of the turnover influence on residents' QOL. The availability of data connecting NHA departure with nursing home resident QOL might assist NHAs with future turnover decisions. Homogeneous sampling enabled me to gain an in-depth understanding and description of how NHA turnover influences residents' QOL relative to residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities.

There are four types of designs for case studies, single-case holistic design, single-case embedded design, multiple-case holistic design, and multiple-case embedded design (Yin, 2009). This study was a single-case holistic design with seven NHAs. The rationale was to capture the influence of NHA turnover on nursing home resident QOL. A researcher is expected to know what his/her unit of analysis is. According to Babbie (2008), "you must decide whether you're studying marriages or marriage partners, crimes or criminals, corporations or corporate executives" (p. 109). For this research, the unit of analysis was the experiences of NHAs, and seven NHAs were studied.

I retrieved OSCAR files from the NHAs current and previous nursing homes. The reason for the selection of seven participants is that an in-depth study of seven NHAs, who changed nursing homes at least one time in 5 years illuminated the administrators' description of their turnover, and its influence on residents' QOL. The participants were NHAs who have turned over at least one time in 5 years, but are currently administrators of record in five counties in Maryland. The study of administrators who have changed nursing homes at least one time in 5 years, and are still working in the industry enabled me to present their points of view of the experience.

The data collection methods that were used for this study were interactive interviewing, questionnaires, observations, OSCAR file, and nursing homes' plan of corrections for the cited deficiencies. I conducted interactive interviews with the participants face-to-face in their offices or by phone, recorded observations of the participants and nursing homes on the observation form, retrieved the OSCAR files from CMS website, and collected the nursing homes' plan of corrections from administrators. Each participant was scheduled for one detailed interview lasting for 60 to 90 minutes. I developed open-ended questions from the questionnaire based on a pilot study was used to collect data for this study. The participants were asked to describe what happens in a nursing home after a NHA turnover and how turnover influences the nursing home residents' QOL based on the research questionnaire. The interactive interviewing enabled me to ask participants questions from the questionnaire, and gave the participants opportunities to answer and ask questions.

I recorded the observations on the observation form after each interview. The OSCAR report of 2008 to 2013 provided the regulatory surveys reports on each nursing home's QOL measures outcomes. The plan of correction showed how the nursing homes planned to correct the QOL deficiency citation(s). Recurrent deficiency citation(s) was/were associated to the administrator of record at the time of regulatory visit(s). Duration of data collection for the participants was 9 months which resulted in data saturation. The participants were contacted for follow-up interviews by e-mail and/or telephone, and e-mail and/or telephone were used if additional data or clarification of information was needed.

The interviews were hand-written as field notes. Participants' observations were written on observation forms. Audiotapes were also used during the face-to-face interviews for six out of the seven participants. Transcribed data were submitted to the participants who elected to review it for approval. The technique for data collection for this study involved interactive interviewing based on interview questionnaires, participant and nursing home observation, OSCAR files review, plan of correction review, and Internet data. I used data analysis strategies, which involve manually analyzing stories and developing themes from the stories, and checking the accuracy of data with qualitative software NVivo 10. The written report was from a narrative of NHAs' stories.

Research Questions

1. What are the NHAs' experiences in regard to their turnover impact on residents?
2. How does NHA turnover influence resident QOL?

The subquestions are as follows:

1. In what way does the turnover of NHAs influence residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities?
2. What is the connection, if any, between a high turnover among administrators and a low QOL for residents?

The research questions guided me in the exploration of the phenomenon. The questions also enabled me to gain an in-depth understanding and description of how

NHAs connect their turnover impact to residents and turnover influence on residents' QOL in regard to residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities. A more detailed discussion of the study's paradigm and design will be presented in Chapter 3.

Conceptual Framework

Health Services Quality Model

Donabedian (1988) stated in his health services quality model that QOC could be classified into three categories: structure, process, and outcome. Structure means what the organization does, which is the settings of care which includes material resources, human resources, and organizational structure (p. 1745). Process means how the organization accomplishes its obligations, which are the activities, performed when care is provided and received. Outcome means what is achieved in the end, which are the results of the care provided. According to Donabedian, for QOC to be addressed, there must be an established system to link structure to the process, and process should be linked to the expected outcome (p. 1745). The focus of this study was on how NHA (structure) turnover influences the services provided by nursing home employees (process) resulting in residents' QOL (outcome). Figure 1 illustrates the Donabedian model of quality in regard to this study.

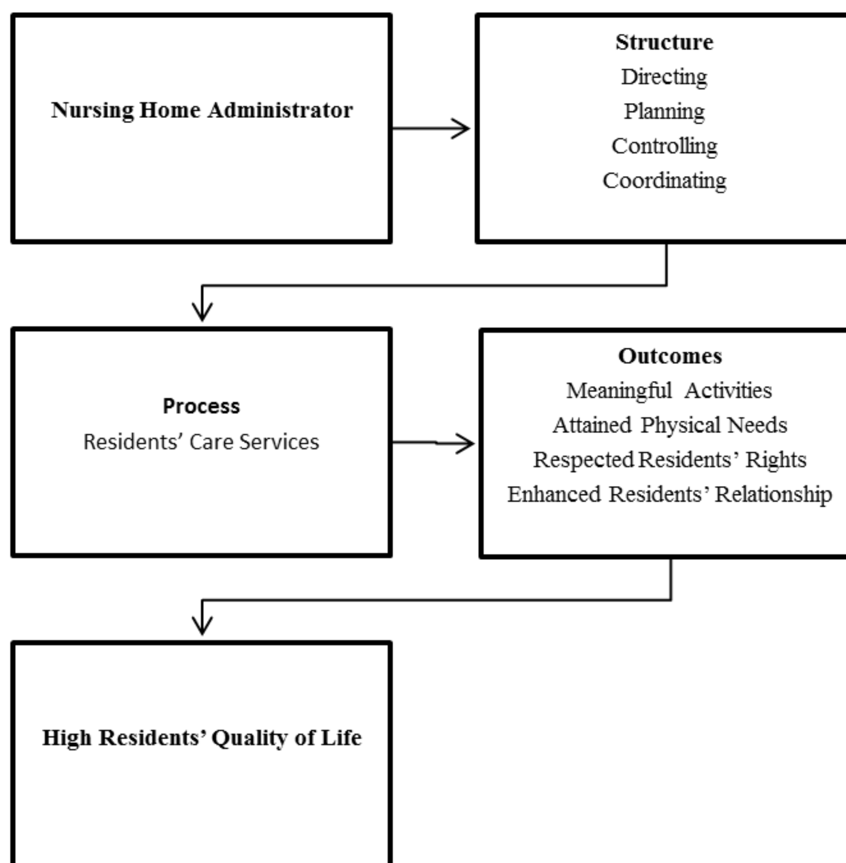

Figure 1. Donabedian model of quality.

Structure

Organizational leaders who represent the structure of the organization can affect the organizational outcomes such as residents' QOL due to leadership instability. Relative to this study, the NHAs fall under human resource, which represents the structure of QOC. Top management of nursing homes is accountable for the operation of the nursing homes and is responsible for directing, planning, controlling, and coordinating all activities in a nursing home. Castle et al. (2009) stated that the nursing home leadership has to be consistent in addressing and improving resident's needs, in

order to correct deficiencies in the organization (p. 494). Repeated administrator turnover leads to instability in leadership roles and organizational quality deficiencies.

I found that NHA turnover resulted in absent leadership presence and facility-wide connection break. Seasoned administrators who left nursing homes were replaced by inexperienced leaders who had little or no healthcare leadership skills, which led to nonexistence of coordination, collaboration, and supervision needed for organizational success (Hunt et al., 2012). It is important for NHAs to remain in their positions long enough to plan, direct, control, coordinate, and evaluate implemented quality improvement processes. Long-term care employees need dedicated supervisors in order for them to provide quality services to enable residents to meet their QOL needs. Organizational leadership supervision has been found to affect employees' intention to leave or stay with nursing homes (Bishop et al., 2008).

Process

The resident services provided by nursing home employees represent the process of QOC. The frontline employees are the individuals who provide services for nursing home residents to enable them to achieve good QOL. The turnover of NHAs adversely impacts the turnover of nursing home frontline employees (Castle, 2008; Donoghue, 2009; Donoghue & Castle, 2009; Hunt et al., 2012). Nursing homes with long tenured employees are able to provide high quality care and achieve their organizational goals (Donoghue, 2009), which was echoed by two study participants.

Federal, state, and county regulators visit nursing homes at least yearly to assess their compliance with stipulated regulations relative to the services that they provide.

Long-term care facilities that do not provide services as stipulated in the regulation are cited for substandard findings. Organizational employees should be directed to provide services that address residents' physical needs such as activities of daily living. Scheduled resident activities should be meaningful to residents, stimulate and improve residents' cognitive functioning, and be based on residents' interests. Lucie et al. (2008) suggested that the nursing home residents should be encouraged to participate regularly in physical activities and leisure time activities, in order to improve their QOL (p. 64). Residents' right to privacy, choices, dignity, autonomy, and so forth should be respected by nursing home staff.

Residents should be encouraged to maintain past relationships and to establish new ones, and participate in group and family activities. Residents with committed frontline nursing home staff were noted to be satisfied with their QOL and their relationship with the staff (Bishop et al., 2008). Nursing homes need dedicated care team members, since consistency of assignment is associated with fewer deficiency citations (Castle, 2011). The study showed that there was no continuity of care when there was NHA turnover. The QOC provided to the residents is dependent on several factors such as consistency of care, how much is done, care practices, and coordination of care (Castle & Engberg, 2008). I found that NHA turnover resulted in poor performance by the employees due to direction void.

Outcome

High QOL achieved by the nursing home residents represents the outcome of quality of services rendered to residents. Long-term care staff should provide meaningful

activities to residents, meet residents' physical needs, ensure residents' rights are respected, and nurture and encourage residents' relationship. The NHAs are responsible for directing the caregivers toward the organizational goal, such as attaining and maintaining high residents' QOL. Castle and Ferguson (2010) found that many nursing homes' level of quality was substandard during regulatory surveys (p. 439). Recurrent employees' turnover creates problems for organizational outcomes because of staffing issues. Staffing issues could affect the quality of services rendered to residents (Castle & Engberg, 2008; Hunt et al., 2012; Hyer et al., 2011).

Tourangeau, Widger, Cranley, Bookey-Bassett, and Pachis (2009) used the Donabedian model to conduct a survey study on how institutional long-term care (ILTC) employees responded to the structural characteristics of their work environment. Tourangeau et al. (2009) stated more than a third of the facility employees had intent to turnover (p. 179). High departure of many levels of a facility's staff often leads to poor quality outcomes (Hunt et al., 2012). The employees of the ILTC facilities studied by Tourangeau el al. rated their job satisfaction as neutral or somewhat satisfied. This meant that the employees in the study were not satisfied with their work environment. The employees in nursing homes with frequent leadership changes might not like their unstable work environment as the above mentioned research participants, resulting in frontline employee turnover, which could adversely impact residents' QOL.

When employees are not satisfied with their jobs, they have the tendency to turnover. Numerous NHA turnovers often result in nursing homes' inability to implement systems that guarantee high positive residents' outcomes. Change in the leadership

positions, in organizations, could negatively or positively impact organizational outcomes. Thomas (2011) confirmed what previous researchers found that nursing assistant (process) turnovers affected residents' safety outcomes (para 3). NHAs control the care provided by NH employees by managing the resources needed for staffing, education, care practices, and program development (Castle et al., 2009; Hunt et al., 2012).

According to an Internet search result, the Donabedian model was cited 3719 times. There were researchers who used Donabedian's health services quality model in their quantitative studies to address nursing home issues. Researchers used the Donabedian model because the model is used to assess the quality of health care provided to individuals. Several researchers used the Donabedian model to understand nursing homes' quality and employee turnover issues (Castle & Ferguson, 2010; Thomas, 2011; Tourangeau et al., 2009). I explored how the NHA perceived turnover and its influence on nursing home residents' QOL.

Researchers have also shown that the turnover of NHAs is associated with negative health outcomes for residents, staff job dissatisfaction, poor quality of services, deficient survey outcomes, lack of organizational goals' accomplishment, and turnover of other nursing home personnel (Castle & Lin, 2010; Donoghue, 2009; Holecek et al., 2008; Hunt et al., 2012; Zinn, Mor, Feng, & Intrator, 2009). The application of the health services quality model enabled me to understand how NHAs perceived their turnover and turnover influence on residents' QOL. The findings of this study provided data to enable nursing home stakeholders, such as CMS (public administrators) to implement nursing

home initiatives which will address the retention of NHAs, and to produce continuous quality improvement measures to ensure that residents achieve and preserve high QOL.

Definitions of Terms

Activities of daily living (ADL): Activities that an individual performs daily such as moving, dressing, bathing, eating, and toileting (Eliopoulos, 2010, p. 439).

Nursing home: A long-term care facility that provides 24-hour supervision and nursing care to individuals who are not able to care for themselves in the community or be cared for in the community (Eliopoulos, 2010, p. 121).

Nursing home administrator: A top management individual in a nursing home responsible for the overall organization of resources and finance to ensure that resident's needs are met and organizational goals are achieved. The NHA also interacts with the owners, board of directors, and outside agencies (Allen, 2007, p. 8).

Nursing home resident: An individual who lives in a skilled nursing facility, because of his/her inability to perform activities of daily living independently, and the nursing home is his/her home (Leister, 2009, p. 14).

Older adults: Older adults are individuals who are 65 years old and older (Eliopoulos, 2010, p. 4).

Outcome: This is the end product of the lack of performance or performance of a task (CMS; 2000).

Quality: Quality is the ability of a health plan to keep its members healthy, and how it treats their illnesses. Quality also refers to doing what is right at the right time and

in a right way, for the right person. The objective is to get the best possible results (CMS; 2000).

QOL: QOL represents either how well human needs are met, or the extent to which individuals or groups perceive satisfaction or dissatisfaction in various life domains (Costanza et al., 2007, p. 269).

Assumptions of the Study

It was assumed that the NHAs who were selected for the study would be available for face-to-face interview, willing to complete and return the research tools on time, and would complete the research tools with honesty. The interactive interview enabled the participants to ask and answer questions. I assumed that I would be able to clarify and answer participants' questions during face-to-face interviews. I assumed that I would also be able to observe participants' nonverbal cues or body language relative to the interview questions.

It was assumed that research participants would be able to read at undergraduate level in order to provide an appropriate response to research questions. An undergraduate degree is the educational requirement for licensure as a NHA in the State of Maryland. It was assumed that the NHAs turnover, and that the NHAs could convey the influences of their turnover on residents' QOL. Each nursing home in America is managed by a licensed NHA, in accordance with federal and state regulations. The list of nursing homes in the State of Maryland is available on online. I contacted each nursing home in the five counties in Maryland to inquire of the name of the administrator of record before information about the study was sent to the facility by e-mail and/or postal service. I also

called each selected facility to verify the name of the administrator of record before data collection.

Limitations of the Study

1. I did not interview the NHAs with whom I had worked with to prevent participants' selection bias and compromise of the research data.
2. There were other unknown variables that might affect the research study data.
3. Researcher bias in qualitative research studies is sometimes unavoidable because the researcher is the instrument of data collection. The researcher's bias exists in the study despite his/her effort to eliminate personal bias. Researcher's bias could be reduced if the researcher is unaware of the study's expected outcome (Pannucci & Wilkins, 2010). I was unaware of study outcome before the study.
4. Data collected were self-reported by participants.
5. Since this study is a qualitative case study, the study evolved as need be. The study's original criteria were modified to accommodate unexpected recruitment issues.

Delimitations of the Research

This exploratory study was about NHA turnover and its influence on residents' QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-determination and participation), residents' relationships (participation in resident

and family groups), and residents' meaningful activities (activities) from administrators' viewpoints. The delimitations of the study are as followed:

1. The point of view of residents, residents' family members and other nursing home employees was not needed for this study, but they may be useful.
2. Due to financial constraints, it was not cost effective to conduct face-to face interviews with all the NHAs in the United States. Therefore, NHAs employed in the five counties in Maryland were interviewed and surveyed to understand the influence of their turnover on residents' QOL such as residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities.
3. There is a specific training requirement for NHAs; therefore, limiting my ability to inquire of the experience of other non-licensed top healthcare managers who work in nursing homes.
4. The study was focused on NHAs and no other type.
5. NHAs are licensed by states' boards of NHAs.
6. The study was focused on the experiences of NHAs in the five counties in Maryland, and the findings cannot be generalized to a larger population.
7. Interview questionnaire, observations, demographic survey, OSCAR file and plans of corrections were used.

Summary

Chapter 1 provided information relative to the problem of the study and background of the study. The regulatory definitions of QOC and QOL were provided in Chapter 1. In Chapter 1, the statement of the problem, purpose of the study, and significance of the study were also presented. Chapter 1 also included information on the nature of the study, research questions, conceptual framework, and definition of terms. Finally, the assumptions of the study, limitations of the study and delimitations of the study were presented in Chapter 1. Chapter 2 includes information on the historical and recent literature concerning the research problem under investigation. Chapter 3 is an explanation of the methodology used to collect data, Chapter 4 is a report of the data, and Chapter 5 is the interpretation of the data.

Chapter 2: Literature Review

Introduction

Based on recent research findings (e.g., AHCA, 2011; Hunt et al., 2012; Kash, Naufal, Dagher, & Johnson, 2010), NHA turnover continues to be problematic in nursing homes and could adversely influence residents' QOL. The specific problem addressed in this study was that the nursing home resident QOL seemed to be influenced by NHA turnover. Nursing home residents depend on NHAs to receive quality care from nursing home employees in order for them to attain and maintain high QOL. This chapter is an exhaustive review of literature on NHA turnover and residents' QOL. The literature is focused on nursing home residents' QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-determination and participation), residents' relationships (participation in resident and family groups), and residents' meaningful activities (activities).

Donabedian's health services quality model of 1988 was reviewed. Specifically, a discussion of why NHAs turnover, organizational changes that occur as a result of NHA turnover, and NHA turnover influence on the quality services provided to nursing home residents are presented. Included in the analysis, are research studies on the questions addressed in this study. Researchers who explored NHA turnover and QOL issues are integrated in this chapter.

The study questions are as follows:

1. What are the NHAs' experiences in regard to their turnover impact on residents?

2. How does NHA turnover influence resident QOL?

The subquestions are as follows:

1. In what way does the turnover of NHAs influence residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities?
2. What is the connection, if any, between a high turnover among administrators and a low QOL for residents?

Researchers challenged some of the outcomes of the research in this area are included, in order to present balanced, honest discussion. This chapter concludes with the justification on how previous research studies have influenced this research. NHA turnover and QOL literature review shaped the groundwork for this research and dates back to the mid-1960s. The central themes for the literature review were (a) Impact of NHA turnover on nursing home residents, (b) why NHA turnover, (c) effects of NHA turnover on nursing home outcomes, (d) rate of NHA turnover, (e) definition of QOL and QOC, (f) impact of disease conditions on resident QOL, (g) and lack of qualitative research that associated administrator turnover with resident QOL. These themes provided the framework for this study on the influence of NHA turnover on resident QOL.

I used over 245 peer-reviewed articles and dissertations, 30 electronic and paper books, 14 online and paper journals and 13 online databases for the literature review. The literature search strategy was conducted electronically, with the use of Google Scholar, Yahoo, and Google and Bing search engines. Databases such as Academic Search

Complete, Business Source Complete, and CINAHL plus with Full Text, PubMed, Dissertations and Theses at Walden University, Proquest Health and Medical Complete were also used for searches. The sources of the peer-reviewed articles acquired and reviewed for this study were obtained electronically and conventionally through obtainable printed versions of professional journals. Some articles were purchased from the publishers and downloaded electronically. Some books provided overview of decades of turnover, quality, older adults, nursing home turnover, and QOL research. Several terms were combined to locate relevant articles from the database searches and they are as followed: *nursing home administrator, long term care, older adults, nursing homes, nursing home residents, turnover, quality of care, quality of life, employee turnover, turnover theories, quality theories,* and *quality of care theories.*

Conceptual Framework

Donabedian (1988) health services quality model was used to frame this qualitative case study. This model provides a framework for scholars to examine health care provided to individuals and to assess the quality of the health services. According to the Donabedian model, there are three categories that QOC provided could be classified called structure, process and outcome. Structure means the characteristics of the locations of care such as human resource. Process means what is done during care. Outcome means effects of care given on the individual's health status.

According to the model, structure should be linked to process and process should be linked to outcome in order to assess the QOC appropriately. Donabedian (1988) also stated that good QOC is usually achieved when good structure is linked to good process,

and good process leads to a good outcome (p. 1745). For this study, structure was represented by NHAs, who were responsible for planning, directing, controlling, and coordinating the services provided to residents. Process was represented by nursing staffing who were responsible for providing services to enable residents achieve and maintain good QOL. Outcome was represented by meaningful activities for residents, attained physical needs by residents, respected residents' rights, and enhanced residents' relationship which was high QOL for residents.

There are few researchers who used Donabedian's health services quality model to conduct quantitative studies that addressed nursing home issues. Some researchers used the Donabedian model to understand nursing homes' QOC and employees' turnover issues (Castle & Ferguson, 2010; Thomas, 2011; Tourangeau et al., 2009). I used Donabedian model to understand how the NHA turnover influences nursing home residents' QOL from NHAs' perspective. The application of the health services quality model enabled me to understand how NHAs connect their turnover influence on residents' QOL.

Some researchers showed that the turnover of NHAs is associated with negative health outcomes for residents, staff job dissatisfaction, poor quality of services, deficient survey outcomes, lack of organizational goals' accomplishment, and turnover of other nursing home personnel (Donoghue, 2009; Holecek et al., 2008; Zinn et al., 2009). The findings of this study provided data to enable nursing home stakeholders to implement nursing home initiatives which

will address the retention of NHAs, and to generate continuous quality improvement measures to ensure that residents achieve and preserve high QOL.

Resident Quality of Life

There are various definitions of QOL; some of the definitions are specific to varieties of issues that affect human beings. QOL has varying levels and researchers stated how difficult it has been for scholars to produce a definitive model or framework of QOL that is acceptable to all research communities (Brajkovic et al., 2009; Stadnyk et al., 2009; Zubritsky et al., 2012). Zubritsky et al. (2012) stated that the "gaps in knowledge of the linkages and intersections across and among HRQOL domains remains undefined (p. 5). This may be the reason why several of the researchers on QOL focused on a specific aspect of QOL relative to disease conditions, such as chronic pain, cognitive impairment, stroke, urinary incontinence, restraint use, dementia, prevalence of pressure ulcer, and sick older adults (Abrahamson et al., 2012; Dugger, 2010; Luleci et al., 2008).

CMS use the regulations found in the SOM for long-term care facilities to evaluate the quality of services provided by nursing homes. According to the online CMS SOM for long-term care facilities, nursing homes are expected to care for their residents in a custom and in an environment that supports, maintains or/and enhances each resident's QOL, in order for nursing homes to achieve high residents' QOL (F240, §483.15, para 1). The areas of focus based on this guideline are as follows: dignity, self-determination and participation, social services, participation in resident and family groups, accommodation of needs, activities, participation in other activities, and environment.

The regulation also requires a facility's environment to cultivate individualism of the residents (F240, §483.15, para 2). Recurrent leadership turnover in NHs could make it difficult for nursing homes to achieve good QOL for residents due to lack of consistent leaders and frontline employees. Dedicated nursing home leadership is required in order for nursing homes to address residents' QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-determination and participation), residents' relationships (participation in resident and family groups), and residents' meaningful activities (activities). These issues are why this research focused on NHAs' description of their turnover and its influence on residents' QOL. Retention of organizational employees (top management and staff) creates a culture of organization specific knowledge and experience, which leads to quality improvement (Thomas et al., 2012). Long term care employees should be knowledgeable of organizational expectations through consistent leadership.

Scholars dealt with residents' QOL from aspect of disease conditions. Each article showed that resident's QOL relative to disease condition could be affected by the services that they receive from nursing home employees. Zanocchi et al (2008) noted that chronic pain could affect residents' mood, life style, functional status, nutrition, sleep, and QOL (p. 126) while Costanza et al. (2007) stated that meeting human needs increases QOL (p. 275). Nursing home residents' pain might not be appropriately addressed by changing nursing home caregivers, who lack an ongoing relationship with the residents. The implementation of pain management measures might not be effective in nursing homes with high leadership turnover, which often leads to high frontline employee

turnover. The NHAs' dedication and long tenure is needed to monitor and evaluate the outcomes of the systems that they implemented.

Halvorsrud et al. (2010) revealed that there are several predictors of QOL among older adults, such as physical function, health satisfaction, depressive symptoms, and environmental conditions (p. 241). Environmental conditions have been shown to have indirect effects on QOL of sick older adults, specifically, on the sick older adults' depressive symptoms and health satisfaction (Halvorsrud et al., 2010, p. 255). Nursing home employee departure has an adverse impact on the outcome of resident care (environmental condition; Abrahamson et al., 2012; Donoghue, 2009; Halvorsrud et al. 2010), which could also influence residents' QOL. Consistent leadership and caregivers to address residents' needs could improve residents' QOL, because residents have other needs different from pathological needs. Addressing the influence of NHA turnover on residents' QOL will enable nursing home stakeholders to understand QOL issues associated with turnover. The study affected positive social change by providing data to enable nursing home stakeholders to implement nursing home initiatives which will address the retention of NHAs, and to generate continuous quality improvement measures to ensure that residents achieve and preserve high QOL.

Turnover and Quality of Life

Tellish-Nayak (2007) mentioned that in order for nursing homes to provide quality services, there should be dependable and proven leaders who are able to implement required innovative changes and continuously monitor the changes for desired outcomes (p. 20). Leaders are expected to lead by example. When the individual that

initiates an idea is not available to motivate, implement and monitor the progress of the idea, the idea might not blossom as intended. Tellish-Nayak also stated that due to NHAs' turnover, quality improvement programs in nursing homes are not able to improve the quality as desired (p. 20). Hunt et al. (2012) noted in their qualitative study that facility-wide turnover and multilevel turnover lead to poor QOC and prevented the nursing homes from accomplishing CMS-mandated quality improvement initiatives (p. 18).

The departure of NH leadership often results in a chain reaction of turnovers, where the departmental directors turnover after the administrators, and the frontline employees turnover after their directors (Donoghue & Castle, 2009; Hunt et al., 2012; Tourangeau et al., 2009). The nursing homes with unstable leaders often face repeat deficient citations, which prevents them from achieving their organizational goals. Leaders in unstable organizations are not able to implement effective quality assurance programs. It is difficult for nursing homes to guarantee their residents a high QOL with repeated leadership turnover.

There were several studies (e.g., AHCA, 2011; Castle, 2008; Holecek et al., 2008) conducted on NHAs turnover, and on residents' QOL relative to disease conditions (e.g., Keefe et al., 2009; Koren, 2010; Luleci et al., 2008). There is limited or no research on NHAs awareness of the outcome of their departure and how that impact QOL of the residents. The success or failure of organizational goals is dependent on dedicated organizational leadership. The quality of the services provided by nursing home employees is also dependent on NHAs, who are the leaders of the organizations. As

stated by the participants of this study, administrators of nursing homes who remain in their nursing homes for a long duration are able to implement processes and maintain an ongoing evaluation of the processes, in order to achieve positive organizational outcomes from the implemented processes (Castle et al., 2009).

American Health Care Association (AHCA; 2011) revealed that employee turnover is still a problem in the nursing homes because the average NHA turnover rate was 18.9% in 2010 and that some states' rate was as high as 43.1% (p. 14). The numerous turnovers of NHAs leads to inconsistent leadership and management styles. Donoghue and Castle (2009) noted that leadership styles could influence employee turnover (p. 166). The repeated changes in organizational process due to change in leadership could be confusing to the frontline employees and could lead to frontline employees' termination of their employment. Hunt et al. (2012) stated that turnover adversely affected residents' care at the facility of their study (p. 18). Confusion about processes could result in poor services and low QOL for the residents. Lack of dependable leadership impacts staff ability to accomplish organizational goals and share in organizational mission and vision. Newly hired NHAs have the tendency to replace old employees with new employees in order for them to apply their leadership style and new organizational strategies (Castle et al., 2007).

In regards to the percentage of NHAs that turnover, Holecek et al. (2008) found in their study of regulatory process influence on NHA job satisfaction and job seeking that 74% of NHAs were satisfied with their jobs, and 72% of NHAs would stay in their job for the next 12 months due to job security. Thirty percent of the NHAs in the study stated

that they sent out their resumes in the last 12 months (p. 222). Holecel et al. (2008) found that the number of regulatory deficiency citations predicted NHA job seeking (p. 224). The findings of this research provided new data to use for quality improvement measures relative to residents' QOL based on NHAs job satisfaction and job seeking.

Donoghue (2009) noted that the turnover of NHAs created unpredictable environments, which, influences nursing home nurses' turnover (p. 93). Hunt et al. (2012) stated that in nursing homes with frequent turnover, there is lack of supervision, teamwork, and coordination needed to achieve success (p. 18). I confirmed the findings of Hunt et al. Without consistent leaders and consistent frontline employees, residents of nursing homes would not receive the services needed to address their QOL needs. In order for nursing homes to address residents' QOL issues such as residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities, there should be reliable nursing home leadership. NHA turnover affects staff turnover, quality of residents' services, survey outcomes, and organizational outcomes (Castle, 2008; Castle & Lin, 2010; Donoghue, 2009).

Castle and Engberg (2008) indicated that resident care is dependent on consistency of care, coordination, care practices, and how much is done for the residents (p. 474), and Hunt et al. (2012) mentioned that the QOC that nursing home residents receive continuously decreases when there is lack of coordination, teamwork, and supervision due to employee turnover (p. 18). When there is persistent frontline employee turnover in nursing homes, there is the inconsistency of care providers, which could

result in poor services. Nursing homes with repeated NHA turnover often have recurrent survey deficiency citations, due to poor quality of services provided to residents. Persistent deficiency citations could lead to the termination of nursing home from Medicare and Medicaid participation (Holecek et al., 2008; Li, Harrington, Spencer, & Mukamel, 2010), and the possible transfer of residents to other nursing homes. Transference of nursing homes residents from one nursing home to another nursing home could disrupts services received by residents, and could affect the residents' overall health status (Li et al., 2010). Nursing home residents who receive poor quality of service due to changing staff could become sick and transferred to hospitals resulting in inability to accomplish or preserve their highest QOL possible.

NHAs Turnover

AHCA (2010) found that the rate of NHA turnover in 2008 was 22.9% (p. 14), while Hunt et al. (2012) found the rate of NHA turnover was 300% at the site of their study. In order to decrease the rate of turnover in nursing homes, it is important to understand why NHAs continue to turnover despite quality improvement initiatives to retain effective nursing home leaders. NHAs understanding of their turnover impact on resident QOL might prevent NHAs from frequent voluntary turnover. Castle (2008), Castle and Lin (2010), and Donoghue and Castle (2009) have attempted to understand why administrators turnover. Numerous factors could contribute to nursing administrator turnover and intent to turnover, such as performance outcomes, employees' turnover issues, personality characteristics, management practices, educational level, deficient citations, job tenure, termination, lack of job skills, management tenure, nursing homes

characteristics, turnover opportunities, leadership style, perception of the survey process, job satisfaction, environmental factors, chain and for-profit nursing homes, payer mix, and so forth. Holecek et al. (2008) stated that when NHAs receive deficient citations, they are held accountable for the survey outcomes, organizational standing in the environment, financial issues, and employee turnover (p. 217).

Individual factors and behavioral intentions also contributed to turnover and the intent to turnover of NHAs (Kash et al., 2010). NHAs who are exhausted from their jobs are likely to turnover or have the intent to turnover (Wilson, 2009). The study participants expressed that their job was very time consuming and exhausting. Employees who have positive supportive relationships with their supervisors might not turnover or have the intent to turnover (Robinson & Pillemer, 2007). The above mentioned researchers showed that there are several factors that lead to NHAs' turnover. Limited or no research has addressed turnover from the perspective of the administrator, and how NHA departure influences QOL of nursing home residents. The knowledge of NHAs turnover influence on resident QOL might reduce the rate of voluntary NHA turnover in nursing homes.

Current Impact of Nursing Home Administrator Turnover

Previous quantitative QOC researchers have shown that the turnover of NHAs is associated with negative health outcomes for residents, staff job dissatisfaction, poor quality of service, deficient survey outcomes, lack of organizational goals' accomplishment, and turnover of other nursing home personnel (Castle & Lin, 2010; Decker & Castle, 2011; Temple, Dobbs, & Andel, 2009). Castle (2011) associated

nursing homes deficient citations to the consistent assignment of low-performing nursing assistants, which resulted in QOL issues deficiency citations for residents, staffing, and facility (p. 750). Castle and Lin (2010) noted that high turnover of NHAs often leads to poor QOC provided to the residents (p. 173). Qualitative case studies are needed that address the influence of NHA turnover on residents' QOL. The specific problem of this study was that the nursing home resident QOL seems to be influenced by NHA turnover. The study research question was based on literature reviews relative to residents' QOL, and NHAs' turnover.

NHAs are responsible for the daily operations of nursing homes, and they are expected to ensure that the nursing home residents are provided with the highest QOL that is possible within their capabilities (Tellish-Nayak, 2007). The services provided to the residents of nursing homes should enhance residents' QOL. The turnover of NHAs has several adverse effects on nursing homes, nursing home employees and nursing home residents. There are several research studies on the turnover of NHAs, and the turnover's impact on nursing homes' outcomes. A few researchers have addressed the impact of turnover on nursing homes and residents' services, but no researcher has specifically addressed the influence of NHA turnover on resident QOL from an administrators' perspective.

The turnover of NHAs could be voluntarily or involuntarily. Turnover has various adverse effects on the organizations because ineffective NHAs involuntarily turnover and some effective NHAs voluntarily turnover. This research provided preliminary evidence of how NHA turnover influences resident QOL. The NHAs' knowledge of how much

their departure impacts residents could prevent the NHAs from turning over frequently. The NHAs might stay at their jobs for long duration.

The previous researchers who studied the turnover of NHAs could not agree on the percentage of administrators who intended to stay or leave their jobs. Castle (2008), Castle et al. (2007), and Donoghue and Castle (2009) found that 41% to 53% of NHAs turned over, or turned over within one year while Hunt et al. (2012) stated that 300% NHAs turned over during their study. The persistent high turnover of NHAs leads to poor QOC (Castle & Lin, 2010).

On the other hand, Holecek et al. (2008) found that 72% of NHAs were secure in their positions, and 78% of NHAs would stay in their positions for the next 12 months. Regardless of the reasons for the turnover or the rate of turnover, persistent turnover is a problem in the nursing homes that must be addressed to guarantee residents' highest QOL. Deficiency citations do not represent a nursing home's quality status (Castle, 2008). There is an association between net employee turnover and cost savings (Mukamel et al., 2009). The above mentioned researchers demonstrated that organizations might use employee turnover as a cost saving strategy. Some organizations that have a lower staffing level have been known to have an increase in profits (Kash, Castle, & Phillips, 2007).

Organizations that experience short tenure in leadership often face organizational instability and uncertainty, which leads to negative outcomes (Castle et al., 2007). These research findings showed that NHA turnover resulted in uncertain environment and poor performance. Residents with the same nursing assistants for a long duration confirmed

that they were satisfied with their relationship with nursing staff and their QOL (Bishop et al., 2008). There is no known current regulation to ensure competent NHA recruitment and retention. Addressing the influence of NHA turnover on residents' QOL will enable nursing home stakeholders to understand what needs to be addressed in nursing homes to prevent frequent turnover, improve QOC, and maintain appropriate QOL for nursing home residents.

Coherent organization mission led to better QOL for dementia residents and resulted in successful interpersonal relationships among the employees and residents of the units (Robinson & Pillager, 2007). It is difficult for an organizational mission to be upheld with numerous leadership changes. Employees who have a positive relationship with their supervisors, coworkers, and residents' family members might not turnover (Robinson & Pillager, 2007). Reliable organizational leaders share mutual interest with the organizations and the employees, which results in effective organizational outcomes. Numerous nursing home employee turnovers often lead to inconsistent care providers, which affects care provided to residents (Hunt et al, 2012; Thomas, 2011). It is difficult for residents of nursing homes and their family members to build concrete relationship with nursing home employees who continuously turnover.

Ensuring high QOL for residents of nursing homes is dependent on reliable leadership and dependable caregivers. Participation in activities of choice is one of the ways that residents of nursing homes could preserve their QOL. New nursing home employees who have not established any relationship with residents might not fulfill the residents' needs. NHA turnover makes it difficult for nursing homes to have consistent

caregivers, since NHA turnover often results in caregivers' turnover (Donoghue, 2009; Donoghue & Castle, 2009; Hunt et al., 2012). The absence of stable leadership in an organization routinely disrupts organizational goals, resulting in adverse organizational outcomes. Sinn et al. (2009) stated that "where in the organization change occurs determines whether it is disruptive and thus contributes to performance failure or adaptive, protecting against failure" (p. 750). NHAs departure from NHs is disruptive to all the individuals associated with the NHs. Scholars have shown that NHA turnover adversely affects organizational outcomes (Castle & Lin, 2010; Donoghue, 2009; Her et al., 2011).

Residents' inability to access quality services often leads to poor QOL, resulting in unmet physical needs, lack of meaningful activities, ignored residents' rights, and unfulfilled residents' relationship. I explored how the turnover of NHAs influences residents' QOL issues such as residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities.

Summary of Literature Review

NHA turnover and residents' QOL have been areas of concern for scholars for many years. Scholars noted that turnover could be voluntary or involuntary. Regardless of the type of turnover, there are adverse effects of turnover. The participants of this study stated that NHA turnover resulted in direction void, poor performance, no advocate, connection break and uncertain environment. Leadership turnover often leads to frontline employees' departure, which negatively affected organizational overall outcomes (Castle & Lin, 2010; Hunt et al., 2012; Thomas et al., 2012).

Some researchers attempted to understand administrator turnover from various perspectives such as the rate of nursing home employees' turnover, why NHAs turned over, the outcomes of the turnover on NHAs, and residents' QOC. With the issue of QOL, some scholars attempted to understand the impact of disease conditions such as stroke, dementia, pressure ulcer, and so forth on nursing home residents' QOL (Abrahamson et al., 2012; Crespo et al., 2012). The researchers found that residents' QOL was affected by certain disease conditions (Brajkovic et al., 2009; Dugger, 2010).

Limited or no researcher has concentrated on the influence of NHA turnover on residents' QOL, from administrator points of view. I explored how NHAs connect their turnover influence on residents' QOL. The study affected positive social change by providing data to enable policy makers and nursing home stakeholders to implement nursing home initiatives which will address the retention of NHAs, and to generate continuous quality improvement measures to ensure that residents achieve and preserve high QOL.

In Chapter 3, I present why the qualitative methodology was the best method for the research. The research paradigm and design, and researcher's role in the case study are presented in Chapter 3. Chapter 3 includes and explanation of the research methodology and evaluation of the effectiveness of the study tool. In Chapter 3, the sampling design, which includes the study participants, sampling method and strategy, sampling characteristics and demographics, and sampling size will be presented. I included discussions on research measures, research questions, research procedures, data

collection, data analysis, and process verification. Finally, ethical considerations for the participants are presented in Chapter 3.

Chapter 3: Research Method

Introduction

Qualitative studies on the influence of NHA turnover on resident QOL are nonexistent or scarce. Due to the increase of older adults entering nursing homes and the focus of regulators on residents' QOL during survey visits, researchers who address the influence of nursing home top management turnover on resident QOL are important. The purpose of this qualitative case study was to explore how NHAs connect their departure with resident QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-determination and participation), residents' relationships (participation in resident and family groups), and residents' meaningful activities (activities). Voluntary NHA turnover could be reduced if NHAs become aware of the negative impact their departure have on the QOL of residents. The turnover of NHAs could influence residents' QOL with regard to residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities.

An explanation of the qualitative case study methodology is presented in this chapter. Evaluation of the effectiveness of the study tool will also be presented in this chapter. The research design and sampling design, which includes the sampling method and strategy, sampling characteristics and demographics, and sampling size, will be presented in this chapter. This chapter will also include discussions on research measures, research procedures, data collection, data analysis, and process verification. Finally, ethical considerations for the participants will be presented.

Research Paradigm and Design

Qualitative Paradigm

Qualitative researchers use words and open-ended questions to explore and understand a participant's perception of a phenomenon, quantitative researchers use numbers and closed-ended questions to a theory, and mixed-methods research is a combination of quantitative and methods used to increase the strength of research findings (Creswell, 2009). Qualitative paradigm was the applicable choice for this study instead of the quantitative paradigm. For the study, I investigated the understandings and knowledge of nursing homes administrators from their perspectives as I explored the connection of their turnover to nursing home residents' QOL.

This study intent was to draw from NHAs' experiences and knowledge. I placed participants' subjective accounts into perspective. With the use of interviews, observations, plan of corrections and OSCAR file, which answered the research questions, I was able to illuminate the participants' descriptions and understandings of the phenomena. Theories were not tested, and there was no need for the combination of qualitative research method and qualitative research in this study. Each participant was asked to describe what happens at a nursing home when a NHA leaves, and how the resident QOL is affected based on the interview questionnaire. Additional questions were asked during the interview based on the participant's responses to the interview questions and to illicit additional information relative to the study topic. Instead of numeric format, I used words to describe the meaning and understanding of the data collected from

interviews, observations, OSCAR files from present and previous NHs, and plan of correction.

Case Study Design

Case study design was the choice for this study. Case study design enables a researcher to conduct an in-depth study of a single phenomenon at a given time with the use of multiple sources (Babbie, 2008; Creswell, 2007; Yin, 2009). The case study design focused on NHAs' description of how their departure influences residents' QOL. In this study, I tried to understand the changes that occur when NHAs depart from nursing homes relative to resident QOL. NHAs were asked to describe their turnover experiences and their understanding of how their turnover influences residents' QOL.

If the NHAs understand the detrimental effect of their departure on the resident QOL, the administrators may stay in the nursing homes for long duration. In case study design, it is important to collect data from multiple sources in order to present understanding of the study phenomenon. The data collection methods that were used for this study were interactive interviewing, questionnaires, observations, OSCAR file, and nursing homes' plan of corrections for the cited deficiencies. The review of the nursing homes QOL deficiencies on the OSCAR files enabled me to understand the nursing homes deficiency pattern during the NHA tenure at the facility and after he/she departed from the facility.

The information on the plan of correction enabled me to understand nursing homes corrective plans and to track the names of the NHAs of the nursing home during the selected years. I conducted face-to-face interactive interviews with the participants in

their offices or by phone, observed significant events and behaviors in the nursing homes, retrieved the OSCAR file from CMS website, and collected the nursing homes' plan of corrections. During the data collection, the focus was on the influence of NHA turnover on resident QOL. Data collection and data analysis should be guided by the theoretical proposition (Yin, 2009). The theoretical proposition for this research expected that NHA turnover would adversely influence nursing home resident QOL.

Other Designs

The case study approach was chosen because the focus of the study was an in-depth understanding and description of administrators' their turnover and how their departure influenced residents' QOL. The case study approach was chosen over narrative paradigm because I did not explore how the participants felt about the experience. Phenomenology approach was not chosen because the study did not focus on the meaning of turnover experience to NHAs. Merriam (2009) stated that in ethnography paradigm, a researcher is a participant observer and focuses on human society and culture, while in in grounded theory, "the end result of this type of qualitative study is a theory that emerges from, or is 'grounded' in, the data – hence, grounded theory" (p. 29). In this study, I was not interested in focusing on human society and culture or the emergent of a theory from the collected data.

The study question and the subquestions were based on the conceptual framework of this study and the literature review. The study questions are as follows:

1. What are the NHAs' experiences in regard to their turnover impact on residents?

2. How does NHA turnover influence resident QOL?

The subquestions are as follows:

1. In what way does the turnover of NHAs influence residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities?
2. What is the connection, if any, between a high turnover among administrators and a low QOL for residents?

The design of the study was for NHAs to describe in detail how their departure influences residents' QOL. The unit of analysis was studying of the experiences of NHAs in the five counties in Maryland with shared experiences.

Researcher's Role in Case Study

A qualitative study is expected to meet certain characteristics. One of the characteristics is that the researcher is the instrument for data collection. Merriam (2009) stated that in the role of a researcher as the instrument of data collection and analysis, the researcher is able to "check with the respondents for accuracy of interpretation, and explore unusual or unanticipated responses" (p. 15). In the role of the researcher as an instrument for data collection, it is crucial for the researcher to ensure that adequate data is collected for the study. Inadequate data collection could affect the study's trustworthiness, credibility, transferability, and confirmability.

Qualitative researchers are expected to collect research data by themselves, and various sources should be used for data collection by the researcher. For this study, I collected data from Maryland Office of Health Care Quality, Maryland Board of NHAs,

participants, nursing homes' plan of correction, OSCAR, and the internet. Creswell (2007) stated that collecting data, analyzing data, and writing data are interrelated and should be simultaneously performed during the research process (p. 150). There was ongoing data collection and data analysis until the researcher reached data saturation with seven participants.

Researchers are expected to understand and acknowledge their personal biases so that the preconceptions do not adversely affect research study outcomes. The knowledge of personal biases enables researchers to manage the biases so that the biases do not interfere with any of the research process. In the interest of transparency, I am a licensed NHA and a registered nurse in the State of Maryland and the District of Columbia. I have not been the administrator of record of any nursing home in the District of Columbia or State of Maryland. In order to avoid selection bias, the participants were NHAs with whom I had no personal or professional relationship. Homogeneous sampling was used for this study. The reason for the choice of homogenous sampling is because the study focused on turnover experiences of NHAs in the five counties in Maryland. Homogeneous sampling enabled me to gain an in-depth understanding of NHAs' description of the phenomena, and provided a detailed description of how the turnover of NHAs influences residents' QOL.

The AHCA (2011) found that the average NHA turnover rate was 18.9% in 2010 and that some states' rate was as high as 43.1% (p. 14). The State of Maryland had a NHA turnover rate of 25.8% in 2008 (AHCA, 2010), 25.2% in 2009 (AHCA, 2011), and 23.8% in 2010 (AHCA, 2011). Maryland was also chosen for the study because there are

an adequate number of nursing homes in Maryland for a qualitative case study. Maryland also had nursing home employees' turnover rate of 40.8% in 2008, 37.0% in 2009, 32.5% in 2010 and 38.1% in 2011 (AHCA, 2012). I also live in Maryland.

A qualitative researcher is expected to continue to collect data, analyze data, and write data throughout the study. Rigor in data collection process and data analysis is very important in a qualitative study. The technique for data collection for this study involved interactive interviewing based on interview questionnaires, observations of significant events and behaviors, OSCAR files review, plan of correction review, and Internet data. I used data analysis strategies, which involve manually analyzing stories and developing themes from the stories, and checking the accuracy of data with qualitative software NVivo 10. The written report was from a narrative of NHAs' stories.

Research Methodology

Merriam (2009) stated that qualitative researchers are inquisitive about how individuals interpret their experiences, construct their words, and attribute meaning to their experiences, while quantitative researchers are interested in how much and how many of a phenomena and that quantitative report is presented in numeric format (p. 5). Qualitative research method is the appropriate method for this study. I used words to describe the influence of turnover of NHAs on nursing home resident QOL from administrators' points of view. Specifically, the purpose of this qualitative case study was to explore how NHAs connect their departure with resident QOL issues such as residents' physical needs (accommodation of needs), residents' rights (self-determination and

participation), residents' relationships (participation in resident and family groups), and residents' meaningful activities (activities).

The participants of this study were able to illuminate what happened at the facilities where they worked, and what they heard from their colleagues about NHA turnover. With the use of qualitative research method, researchers are able to address the whole phenomena and provide a detailed description of the phenomena. Maxwell (2005) mentioned that in a qualitative research, the researcher is interested in the physical events and behavior that are occurring, how the participants interpret the events and behavior, and how the participants' understanding of the events and behavior impact their behavior (p. 22). The NHAs' detailed experiences were described in the written report.

Data on the 109 nursing homes in the five counties in Maryland were retrieved from Maryland Office of Health Care Quality's Website as directed by the Executive Director of Maryland Board of NHAs. The list included the names of the nursing homes, location of the nursing homes, Medicare and Medicaid status, bed capacity, and nursing homes telephone numbers. Each facility in the five counties was contacted by telephone by me to obtain the name of the administrator of record prior to scheduling an interview and/or sending out a questionnaire.

A face-to-face interview was conducted in each participant's office or by phone according to his/her request. Open-ended questions were used from the interview questionnaire created by the researcher for data collection. The participants were asked to describe in detail how their turnover influences residents' QOL based on the research

questionnaire. The NHAs were also asked for the names of their previous nursing homes which the participants provided.

The original proposal inclusion criteria of the 10 participants was NHAs (a) who were currently administrators of record in the X County for 5 years or more, and (b) who have turned over at least two times in 5 years. The study of administrators who turned over several times in 5 years will enabled me to present several points of view of the phenomena. Due to the difficulty in recruiting NHAs who met the original criteria, the criteria were modified to accommodate available potential participants. The actual inclusion criteria of the seven participants were NHAs (a) who were currently administrators of record in the five counties in Maryland for with 5 years or more experience, and (b) who had turned over at least one time in 5 years. The study of administrators who turned over at least one time in 5 years enabled me to present several points of view of the phenomena and to reach data saturation.

The data collection methods that were used for this study were face-to-face or phone interactive interviewing, questionnaires, observations of significant events and behaviors (NH cleanliness, space, NHA and residents' interactions), OSCAR file from NHAs present and previous nursing homes, plan of correction, and Internet data. The face-to-face or phone interviewing enabled me to ask participants questions from the interview questionnaire, and gave the participants opportunities to answer and ask questions. Follow-up interviews were conducted by e-mail and/or telephone. The interviews were written on field notes and recorded on audio tape except for participant

NHA0051, who declined audio tape. I later transcribed the data immediately after the interview to eliminate ambiguities.

Interview questionnaires were mailed and/or e-mailed to participants who are not available on site for face-to-face interview. The observations enabled me to document any significant events or behaviors that occurred before, during and after the interviews in the location. The OSCAR file from NHAs present and previous nursing homes provided data on nursing homes' operations, and 2008 to 2013 regulatory compliance for annual and complaints surveys results. OSCAR file enabled me to link the QOL citations to specific administrator of record and duration of his/her employment at the facility. The nursing homes' plan of correction provided data on facility's corrective measures for cited deficiencies, and the anticipated time of correction. The plan of correction also provided the names of the NHAs of record at the time of the regulatory visits, which is not on the OSCAR file.

Creswell (2007) stated that there are specific characteristics that a qualitative research study should meet, and they are as follows: data collection should be in a natural setting, the researcher is the instrument of data collection, data should be from various sources, data analysis should be inductive, the focus should be on participants' meaning of the experience, qualitative research design is emergent, theoretical lens is used to view the research study, the phenomena are interpreted by the researcher, and the researcher presents a holistic account of the phenomena under study (p. 37-39).

Evaluation of the Effectiveness of Study Tool

Maxwell (2005) stated that in order for researchers to develop accurate and appropriate data collection tool for studies, researchers should predict "how the interview questions and observational strategies will actually work in practice" (p. 92). In order for a researcher to collect data that are representative of the selected population, the researcher must use appropriate data collection tool. Regulatory deficiency data were collected from NHAs present and previous nursing homes. A pilot study was used to test the study interview questionnaire. A personalized e-mail of introduction was sent to two purposeful samples of NHAs. The pilot study participants were current practicing NHAs licensed in the State of Maryland, or District of Columbia, after the permission to proceed with the study was received from Walden University's Vice President of Research and Assessment through the Institutional Review Board (IRB) procedure. The letter explained the purpose of the study. Administrators were asked for confidential, voluntary participation in the pilot study. The letter also explained that the administrators were not the participants of the study and that their suggestions would enable me to produce appropriate interview questions for the research questionnaire. The administrators were also informed in the e-mail that I would contact them upon receipt of their acceptance via e-mail to schedule a time to e-mail the sample questions to them for review, response, and suggestions.

My initial research questions were submitted to two selected NHAs for review, response, and suggestions. The use of practicing NHAs for the pilot study addressed the credibility of the study. The actual questionnaire that was used for this study was

produced by me, based on literature reviews of the research topic and the professional suggestions of two licensed NHAs. The study questionnaire is in Appendix A. This data collection tool enabled me to collect data relative to the study issues.

I collected data, transcribed data, and preserved data in controlled environments to ensure data trustworthiness. The preservation of research data will enable other researchers to have access to the information, upon request, for transference of the research conclusions to future studies. To ensure dependability and confirmability, my dissertation committee members reviewed my research methods to ascertain that the research data such as field notes, audio record, data analysis documents, and original transcripts are complete and available. Collected and transcribed data were saved in paper copies and back-up disks, and will be secured in locked cabinets for 5 years. I am the only individual that has access to the collected data. In order to ensure anonymity, identifying information was removed before the data was validated.

Sampling Design

The sampling design for this qualitative case study was a purposive sample. Frankfort-Nachmias and Nachmias (2008) stated that the sampling frame determines the accuracy of the sample since all aspects of the sampling design is influenced by it (p. 165), and that "a sample is considered to be representative if the analysis made using the sample units produce results similar to those that would be obtained had the entire population been analyzed" (p. 167). Five counties in Maryland NHAs were the appropriate sample for this study. The State of Maryland had NHA turnover rate of 25.8% in 2008 (AHCA, 2010), 25.2% in 2009 (AHCA, 2011), and 23.8% in 2010

(AHCA, 2011). There are an adequate number of nursing homes in the counties for a qualitative case study. I live in Maryland. The use of Maryland nursing homes would reduce data collection cost for me, although some of the nursing homes were far from the researcher's residence.

Study Participants

The case approach of this study focused on gaining in-depth information on administrators understanding of how their turnover influences residents' QOL. There are 109 nursing homes in the five counties in Maryland, and 109 NHAs of record working in the nursing homes. The participants of this study were seven NHAs out of 109 NHAs currently employed in the five counties in Maryland.

The chosen administrators had at least 5 years or more experience as NHAs, are currently employed at nursing homes in the five counties, and have turned over at least one time in 5 years. The unit of analysis was the experiences of NHAs in the five counties in Maryland. There are seven NHAs in the research. When there were fewer than 10 participants, but more than three participants who accept to participate in the study, I interviewed the participants for the study data.

I contacted the NHAs after the permission to proceed with the research study was received from Walden University's Vice President of Research and Assessment through the IRB procedure. The inclusion criteria of the seven participants were NHAs (a) who were currently administrators of record in five counties in Maryland with 5 years or more experience, and (b) who had turned over at least one time in 5 years.

Sampling Method and Strategy

E-mails and a certified postal letter were sent to the Executive Director of Maryland Board of NHAs explaining the research topic, purpose, and participants. Access to the names of the NHAs currently working in Prince George's County, Maryland and their locations of employment was requested. I received a web address from the Executive Director of Maryland Board of NHAs for Maryland Office of Health Care Quality. Data on all nursing homes in the State of Maryland were retrieved from Maryland Office of Health Care Quality's website. The list included the names of the nursing homes, location of the nursing homes, Medicare and Medicaid status, bed capacity, and nursing homes telephone numbers.

A personalized letter of introduction was sent via postal service to all administrators of record of nursing homes in the five counties in Maryland, after the permission to proceed with the study was received from Walden University's Vice President of Research and Assessment through the IRB procedure. The letter explained the purpose of the study. Administrators were asked for confidential, voluntary participation in the study. The administrators were informed in the letter that I would contact them upon receipt of their acceptance letter to schedule a face to face or phone interactive interview.

Sampling Characteristics and Demographics

The original dissertation inclusion criteria of the 10 participants was NHAs (a) who were currently administrators of record in the X County for 5 years or more, and (b) who had turned over at least two times in 5 years. The actual inclusion criteria of the seven participants was NHAs (a) who were currently administrators of record in five counties in Maryland with 5 years or more experience, and (b) who had turned over at least one time in 5 years. The exclusion criterions for the participants was as follows: (a) Assisted Living Administrators, (b) NHAs with fewer than 5 years' experience, (c) NHAs who are Regional Managers, and (d) Contract NHAs.

Sample Size

The participants of this study were seven NHAs which resulted in data saturation out of 109 NHAs currently working in the five counties in Maryland. The seven participants were NHAs, who have turned over at least one time in 5 years. The unit of analysis was the experiences of seven NHAs in the five counties in Maryland.

Research Measures

The purpose of this qualitative case study was to determine if administrators are aware of the negative impact their departure from a nursing home has on residents' QOL in regard to residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities. The turnover of NHAs has been an issue of concern to nursing home stakeholders, but limited or no study has determined if administrators connect their voluntary departure from a facility with residents' QOL. I sought to contribute to the gap in knowledge relative to the influence of NHA turnover on

residents' QOL. Finally, turnover of NHAs, which was the focus of this study, has been associated with several issues in nursing homes; however, the scarcity of literature on NHA turnover influence on residents' QOL at the present time makes it an assumption rather than certainty.

Research Procedures

The list of the procedures used for participants' selection, data collection and analysis, and findings' validations are as follows:

1. Permission was received from Walden University IRB for participants contact by e-mail or postal service.
2. Introduction letter about the research study was mailed by postal service to all the NHAs currently employed by nursing homes in five counties in Maryland. The cover letter provided a detailed explanation of the study, the role that the participant will play in the research, and the confidentiality of the data collected. The cover letter also stipulated that participation was voluntary and that the participant could stop participation at any time during the study for any reason.
3. Face-to-face or phone interview was scheduled with the selected NHAs.
4. The face-to-face or phone interview was conducted at each participant's office or by phone per his/her request. Participants who were not available for face-to-face interviews received interview questionnaire by e-mail and/or telephone interview.

5. Interview questions were from the questionnaire produced by the researcher.
6. The interviews responses were recorded on field notes and with audio recorder except when refused by participant.
7. OSCAR files of NHAs present and previous nursing homes were retrieved from CMS website.
8. Plan of corrections were collected from the nursing homes.
9. I transcribed the field notes, observations, OSCAR files, plan of corrections, and audiotapes.
10. Transcribed data were summarized by simple coding into coding descriptions.
11. Identified codes were reduced to themes and patterns.

Data Collection

Errors in data collection in qualitative research studies affect the rigor of the studies, such as trustworthiness, confirmability, transferability, and credibility (Macnee & McCabe, 2008). Walden University requires that all studies that involve human participants must be granted permission by the IRB to perform the study. This study did not deal with a protected class. Upon receipt of permission to proceed with the study, a cover letter and a consent form (Appendices B and C) were mailed to the target population. The cover letter provided a detailed explanation of the study, the role that the participant will play in the research, and the confidentiality of the data collected. The

cover letter also stipulated that participation was voluntary and that the participant could stop participation at any time during the study for any reason.

I conducted face-to-face or phone interactive interviews with the participants at their offices. Each participant was scheduled for one detailed interview lasting for 60 to 90 minutes. Open-ended questions from the questionnaire developed by me were used to collect data for this study. The participants were asked to describe how their turnover influenced the nursing home residents' QOL based on the research questions. Additional questions were asked outside the questionnaire based on participant's response and feedback.

I also observed significant events and behaviors at the location before, during, and after the interview relative to the responses of the participants. OSCAR files were retrieved from CMS website, and plan of corrections was collected from each nursing home. Duration of data collection for the participants was 9 months with data saturation. The participants were contacted for follow-up interviews by e-mail or telephone. Telephone and/or e-mail was also used if additional data or clarification of information was needed.

Participants who were not available for face-to-face or phone interviews received interview questionnaires by e-mail. Interactive interviewing via face-to-face enabled me to ask the participants questions from the interview questionnaires. The interactive interview also enabled the participants to ask and answer questions. I was able to clarify and answer participants' questions during face-to-face or phone interviews. I was also

able to observe participants' nonverbal cues or body language relative to the interview questions.

Good interviewing skills and observation skills enabled me to document what was heard and seen during the data collection process. Transcribed data were provided to participants who agreed for verification of accuracy of the data. Participants were reminded that they can change their mind about participation in the study at any time, and the data collected from them and the nursing homes where they work and worked would not be used.

Data Analysis

I performed the data analysis for this study. A file was created for each participant. The file for each participant contained me name, participant's ID number, facility's ID number, date of data collection, site of data collection, type of data collection, and demographics or codes for analysis. There are several strategies of data analysis. Creswell (2007) stated that qualitative research data analysis involves data preparation and organization for analysis, data coding and reduction of codes, reducing data into themes, and representing data into figures, tables, or a discussion (p. 148). Hunt et al. (2012) and Siegel et al. (2012) conducted research about nursing home leadership issues with the use of the self-produced interview questionnaires. The interview questionnaires were based on the study variables. Siegel et al. used the content analysis and thematic analysis to analyze the data obtained from the semi-structured interviews, while Hunt et al. used immersion and content analysis to analyze collected research data.

These researchers also used qualitative data management software such as NVivo 9 and Atlas.ti respectively to access coded quotations from transcribed documents.

The data analysis strategies that were used for this study were as follow: field notes and audiotape transcriptions, files and records transcription, summarization of transcribed text documents, data coding, codes reduction through themes, and themes categorization. Audiotapes, observation and field notes from interviews were transcribed into a text document. OSCAR files from NHAs present and previous nursing homes and plan of corrections were also transcribed into text documents. Transcribed data were summarized. Simple coding was used to manually condense text document into codes. Simple coding enabled the researcher to interpret phrases, keywords used by the participants, and paragraph sections according to the meaning of the terms. The identified values assisted with the analysis of collected data. Themes were used to reduce the number of codes. The themes were categorized by the use of nonhierarchical (flat coding). NVivo 10 data analysis software was used to perform phrases, paragraphs and word frequency count from the transcribed data. NVivo 10 also enabled me to retrieve coded information from transcribed documents for the study. Corbin and Strauss (2008) stated that qualitative data analysis is, “an intuitive sense of what is going on in the data; trust in the self and the research process; and the ability to remain creative, flexible, and true to the data all at the same time” (p. 16). I showed that the result of the data analysis is representative of the data collected.

Study Ethical Considerations

This study did not deal with a protected class. Since participants' face-to-face or phone interviews was conducted in their offices and by phone, there was no need for the agreements to gain access to participants. I retrieved the OSCAR files from CMS website, and the copies of plan of corrections were emailed to the researcher or collected by the researcher from the nursing homes. In order to ensure validity and reliability of the study the following measures were instituted: subject matter experts were used to review the interview questionnaire for suggestions, ongoing member check guaranteed that data collected, transcribed and interpreted was without error, there was step-by-step documentation of how codes were developed from collected data to analysis of data, and qualitative software NVivo 10 was used for assurance of data accuracy. Upon receipt of permission from Walden University IRB to proceed with the study, a cover letter and a consent form (Appendices B and C) was mailed to the target population.

The cover letter provided a detailed explanation of the study, the role that the participant will play in the research, and the confidentiality of the data collected. The cover letter also stipulated that participation was voluntary and that the participant could stop participation at any time during the study for any reason. When a participant withdrew from the study, the participant's data were not used in the research. Replacement participants who meet the research criterion were used to replace the withdrawn participants if needed. Collected data were saved in paper copies and back-up disks, and secured in locked cabinets for 5 years. I am the only individual who has access

to the collected data. In order to ensure anonymity, identifying information was removed before the data was validated.

Summary

I attempted to address the gap for the limited existent literature relative to the influence of the turnover of NHAs on nursing home residents' QOL, from administrator points of view. Chapter 3 was an explanation of the qualitative case study that enabled me to collect and analyze the research data. Chapter 4 is an in-depth description of data collection and data analysis.

Chapter 4: Results

Introduction

The purpose of this qualitative case study was to explore how NHAs connect their departure with resident QOL. By revealing the descriptions of NHAs on how their turnover influences resident QOL, I attempted to address the gap of knowledge and provide recommendations to prevent voluntary NHA turnover. The participants were recruited from the lists of all nursing homes in Maryland retrieved from Maryland Office of Health Care Quality. The interviews were based on the study interview questionnaire. The research presented the participants with an opportunity to tell their stories based on their turnover experience and how turnover influences resident QOL, hence providing data that could be used to address NHA turnover and resident QOL needs. The participants' shared experiences of their turnover and turnover influence on resident QOL was a significant outcome of the research interviews. Well-informed research interviews can provide a significant understanding of human and behavioral actions (Yin, 2009). The process of interview confirmed the selected participants of this study.

Data Collection Process

This chapter is a summary of the findings of this study of NHAs from five counties in Maryland. In Chapter 4 an in-depth description of the pilot study was used to ensure that the interview instrument was appropriate for study data collection, the difficulties and challenges encountered during recruitment and setting, participants demographics, data collection, data analysis, evidence of trustworthiness, results, and

summary will be provided. Chapter 4 includes the themes that emerged from the analysis of the collected research data.

Pilot Study

A pilot study was used to test the appropriateness of the study interview questionnaire. I started my pilot study after the permission to proceed with the study was received from Walden University's Vice President of Research and Assessment through the IRB procedure on November 15, 2013 with Approval Number 11-15-13-0200184. On November 18, 2013, a personalized e-mail of introduction was sent to five purposeful sample of NHAs. The e-mail explained that the administrators were not the participants of the study and that their suggestions will enable me to produce appropriate interview questions for the research questionnaire. The Pilot Study Cover Letter is in Appendix D.

Three administrators consented to the pilot study by e-mail. The sample interview questionnaire that the researcher produced was e-mailed to the three consented participants. Two administrators answered the questions on the interview questionnaire without any suggestions. One administrator did not answer the questions but suggested that I ask the administrators their definition of QOL. The original interview questionnaire approved by IRB was not changed, since Chapter 2 of the dissertation explained how difficult it was for scholars to define QOL. One administrator that responded to the questions on the interview questionnaire and the administrator who made the suggestions without answering the questions were used as the professional experts for the study instrument because they have turned over at least one time in 5 years. For confidentiality

reasons, name codes were used to maintain the participants' privacy. The profile of the two pilot study participants is as follows.

The two pilot study participants ranged in age from 55 years to 74 years. The average time the participants practiced as licensed NHAs was 21.5 years, with a range of 10 years to 33 years. The average time at present facility was 2.29 years, ranging from 1 month to 4.5 years. The average number of turnover in 5 years was 3.5 times, ranging from one time to six times. The responses and suggestions of the pilot study participants to the questions informed me that the interview questionnaire was appropriate for this study. The interview questionnaire was used for the study as approved the by IRB.

Table 1

Pilot Study Participants

Participants	Age Range	Years as a NHA	Number of NHs as a NHA	Years at Present NH	Turnover in 5 Years	Number of Turnover in 5 Years
NHAPS2	55 - 64	10	3	4.5	Yes	I
NHAPS3	65 - 74	33	12	0.08	Yes	6
Average		21.5	7.5	2.29		3.5
Total		43	15	4.58		7

Recruitment and Setting

I used the evolving qualitative approach. The basis of the qualitative approach is that the researchers are unable accurately to predict the directions or the outcome of the research investigation; instead, qualitative researchers try to understand the emergent nature of the process and continuously revise the study as needed (Babbie, 2008; Frankfort-Nachmias & Nachmias, 2008; Gomm, Hamersley, & Foster, 2000; Yin, 2009).

It is important for qualitative researchers to present in detail the specific steps that the study used to address the research questions.

I mailed 20 letters by US Postal Services containing introductory/cover letter, IRB approval letters, consent form, and a self-addressed stamped envelope to all NHAs employed by X County, Maryland nursing homes on December 2, 2013. By December 12, 2013, I received one consent to participate in the study by mail and one declined to the study by e-mail. E-mails were sent to 16 NHAs based on their company's e-mail addresses online. I was unable to locate two NHAs' e-mail addresses online. Six of the e-mails were delivered to the NHAs, but 10 of the e-mails were undeliverable. None of the administrators responded to the sent e-mails.

On December 24, 2013, a second round of letters was sent by US Postal Services to all the NHAs, who did not respond to the first mail. By January 16, 2014, I received two consents to participate in the study by mail and one decline by e-mail. The third round of letters was sent again by US Postal Services on January 17, 2014 to the NHAs in X County, Maryland, who had not responded to the posted mails or e-mails. No NHA responded to the third letter by the end of January 2014.

I interviewed the three participants that consented to the study in their offices by their request. The participants refused video conferencing, which was stated as the location of data collection in Chapter 3. Two out of the three participants turned over once in 5 years while one participant had not turned over in 5 years. In Chapter 3 I explained that when there are less than 10 participants, but more than three participants who accept to participate in the study, I will interview the participants for the study data.

Based on the direction of my committee member, on February 4, 2014, I sent letters to all 34 NHAs employed in Y County, Maryland by US postal services. One NHA declined participation and two NHAs consented participation by February 19, 2014. One of the NHAs who agreed to participate in the study declined any recording. It is suggested that recording devices not be used by researchers if participants refuse or are uncomfortable with the device (Yin, 2009). The two consented NHAs were scheduled for interviews on February 28, 2014 and March 15, 2014. On February 21, 2014, study information was mailed again to 20 NHAs in Y County, Maryland. No other NHA consented to the study in Y County, but four NHAs declined participation by February 27, 2014. I conducted interviews on February 28, 2014 and March 15, 2014 with the consented participants. I reached data saturation with the interview of the fifth participant. At this point, I observed themes repetition, and there were no new emerging themes which is evidence of data saturation, so I did not contact any more NHA for study participation. Two NHAs declined participation on March 15, 2014 by mail.

Based on the suggestions of my dissertation committee members, I started participants' recruitment again. On July 3, 2014, letters were mailed to all 24 nursing homes in Z County and ZA County, Maryland. By July 7, 2014 three NHAs declined participation by e-mail, and one NHA consented to participate in the study. The NHA that consented was interviewed on July 10, 2014 (sixth interview), but she had not turned over in 7 years. On July 15, 2014, 15 letters were mail to ZB County, MD, and on July 18, 2014, 17 letters were mailed to ZB County, MD. One NHA consented to participate in the study on July 20, 2014, and was interviewed by phone on August 12, 2014 (eighth

interview). I called all the nursing homes in Z and ZA counties by phone in search of potential participants on July 21, 2014. One NHA agreed to participate during the phone call. The NHA was interviewed in his office on July 29, 2014 (seventh interview).

On August 8, 2014, I called all the nursing homes in ZB County. One NHA agreed to participate in the study, and the ninth interviewee was interviewed on August 21, 2014 in his office. After nine interviews, I observed continuous themes repetition, and there were no new emerging themes which is evidence of data saturation, so I did not contact any more NHA for study participation.

The original recruitment process in Chapter 3 stated that the inclusion criteria of the 10 participants or until data saturation will be NHAs (a) who are currently administrators of record in the X County for 5 years or more, and (b) who have turned over at least two times in 5 years. Due to my difficulty in recruiting participants that meet the criteria, the actual inclusion criteria of the seven participants was NHAs (a) who were currently administrators of record of five counties in Maryland with 5 years or more experience, and (b) who had turned over at least one time in 5 years. AHCA (2011) stated that the average NHA turnover rate was 18.9% in 2010 and that some states' rate was as high as 43.1% (p. 14). The turnover rate for the State of Maryland was 23.8% at the same period.

Participant Demographics

I used multiple data forms that were relevant for the research. The study data were collected through (a) semistructured in-depth interviews which involved asking each participant the series of questions from the interview questionnaire (Appendix A), (b) a

plan of correction from the nursing homes, (c) OSCAR files of present and previous NHAs' NHs from CMS website, and (d) observations of activities and events at each facility (Appendix E). The interview sample was made up of seven NHAs from five counties in Maryland. The average years of experience as NHA of the participants was 19.64 years, ranging from 7.5 years to 32 years. The average number of nursing homes as NHAs was 5.29 nursing homes, with a range of two nursing homes to 16 nursing homes. The average number of years at the present nursing homes was 2.59 years, ranging from 3 months to 4.75 years. The average number of turnover in 5 years was 1.14 times, with a range of 1 time to 2 times. The data collection took place at participants' offices in Maryland and by telephone interview. One participant was interviewed by phone as per the participant's request.

Table 2

Research Interview Participants

Participants	Age Range	Years as a NHA	Number of NHs as NHA	Years at Present NH	Turnover in 5 Years	Number of Turnover in 5 Years
NHA0004	55 - 64	20	4	0.25	Yes	1
NHA0020	45 - 54	18	4	.5	Yes	1
NHA0050	45 - 54	12	2	4.75	Yes	1
NHA0051	55 - 64	32	3	4.75	Yes	1
NHA0057	45 - 54	7.5	2	4.5	Yes	1
NHA0077	55 - 64	30	16	.38	Yes	1
NHA0088	45 - 54	18	6	2	Yes	2
Average		19.64	5.29	2.59		1.14
Total		137.5	37	18.13		8

I selected the participants of this study with the homogenous sampling technique. Homogeneous sampling is a sampling of people with similar characteristics (Frankfort-

Nachmias et al., 2008). This homogenous sampling focused on NHAs who have turned over at least one time in 5 years from their positions in nursing homes. Nine potential participants were interviewed in their respective offices or by phone as per their request. Seven of the participants interviewed were selected as the study participants because they have turned over at least one time in 5 years. The interview of the seven participants resulted in recurring themes.

I excluded two individuals (my first and sixth interview participants) from participating in the study, because they had not turned over in 5 years. The NHAs expressed passionate interest in the topic of the study. Since, the NHAs did not meet the inclusion criterion, the findings of this research is based on seven interviews comprising of four men and three women.

Since the study is a dissertation, I approached the participant interviews discreetly and systematically. The interviews were conducted with the participants at their conveniences to ensure personal and professional safety. The participants scheduled the interviews at the times when they were less likely to be interrupted. Despite the precautions taken in choosing the appropriate time for the interview, each participant was interrupted at least once during the interview process either by a phone call, overhead pager or an individual.

Each face-to-face interview was conducted in the participant’s office or by phone, and it lasted between 60 minutes to 90 minutes. The interview questions were used for data collection, and follow-up questions were asked based on participants’ responses. Field notes and audio recorder were used to record the interview. One participant refused

audio recording, and I respected his/her wishes. It is recommended that recording devices not be used by researchers if participants refuse or are uncomfortable with the device (Yin, 2009). The interview data were later transcribed into Microsoft Word document and NVivo 10 software.

I saved each interview file on the C-Drive of my laptop with password protection, and backup of the files was saved on a flash drive, which is saved on a locked drawer in my house. To maintain confidentiality of the participants, I coded the participants as NHA and added the assigned facility number in the order that I organized the nursing homes to it. The first participant was coded as NHA0004, and second participant was NHA0020, and so on. "A" was added to the participant's code name for the previous nursing home to different OSCAR result of previous nursing home from the present nursing home.

Upon completion of interview transcription, the transcribed document was e-mailed to each participant that requested to review the data. Five participants requested for the transcribed data and final paper while two participants requested for the final paper. Three participants reviewed the data and accepted it as is, and two participants made minor corrections to the data, such as changing the date he/she started his/her job at the nursing home from 2009 to 2010, and so on. The accuracy of the transcribed data was confirmed by the participants that reviewed the transcribed data.

Although my original idea was that the interviews would be face-to-face video conferencing and recorded, the actual interviews were face-to-face in the participants'

offices or by phone. One interview was conducted by phone, and one participant refused recording.

The second source of data was the plan of correction provided by each facility. In order to enhance the understanding of the influence of NHA turnover on resident QOL from a regulatory point of view, I requested for copies of each facility's plan of correction from 2008 to 2013. The plan of correction stipulates how each facility plans to correct the regulatory deficiencies cited by surveyors at each evaluation of the facility and provides the expected date of completion of the correction. The plan of correction also has the signatures of each administrator of record during the survey. The plan of correction is available at the facility for anyone to review upon request. The review of the plan of correction documents also enabled me to track the names of the administrator of record for each year, and what QOL citations occurred during his/her tenure as the administrator of the facility. The review of the plan of correction also enabled me to relate the cited deficiencies to NHA turnover. The plan of correction was transcribed for each facility and coded.

The third source of data was the OSCAR files. OSCAR files for the previous nursing home and present nursing home were retrieved for 2008 to 2013. Case study researchers should corroborate interview data with other sources of data in order to reduce bias, and the other issues associated with interview data (Yin, 2009). The OSCAR file is a nursing home survey database created by the CMS. The OSCAR file is available at Medicare archive website. The OSCAR file is available to the public to enable individuals to make informed decisions about the quality of services provided by each

nursing home in the US. The OSCAR file contains each facility's demographics such as provider number, provider name, provider location, and so on. OSCAR file also provides the facility's yearly survey reports. The facility survey report of the last 36 months for Maryland is on CMS Nursing Home Compare website while earlier survey reports are on Zip files online.

The OSCAR file enabled me to retrieve facility survey reports from 2008-2010, which were not available on the Nursing home Compare website. The OSCAR file contains all the facility survey deficiencies without the facility corrective measures. The easy access to the OSCAR file also enabled me to retrieve the data even when the current administrators in the nursing homes could not find the previous year's plan of correction. OSCAR file enabled me to link the QOL citations to specific administrator of record and duration of his/her employment at the nursing home. The citations on the OSCAR file were transcribed for each nursing home and coded.

The final source of data was the observations of the nursing homes' environment and activities on the day of participant's interview. The observations lasted between 30 minutes to 1 hour before and after the scheduled interview. The observation data were transcribed and coded.

Data Organization and Storage

I created data tracking and file naming organization before I started the qualitative case study. I organized the data by creating folders for each participant. Each folder contained the following files of the participant and the nursing homes: consent form, interview field note, transcribed data, nursing homes plan of correction, and nursing

homes OSCAR file. Each folder contained dividers that separated each document. The folders, files, and audio recorder were locked in a file cabinet in my house when not in use, and I am the only person that has access to the data. I also created a folder for the combined transcribed data for coding without identifying information and the combined coded data for analysis.

The Microsoft Word research data were saved on my C drive with names relative to the file. Transcribed individual interviews were saved by participant's code name such NHA0004 Interview data, NHA0004 Interview data 1, and so on. The formatted transcribed interviews that were exported to NVivo 10 were save as NHA0004 for NVivo, NHA0004 RQ1 Answers, and so on for coding with NVivo 10 software. The manual coded data were saved as date of the coding followed with Research Coding. For example, data coded on April 1, 2014 would be coded as 040114 Research Coding, and so on. The combined interview manual codes were saved as All Data Manual Codes. Each typed data were saved on my computer C drive and a research flash drive. The hand written coded documents were saved in the locked cabinet in my house.

Five participants requested for the transcribed data and final paper. While two participants requested for the final paper. The accuracy of the transcribed data was confirmed by the participants that reviewed the transcribed data. The study data such as the field notes, observation notes, transcribed data, plan of correction and OSCAR file will be destroyed after 5 years. The electronically saved data in my computer C drive and flash drive will be erased after 5 years. The audio tapes were destroyed after transcription as stated in the consent form signed by the participants for the study.

Data Analysis

Interview Data Coding

Codes are used by researchers to gather numerous classifications of an idea into categories (Frankfort-Nachmias et al., 2008). In an effort to accurately reflect what was stated and to understand the collected data, I used the iterative process of coding. I listened to the audio tapes several times during transcription. The transcribed data, observations, plan of correction, and the OSCAR file were read, coded and reread many times. I tried to understand the importance and the worth of the collected data. I used many steps for the data coding. I started the coding process by highlighting some sections of each transcript of interest with a yellow marker and quotation marks. Then I created nodes for each research question in NVivo 10. I exported the formatted transcribed interviews files into NVivo, and copied and pasted each participant's responses to each question into the NVivo 10 node with the question number. NVivo 10 enabled me to perform word counts and text search of the transcripts, and print the combined responses to each research question.

With the combined answers in one document, I started line-by-line coding of the data manually, looking for text pertinent to the research questions in the document. I used unique identifiers to track sources of the information. I wrote phrases, themes and keywords that I found on the responses with different color pens. The color of the pen used to write the keywords, themes, and phrases represented the stages of coding. After several rounds of manual coding of the combined data, I transferred the condensed codes

into NVivo 10. I used NVivo 10 query and analyze to verify the word frequency, text search, accuracy and consistency of the identified codes with transcribed interview data.

The coding resulted in too many phrases, themes, and keywords. With the research questions in mind, I condensed codes into categories by assigning a descriptive label. The categories that researchers use "must be mutually exclusive and exhaustive" (Frankfort-Nachmias et al., 2008, p. 306). The categories were based on the recurring patterns and themes from the data. The initial categorizing resulted in broad themes, which were reorganized into meaningful categories to aid with data analysis. With ongoing data coding subcategories were identified underneath the main categories. New categories that did not fit prevailing categories were also identified. Different folders were created for responses that were not relevant to study but were thought-provoking, and the responses that were contrary to the themes. On-going data coding was maintained until there were no new pattern or theme emerging from the data. The selected codes and categories relative to the collected data were transferred to NVivo to identify the relationship between the data and themes that occurred.

Plan of Correction and OSCAR File Coding

The plan of correction and the OSCAR data were coded according to their relationship to the research regulatory area of focus. The QOL area of focus for this study was residents' physical needs (accommodation of needs) is Ftag 246, residents' rights (self-determination and participation) is Ftag 242, residents' relationships (participation in resident and family groups) is Ftag 243, and residents' meaningful activities (activities) is Ftag 248. The documents were reviewed for deficiency citations of the

Ftags related to the focus area during regulatory visits to the nursing homes. The NHA of record at the time of the survey was also associated with the deficiency during his/her tenure at the nursing home. The recurrence of the QOL citations was also tracked for each present and previous nursing home for 2008 to 2013.

Observation Coding

At the end of each observation, I wrote my reflection of the experience on the form. The observation information was transcribed into Microsoft Word document. The transcribed Microsoft Word document was exported into NVivo 10 software.

After the data coding, I tried to understand the meaning of the themes and patterns relative to the research questions and subquestions. In order to understand the meaning of the categorized data, I needed to answer the following questions: Did the data answer the research questions? How did the data answer the questions and address the gap of knowledge? What new information did the researcher find? What has the researcher learned from the data? How does the data conform to the theory framework or diverge from it? What positive social impact will the data have? The use of four sources of data enabled me to identify variances, similarities and patterns across the data.

NVivo 10 Software

Since this study was my first field research, I chose to code the data manually before transferring it into NVivo 10. I also had difficulty using NVivo 10 at the beginning of my coding. I attended several NVivo 10 webinars and spent several hours reviewing NVivo 10 video demos that accompanied my NVivo 10 Software license, before I was able to use NVivo 10 for the data coding. I used Microsoft Word and NVivo 10 Software

for the collected data storage and management. The use of NVivo 10 software assisted me with editing and coding and appropriate linking of the transcribed data to identified themes. The use of Microsoft Word enabled me to produced well-formatted documents that were free of grammar and spelling errors. The use of computer aided software assisted me with time management, data coding and organization, editing, and secure storage. Manual coding before software coding was redundant; but, it enabled me to find appropriate themes for the study.

Analysis of Interview Data

I purposefully selected the seven NHAs for this study because they have been the administrator of record in five counties in Maryland for over 5 years, and they had turned over at least one time in 5 years. I used the open-ended interview questions that I produced. The interview questions were generated and guided by the literature review, research questions, and expert reviewers. There were two research questions and two subquestions. The research questions are as follows:

1. What are the NHAs’ experiences in regard to their turnover impact on residents?
2. How does NHA turnover influence resident QOL?

The subquestions are as follows:

1. In what way does the turnover of NHAs influence residents’ physical needs, residents’ rights, residents’ relationships, and residents’ meaningful activities?

2. What is the connection, if any, between a high turnover among administrators and a low QOL for residents?

Specific questions were posed to the participants based on the research questions. Specific questions are in Appendix A.

Analysis of Plan of Correction

An analysis of the plan of correction enabled me to understand the regulatory citations that each facility received for 2008 to 2013. The data review also revealed that some of the participants did not have access to their nursing homes' plan of correction, and did not provide all the requested plan of correction to me. Some of the plans of correction I received from the participants did not contain the administrator's signature. The plan of correction enabled me to link each administrator of record to the regulatory deficiency citations relative to the study focus areas. By relating regulatory citations to administrator of record, I was able to understand the status of corrective measures implemented after citations. If there are recurring QOL citations in a nursing home with frequent NHA turnover, it could mean that the corrective measures proposed by the nursing home were not appropriately implemented due to leadership turnover.

Analysis of OSCAR File

The OSCAR file enabled me to have access to all the survey results for 2008 to 2013 of all the participants' nursing homes in the study. Analysis of the OSCAR file showed all the nursing home QOL citations for each nursing home for the selected years. The OSCAR file also provided the deficiencies of the nursing homes for the previous years that I was unable to find on the CMS Nursing Home Compare website. The data

from the OSCAR file enabled me to understand the nursing home citations and relate the citations to the QOL area of research focus. An increase in the inspection scope and severity of citations in a nursing home with a recurrent participant departure could mean lack of consistent leadership oversight. The OSCAR files also enabled me to understand the pattern of deficiency citations before participant arrived in the nursing home and during his/her tenure at the nursing home. The analysis of the previous nursing home s QOL deficiencies enabled me to track the number of deficiencies after the NHAs departed the nursing homes. The analysis of the research data resulted in the following themes: (a) determinant of turnover influence, (b) facility-wide connection break, (c) absent leadership presence, and (d) facility transformation phase (Table 3).

Table 3

Analysis of Themes

Themes	References
Determinants of NHA turnover influence	11
Facility-wide connection break	7
Absent leadership presence	18
Facility transformational phase	20

Verification of Data

The intent of this qualitative case study was to explore how NHAs connect their departure with resident QOL. Verification of the quality of this study data was done through member check, research bias clarification, and the use of direct quotes with rich, thick descriptions (Creswell, 2007). To ensure member check, the participants who requested a copy of the transcript received the transcript and verified its accuracy. Five participants reviewed the data transcript for accuracy and approved the data. Case study

researchers use thick descriptions to enable readers to make informed conclusions about the cases (Gomm et al., 2000).

In the interviews, rich, thick descriptions with direct quotes were used to establish the turnover accounts of NHAs relative to resident QOL. In this study, there were repetitions of the same or similar information by the participants, which shows some evidence of reliability and validity. To clarify research bias, I did not include any individual that I knew or worked with previously in the study. The participants were not asked questions that did not pertain to the study. Additional questions were asked as needed based on the participant's response to the interview questions. The participants had few discrepancies in connecting turnover with resident QOL. The discrepant case description followed the major themes revealed by the study data.

Themes Identified from the Data

I sought to discover how NHAs connect their departure with resident QOL. I also endeavored to ascertain in what way turnover of NHAs influence residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities. There were common themes that were identified by the participants regardless of their years in the profession and the type of organization they work for. The review of the interview transcripts and field notes enabled me to identify collective themes expressed by majority of the study participants. The recurring themes identifies are as followed: determinants of turnover influence, facility-wide connection break, absent leadership presence, and facility transformation phase.

Themes

Theme 1: Determinants of NHA Turnover Influence

When participants were asked what happens in nursing homes when administrators terminate employment, the participants responded unanimously that there are several conditions that determine the influence of administrator turnover in a nursing home. According to the participants, the conditions that often determine what happens in nursing homes when there is leadership turnover are as follows: resident mental capacity, leadership style of the NHA, facility status, and building status.

The participants stated that residents who are alert and oriented are affected by NHA turnover than cognitively impaired residents. According to NHA0077, “the impact on the residents depends on their mental capacity.” NHA0057 stated, “some residents are close to you for whatever reason”, and “it makes my day and I make their day.” NHA0050 agreed with NHA0057 when she stated that her residents tap on her window to make sure that she was there. NHA0050 continued with “their comfort is with me, and my comfort is with them.” Administrator’s leadership style could determine what happens when he/she leaves the facility, according to the participants. NHA0004 stated that

> Depending on the type of leader that the administrator was, certain programs may have been in place, or certain way things were handled may kind of fall apart for lack of a champion.

NHA0020 concurred with NHA0004 in regards to how the leadership style of the administrator influences the services before and after turnover. NHA0020 stated that

> The Administrator is more of being in command. As I was in the military, it is more of the same being a NHA. The building would reflect your personality. The building would reflect your sense of duty, your sense of pride, your sense of values. I think that when you know everyone is different, everyone has different management styles.

According to NHA0057, “administrators get things done, and things could be affected by the administrator leaving. Every administrator has his/her way of doing things.” NHAs that interact frequently with residents on the units would be missed by the residents more than the administrators that stay in their offices. This study finding supports the argument that NHA leadership style is associated with the quality of the services received by the residents (Castle et al., 2011).

Participants stated that nursing homes with regulatory problems during or after NHA turnover could influence resident QOL. NHA0050 described her facility as “they had actually come out of a survey and had two IJs during the state survey. So it resulted in turmoil in the building when I came to this building.” NHA0051 agreed with NHA0050 and stated that a facility with issues would have a “need for improvement of care and customer service.” Most of the participants stated that old nursing homes without appropriate maintenance could result in frequent NHA turnover influencing resident QOL. NHA0088 commented about the buildings and stated “if you have a building that is a challenge building and the administrator has not necessarily been productive, that affects the QOL in a negative way” NHA0057 agreed with NHA0088

about the building challenge. NHA0057 stated that “old and challenging buildings. They are not pleasant places to work. Administrator of the building is embarrassed.”

Theme 2: Facility-Wide Connection Break

A majority of the participants described nursing home with NHA turnover as an environment with break in connection. According to the participants, there is facility-wide aura of uncertainty for the residents, employees, and family members. The feeling of unknown leads to nervousness, anxiousness, doubt and fear in the residents, family members and employees. NHA0077 described this period in a nursing home as

> Turnover impacts the facility because the residents; staff and family members are not familiar with the new administrator. It takes a while for them to get use to the style of management. There is an element of doubt. The impact on the residents depends on their mental capacity. Most of the residents are not aware of what is happening. It is a change, and people don’t deal well with change.

This study finding supports the contention that residents’ environmental condition could indirectly affect the residents’ QOL (Halvorsrud et al., 2010). Connection break also affects the relationship developed, staff morale, staff behavior and emotional ties. According to NHA0004,

> The staff gets very anxious because their environment is unsure and uncertain. And then the residents too have that uncertainty about what is going to happen. Who is going to come next? What kind of administrator is that person going to be?

NHA0050 stated that because she came to the nursing home where the previous administrator was terminated, there was uneasiness among staff. NHA0050 also explained the environment as

> People were trying to figure out who you are and what you are. Can they play the same game with you that they were doing before you came to the facility? So there are a lot of unknown for the staff.

NHA0020 described influence of turnover of NHA this way

> The change in leadership could affect the morale. It could be good or bad. Also, the department managers you work with. They have to find or figure out this next person in charge. How is that person going to be? What's going to be their hot buttons? What's going to be that thing that they are looking for?

According to NHA0057, there is a "missing administrator presence," while NHA0088 stated "it is a lot of different things that happens" in the facility. The uncertain environment could affect the services that are provided to the residents, therefore, influencing their QOL.

Most of the participants of this study stated that the connection break leads to unsure of relationships, missing emotional and physical connection, lack of trust, loss of sense of comfort and security, no one to talk to and bond with and no caring and responsive relationship. NHA0051 explained the connection break as

> They have to start over and develop relationships with the new NHA. The new NHA would learn what they want and who they are. When I first came here, they

> had a NHA for a few years, one interim for a few months then me. I had to start establishing new relationships with the staff, residents and family members.

NHA0004 commented that

> To the best of their abilities, I mean. I can't force someone's family to come in, but I can make sure that visiting hours are open so that if your child is working 3-11 and they can only see you after work. They can come through to come visit you so that you can maintain relationships, and we can make sure that we have space for privacy if you need that. When someone is there in the interim position, I'm sure they pay lip service to the regulation. They are really not going to be involved in making changes as someone who is there on a permanent basis.

NHA0050 agreed with NHA0004 about residents' uncertainty after connection break. NHA00500 stated that

> You build relationships with the families, with your residents. I have an open door policy I live in a fish bowl. So, most of the residents would come by and would tap on the window. And they are very comfortable with doing that. And there are a few that make sure that I'm in here. They have comfort is with me, and my comfort is with them. I think that when you change that, they are unsure of what is going on.

NHA0057 talked about administrator's relationship with residents in his/her facility. NHA0057 said,

> I think there are differences. There are the ones that are your favorites; you might say. Just like you make your own friends in the real world, there are some of the

residents that you are close to you for whatever reason. I share a birthday with Ms. X, and I see her all the time and we have a regular relationship. It is special. It makes my day, and it makes her day.

Theme 3: Absent Leadership Presence

Most of the study participants agreed that the turnover of NHAs creates absent leadership presence in the nursing home. The leadership void leads to employees performing without rationale, no advocate for residents, no one addressing resident needs, no global attention to details, and no one ensuring odor free facility. NHA0057 comment on this topic by saying,

The main thing that is missing when an administrator leaves is the presence. The main figure to hold everyone accountable for what they are supposed to be doing is not there. They slack off when no one is watching closely.

The turnover of NHAs could affect the nursing employees in the nursing than the turnover of director of nursing (Donoghue, 2009). The participants stated that there is the lack of tracking or erratic tracking of quality measures or outcomes, lack of attention to details, inappropriate hiring practices, lack of choices for residents, lack of connection with residents, no response to residents' needs, no focus on staff performance and no visible NHA presence in the nursing home. This study finding supports the argument that NHA turnover is associated with poor care (Castle et al., 2010; Hunt et al., 2012). When participants were asked about NHA turnover influence on resident QOL, NHA0004 responded with

> I think that when there is administrator turnover there is DON turnover and that whole echelon. Who's keeping track of business? Who's tracking the outcomes? Who is making sure that things are the way they should be? And so, people get complacent about what they say. What I find when you ask, why are you doing it like that? You get; we have always done it like that or the last person who was here wanted us to do it like that.

NHA0051 stated "there are impacts on the demands, goals and expectations of the level of care" while NHA0020 questioned if the effect is measurable.

> There is an effect. Can you measure it? I don't really know. Can you really measure something like that? I wish that we could b/c it would show how important it is to get people who care versus being in charge or in touch. People would get that.

NHA0050 related the effect of NHA turnover on resident quality to regulatory survey of the facility. She stated that

> If you don't have that relationship with the surveyors, it is not going to work for you. They would come down hard on you. If they don't trust you that you are going to make the changes, they are going to work very hard to get you to move.

NHA0004 responded about the influence of turnover on resident QOL as follows.

> Because I have been here for 3 months, and there are a lot of things that I see. They went for 6 months; I think from the time that their previous administrator left until the time that I came without an administrator. The QOL of the residents was affected because nobody was directing the operation. I see the administrator's

> role in assuring that QOL. Whatever that QOL is for the person by keeping their eyes on the price so to say. Because you are the one that has to be looking at things globally. Whether the residents want to have a voice or whether they want to change their living conditions. You are the one that's able to make those decisions and help then make those choices.

NHA0050 stated that it depended on the focus of the NHA. Some NHAs focus on finance while come NHAs focus on the services provided to the residents. An effective NHA is expected to be able to focus on both finance and services of the nursing home. NHA0050 responded,

> The building takes on the administrators' attitude and behavior if I'm an absent administrator; my staff is going to be absent. So my expectation as an administrator is that I need to be able to put my family members here. And I need to trust my staff. I want them to treat the residents the same as they want their family members treated. If I don't care, my staff is not going to care. So, if my residents need something, even it's coming out here and watching the Olympics, and that was important to someone, you know what that takes precedence over me sitting here working on paper.

NHA0051 replied that leadership should respond to residents' QOL needs at all times irrespective of who is in charge. NHA0051 also stated that NHA turnover influences resident QOL adversely by "leadership not having resident council meetings. Leadership could be addressing issues timely or not at all." NHA0020 commented about NHA presence with the following statement

> It is a philosophy. If you have an administrator that does not think that's important for people to bathe in the morning. If you see someone not answer the call light. If you see someone walk pass a thrash on the floor. Those things are little things that count. If you do not care about the little things, then the big things do not make a difference. It is the little things. When you lead by example and walk around. And people know that you are there and what you are going to do. Hopefully, they would start doing it.

The participants agreed that the way that NHA turnover influences residents' physical needs, residents' rights, residents' relationship, and residents' meaningful activities is by creating no advocate for residents' needs, choices, rights, supplies and equipment. Licensed NHAs are considered residents' advocate by the regulators. The absence of an administrator creates a void in resident advocacy. When there is no resident advocate in a nursing home, there are no choices offered to residents, no assurance of residents' rights, no visible leader, no decision maker, no one for residents to talk to and bond with, and there is the a need for residents to develop and establish relationships. NHA0004 responded to question about the ways NHA turnover influences the resident QOL areas of focus by this study with

> Well, people have rights and want having their needs accommodated. Whether it be watching TV until midnight or they want to stay in their pajamas until lunchtime. The administrator is the one who has the final say in supporting that. And so the residents, your job as the residents' advocate is to make sure that they

> have the opportunity to have their needs accommodated. And that people are asking them what are their needs. This is not the elderly army.

NHA0051 responded to the question by saying “The administrator approves orders for supplies and addresses issues such as wheelchair not working or needing to be replaced. Leadership addresses these issues by delegating them to department heads.” The departmental directors ensure that quality services are provided to residents. NHA0050 stated that

> It is the little things that are important to them. We use the word “delight” in the building. It is finding out what delights each resident. It is easier to take care of somebody that is happy and delighted than when you go, you got to get up, you got to get to therapy. If we know what it is that will delight the resident: I want to get up, I want to brush my teeth first. If I miss that part then, the rest of my day is messed up. So we have encouraged our staff to find out what is the one thing that would make taking care of a happy resident. It is much easier than taking care of somebody that is grumpy b/c I didn’t brush my teeth first thing, or I didn’t have my coffee. So we use the word delight. Is everybody delighted?

NHA0020 stated that when it comes to NHA turnover and how it affects resident QOL areas that,

> Those things are really seamless in that regard. It is how you implement it is the thing. It’s in those regulatory standards. This is human nature business, and you can’t sit here and run the building. That’s my opinion. You have to know people. Which means you have to know the visitor, the staff, know where the break rooms

> are. You have to eat the food. That will help all the things you have to do. And when you're doing that, you know what your building feels like. You can get a sense of the building. I just think that it is a matter of personality and leadership style.

Theme 4: Facility Transformation Phase

The facility transformation phase is a period when residents, employees, and family members are adjusting to the changes brought about by the NHA turnover. A majority of the participants described the adjustment phase as the time when everyone associated with the nursing home adjusts to new expectations, new leader, new goals, to new leadership style, new philosophy, new expectations, new people, and new kind of relationship. NHA0051 stated that "It is an adjustment period for the staff. They have to get adjusted to the new styles and expectations and adjusted to the new person." NHA0004 described the adjustment time as follows.

> It provides lots of opportunities to develop new relationships. Things that you realized that didn't work well in your last facility, you have an opportunity to start over. So let's say you decide maybe I shared too much with my boss, so you say here I have an opportunity to establish a different kind of relationship.

The transformation phase is easier for the NHA than the residents, staff and family members because the NHA is in charge. The NHA would implement the changes required to get the organization where it needs to be. NHA0050 explained it well by saying,

> I have a very strong personality of do the right thing. And if you are not willing to do the right thing, don't do it here. You can go elsewhere and do it, but you are not going to do it here.

When the participants were asked what they did during the transformational phase, NHA0077 responded with,

> It takes a while for the administrator to learn what is going on in the facility. If the employees are not doing what they are supposed to be doing, you will have the turnover of employees. That would also affect the QOC also as you bring in new people to replace them.

NHA0057 agreed with NHA0077 relative to what happens in a nursing home with NHA turnover. According to NHA0057,

> When you are the boss, and you go to a new place, it is good not to make changes right away unless it is, of course, patient safety or something else such as egregious thing. I think that you need to observe. That's what I try to do. Over time, you make the changes that you feel need to be made. I came in here and took away dress down Fridays, but I did not do it my first week. I allowed them to know me a little bit then I took away casual Fridays.

NHA0088 concurred with other participants by saying "I treat each building differently. I treat each building like a startup."

Discrepant Cases

Frankfort-Nachmias et al. (2008) stated that negative or discrepant cases are the cases that the data collected from them deviate from the main information or hypothesis

(p. 267). NHA0051 stated that administrator turnover influences resident QOL but that it is not an automatic negative. NHA0051 stated that turnover could improve the organization. NHA0051 commented that

> I know of an administrator that went to another organization and improved staffing and QOC. It is negative when good staff leaves or good leadership leaves. It is also negative when turnover is interpreted by residents and family members as bad.

The premise of this study is that NHA turnover could lead to low resident QOL. NHA0051 stated that he did not know if NHA turnover influences residents' self-determination and participation, and does not think that NHA turnover influences residents' meaningful activities. NHA0051 expressed that turnover is

> It is an opportunity for the NHA to be in a new town with new tenure, new expectations and new staff. The employees may have to work a little harder and faster.

NHA0088 agreed with NHA0051's sentiments. NHA0088 also stated that NHA "turnover sometimes is a blessing and a curse." NHA0088 explained the statement with the following comment,

> If you have a building that is a challenge building and the administrator has not necessarily been productive, that also affects the QOL in a negative way. Sometimes bringing in a new administrator positively affects resident care and QOL. Coupled with sometimes when you bring in a new administrator, the

administrator and the building don't necessarily match. It could affect not only the residents' QOL but also the campus' QOL with the employees.

Evidence of Trustworthiness

The data collection tool enabled me to collect data relative to the study issues. I collected data, transcribed data, and preserved data in controlled environments to ensure data trustworthiness. I organized the data by creating folders for each participant that contained the following files of the participant and the facility: consent form, interview field note, transcribed data, facility plan of correction, and facility OSCAR file. Dividers were used to separate each document in the folder. The folders, files, and audio recorder were locked in a file cabinet in my house when not in use. Each typed data set were saved in my computer C drive and a research flash drive. The hand written coded documents were also saved in the locked cabinet in my house, and I am the only person that has access to the data. The preservation of research data will enable other researchers to have access to the information, upon request, for transference of the research conclusions to future studies.

To ensure dependability and confirmability, my dissertation committee members reviewed the study research methods to ascertain that the research data such as field notes, audio record, data analysis documents, and original transcripts are complete and available. Collected and transcribed data will be saved in paper copies and back-up disks, and secured in locked cabinets for 5 years. I am the only individual that has access to the collected data. In order to ensure anonymity, identifying information was removed before

the data was validated. Transcribed data were provided to the participants that requested to validate the data.

Results

Due to my difficult in recruiting participants that meet the criteria, the actual inclusion criteria of the seven participants in this study was NHAs (a) who were currently administrators of record in five counties in Maryland with 5 years or more experience, and (b) who had turned over at least one time in 5 years. Six out of the seven participants of the study turned over voluntarily, and one participant was transferred by the organization she has worked for 16 years. The NHA that was transferred by the company stated that he/she wanted to turnover at the time he/she was transferred.

There are two primary questions and two secondary questions in this study. The findings of the research provided evidence that the NHA turnover could influence resident QOL, according to the participants. The data collected for the Research Question 1 showed that turnover in the nursing homes could result in turmoil in the nursing home. The uncertainty of the leadership person leads to anxiety and doubt in residents, employees, and family members. The Question 1 data also showed that the influence of leadership turnover could affect continuity of care which influences resident QOL. Due to NHA turnover, the programs that were implemented by the departed NHA could fall apart due to employees' baseless performance or not doing their job. The new NHA could also implement new changes based on his/her leadership vision or style. According to the participants, administrator turnover results in new goals, new expectations, new employees, and new management style.

The data for Research Question 2 showed that all participants agreed that turnover influences resident QOL. The participants differed on their description of how turnover influences resident QOL. Three participants stated that NHA turnover resulted in interim administrators before they arrived at the nursing homes. According to the three participants, the interim administrators were unable to focus on resident needs which affected residents' QOL. Four participants (57%) stated that NHA turnover is not an automatic negative. According to the four participants, the turnover of ineffective and inefficient administrators improves resident QOL.

The regulatory QOL area of focus for this study was addressed in Subquestion 1. The data for Subquestion 1 showed variations in responses received from the participants. Pertaining to residents' physical needs (F-Tag 246), the participants varied in their responses. Four participants responded that NHA turnover influences residents' physical needs, but the influence depends on nursing home's location and stability. Three participants stated that NHA turnover should not influence resident's physical needs because NHAs lead by delegation, abide by code of ethics, and are required to promote residents' QOL. The analysis of the nursing homes deficiencies for the present and previous nursing homes for 2008 to 2013 showed that the NHs were cited for accommodation of needs (F-tag 243) one time in 2013 at the present nursing homes and four times in 2008, 2009 and 2011 at the previous facility.

In reference to residents' right (F-Tag 242), the participants varied in their responses. Five participants responded that NHA turnover influences residents' rights because there is a missing layer of leadership and lack of tracking of quality measures.

One participant responded that he/she did not know, but that NHAs try to accommodate residents' rights. One participant stated that it depended on the NHA leadership style and personality. The analysis of the nursing homes deficiencies for the present and previous nursing homes for 2008 to 2013 showed that the NHs were cited for self-determination and participation (F-tag 242) two times in 2012 and 2013 at the present NHs, and three times in 2010 and 2013 at previous nursing homes.

Pertaining to residents' relationships (F-Tag 243), the participants agreed that NHA turnover influences residents' relationship in several ways. According to the participants, residents develop relationships with NHAs, and the residents are affected when the NHAs leave. The participants also stated that resident and family groups meetings help to keep residents' relationships active, but some NHAs might not focus on the meetings. The analysis of the nursing homes deficiencies for the present and previous nursing homes for 2008 to 2013 showed that the NHs were not cited for participation in residents' and family group (F-tag 243).

In regards to the activities (F-Tag 248), Interview Question 11 for Subquestion 1, the majority of the participant did not connect NHA turnover to residents' meaningful activities. The participants stated that a NHA is indirectly involved in activities, and the involvement is mostly financial. The analysis of the nursing homes deficiencies for the present and previous nursing homes for 2008 to 2013 showed that the NHs were cited for activities (F-tag 248) three times in 2008, 2011 and 2013 at the previous nursing homes and two times in 2009 and 2013 at the present nursing homes (Table 6).

Finally, the data for Subquestion 2 showed no connection of high turnover to low resident QOL, because the interview question focused on if turnover was voluntary or involuntary. When I phrased Subquestion 2 as an interview question in order to solicit more responses for the question, four of the participants stated that high NHA turnover could contribute to resident low QOL due lack of continuity of care and accountability. On the other hand, two participants responded that they were not sure that high NHA turnover could be connected to low resident QOC. One participant did not respond to the question.

The analysis of the OSCAR files for the present and previous nursing homes regulatory deficiency citations showed that there were 10 citations at the present nursing homes. There were 23 citations at the previous facility for 2008 to 2013. 80% of the citations occurred while the administrators were at the present nursing homes, and 57% of the citations occurred while the NHAs were at the previous nursing homes (Table 7 and 8).

OSCAR File

The OSCAR file data from NHAs' present and previous nursing homes was used in this study to relate NHA turnover to QOL regulatory deficiency citations for the selected nursing homes for 2008 to 2013. In 2008, there were no QOL deficiency citations at the present nursing homes; but, one nursing home was cited for dignity, accommodation of needs, notice of room or roommate change, and activities at the previous nursing homes. In 2009, one nursing home was cited for activities at the present nursing homes, and one nursing home was cited for accommodation of needs at the

previous nursing homes. In 2010, one nursing home was cited for dignity at the present nursing homes, while two nursing homes were cited for dignity, one nursing home was cited for self-determination and participation, and one nursing home was cited for notice of room or roommate change at the previous nursing home.

In 2011, one nursing home was cited for dignity at the present nursing homes. Two nursing homes were cited for accommodation of needs, one nursing home was cited for notice of room or roommate change and one nursing home was cited for activities at the previous nursing home in 2011. In 2012, one nursing home was cited for self-determination and participation at the present nursing homes, while three nursing homes were cited for dignity, two nursing homes were cited for self-determination and participation and one nursing home was cited for notice of room or roommate change at the previous nursing homes. In 2013, three nursing homes were cited for dignity, one nursing home was cited for self-determination and participation, one nursing home was cited for accommodation of needs, and one nursing home was cited for activities at the present nursing homes, while two nursing homes were cited for dignity, one nursing home was cited for notice of room or roommate change and one nursing home was cited for activities at the previous nursing homes.

There were more QOL citations in 2013 than any other year covered in this study for the present nursing homes, while there were more QOL citations in 2012 than any other year covered at the previous nursing homes. Four out of seven nursing homes had QOL citations in 2013 while five out of seven nursing homes had QOL citations in 2012. NH0051 had the most citations for the years covered. NH0051 was cited in 2010, 2012

and 2013 at the present nursing homes while NHA0088 had the most citations in the period covered at the previous nursing homes. NHA0088 was cited in 2008, 2010, 2011, 2012 and 2013. For the period of 2008 to 2013, NH0051 had four QOL citations, followed by NH0057 and NH0020, which had two QOL citations respectively. NH0057 was cited in 2011 and 2013 while NH0020 had two QOL citations in 2013 at the present nursing homes.

At the previous nursing homes, NHA0088 had nine deficiencies, followed by NHA0057, who was cited in 2010, 2011 and 2012 with five deficiencies. NHA0050 was cited in 2010, 2012 and 2013 with four citations while NHA0077 was cited in 2009, 2012 and 2013 with three deficiencies at the previous nursing homes. NHA0004 had one citation in 2011 while NHA0020 had one citation in 2012 at the previous nursing homes. NHA0051 had no citation at the previous nursing home.

Three of the participants were the administrator of record during the citations at the present nursing homes, while four of the participants were the administrators of the previous nursing homes at the time of citations. Two of the participants were not the administrator of record during the citations at the present and previous nursing homes. Two of the participants did not have any QOL citation for 2008 to 2013, although they had been at their nursing homes for 4.75 years and 2 years respectively at the present nursing homes, while one participant did not have any citation at previous nursing home and the nursing home did not have any citation after the NHA departed.

Table 4

Present NH Quality of Life Deficiencies for 2008 to 2013

Year	F-Tag	Quality of Life Deficiency Cited	Facility Name
2008	None	None	None
2009	248	Activities	NH0077
2010	241	Dignity	NH0051
2011	241	Dignity	NH0057
2012	242	Self Determination and Participation	NH0051
2013	241	Dignity	NH0020 NH0051 NH0057
	242	Self Determination and Participation	NH0004
		Accommodation of Needs	
	246		NH0020
		Activities	
	248		NH0051

Table 5

Previous NH Quality of Life Deficiencies for 2008 to 2013

Year	F-Tag	Quality of Life Deficiency Cited	NHA Name
2008	241	Dignity	NHA0088A
	246	Accommodation of Needs	NHA0088A
	247	Notice of Room or Roommate Change	NHA0088A
	248	Activities	NHA0088A
2009	246	Accommodation of Needs	NHA0077A
2010	241	Dignity	NHA0088A NHA0050A
	242	Self-determination and participation	NHA0057A
	247	Notice of room or Roommate Change	NHA0057A
2011	246	Accommodation of Needs	NHA0004A NHA0057A
	247	Notice of Room or Roommate Change	NHA0057A
	248	Activities	NHA0088A
2012	241	Dignity	NHA0020A NHA0088A NHA0057A
	242	Self Determination and Participation	NHA0050A NHA0077A
	247	Notice of Room or Roommate Change	NHA0088A
2013	241	Dignity	NHA0050A NHA0077A
	247	Notice of Room or Roommate Change	NHA0088A
	248	Activities	NHA0050A

Table 6

Quality of Life Area of Research Focus

Deficiency	F-tag	Present NH	Previous NH
Self-Determination and Participation	242	2	3
Participation in residents' and Family Group	243	0	0
Accommodation of Needs	246	1	4
Activities	248	2	3

Table 7

Present NH QOL Deficiency Distribution

Name	Employed	2008	2009	2010	2011	2012	2013
NHA0004	2013	None	None	None	None	None	NH (242)
NHA0020	2012	None	None	None	None	None	NHA (241, 246)
NHA0050	2009	None	None	None	None	None	None
NHA0051	2009	None	None	NHA (241)	None	NHA (242)	NHA (241, 248)
NHA0057	2009	None	None	None	NHA (241)	None	NHA (241)
NHA0077	2014	None	NH (248)	None	None	None	None
NHA0088	2012	None	None	None	None	None	None

Table 8

Previous NH QOL Deficiency Distribution

Name	Departed	2008	2009	2010	2011	2012	2013
NHA0004	2013	None	None	None	NHA (246)	None	None
NHA0020	2012	None	None	None	None	NHA (241)	None
NHA0050	2009	None	None	NH (241)	None	NH (242)	NH (241, 248)
NHA0051	2009	None	None	None	None	None	None
NHA0057	2009	None	None	NH (242, 247)	NH (246. 247)	NH (241)	None
NHA0077	2014	None	NHA (246)	None	None	NHA (242)	NHA (241)
NHA0088	2012	NHA (241, 246, 247, 248)	None	NHA (241)	NHA (248)	NHA (241, 247)	NH (247)

Plan of Correction

The plan of correction was needed for this study to verify the NHA of record for 2008 to 2013. Most of the participants did not provide or have the plan of correction for the requested years. One participant provided the plan of correction for the requested period without any signature. One participant provided plan of correction for 2009 to 2012, and there were two NHAs of record for the period according to the signatures in the plan of correction. One participant was the third administrator in the facility between

2010 and 2013, according to the signatures on the plan of correction. The researcher was unable to obtain the plan of correction from the previous nursing homes since the participants did not work at the nursing homes anymore.

Observation

All the nursing homes were clean and well kept. Residents had freedom of movement without clutter. The participants suggested that a clean and clutter free facility demonstrates good QOL for nursing home residents. The residents were familiar with the NHAs and interacted with NHAs as we passed the residents. The participants also stated that the administrator's presence in the nursing home was a sign of good QOL for residents. No odor was noted at any of the facilities, which was stated as a sign of good QOL by the participants. The interruptions that occurred during the interviews illustrated how busy the NHAs were in their nursing homes since most of the participants stated that stress is a factor in NHA turnover.

Summary

The NHA turnover could influence nursing home resident QOL. The literature review in Chapter 2 showed that NHA turnover has been an issue in the long-term care industry and that the turnover has regulatory, service, and financial implications on the nursing homes. Chapter 3 presented the qualitative case study that enabled me to collect and analyze the research data.

I attempted to address the gap for limited existent literature relative to the influence of the turnover of NHAs on nursing home residents' QOL, from administrator points of view. Chapter 4 also provided an in-depth description of the pilot study that was

used to ensure that the interview instrument was appropriate for data collection. The difficulties and challenges that the researcher encountered during the recruitment process was presented in this chapter. Participants' demographics provided a detailed description of the seven participants for the study. The data collection section of this chapter showed how the interview data were collected, how the plan of correction and OSCAR file were retrieved, and how the observations were conducted. The organizations and storage of the data were also presented under data collection. Under the data analysis section of Chapter 4, the data coding, NVivo software use, verification of data, themes identification and discrepant cases were presented. The evidence of trustworthiness section in this chapter addressed the study credibility, transferability, dependability, and confirmability issues about the study. Finally, the results section in this chapter presented the research findings relative to the research questions and subquestions. Chapter 5 is an interpretation of the results.

Chapter 5: Interpretation and Recommendations

Introduction

Researchers have quantitatively documented evidence of the effects of NHA turnover on resident QOC (Castle &Lin, 2010; Thomas et al., 2012). Scholars have also conducted several studies on QOL related to disease conditions (Abrahamson et al., 2012; Willemse et al. 2011). But there is a limited qualitative evidence on the influence of NHA turnover on resident QOL. Several scholars suggested that the QOL issues should be addressed during regulatory survey visits, healthcare organizations should include older adult QOL preservation and enhancement as one of its goals, and organizational outcome should be based on the achievement of QOL by residents and not on the clinical QOC provided to residents (Castle et al., 2009; Netuveli et al., 2008; Sloane et al., 2005). This is why a qualitative case study that addressed NHA turnover influence on resident QOL is important.

The research design chosen for the study was a case study. Case study design enables a researcher to conduct an in-depth study of a single phenomenon at a given time with the use of multiple sources (Babbie, 2008; Creswell, 2007; Yin, 2009). In this study, NHAs were asked to describe their turnover experiences and their understanding of the turnover influence on residents' QOL. Plan of correction and OSCAR files from 2008 to 2013 were used to identify the QOL citations of each nursing home in the study, and the NHA of record at the time of the regulatory visits. If the NHAs know the detrimental effect of their departure on the resident QOL, the administrators may stay in the nursing homes for long duration. Homogeneous sampling enabled me to gain an in-depth

understanding and description of how NHA turnover influences residents' QOL relative to residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities.

A researcher is expected to know what his/her unit of analysis is. According to Babbie (2008), "you must decide whether you're studying marriages or marriage partners, crimes or criminals, corporations or corporate executives" (p. 109). For this research, the unit of analysis is the experiences of NHAs. Seven NHAs were studied which resulted in data saturation. I did not endeavor to prove or disprove any hypothesis. Rather, I sought to understand how NHAs connect their departure with resident QOL. I hoped to address the literature gap regarding the influence of NHA turnover on resident QOL.

I recognized that this study was limited by the size of the study. The sample of this study is too small to represent NHAs throughout the USA, although the sample size is within the standard stated for a holistic case study (Lin, 2009). Researchers should also avoid bias in studies (Yin, 2009). As suggested by Yin (2009), I am a registered nurse and a licensed NHA in the District of Columbia and Maryland. I did not know any of the participants until the time of participation. I have not worked as an administrator of record in any nursing home and have not worked as a registered nurse in Maryland since 1998.

Finally, one of the limitations experienced by me during the recruitment was participant criteria. I was unable to find NHAs, who have turned over at least two times in 5 years. I was only able to find two NHAs, who have turned over one time in 5 years,

and one NHA, who has not turned over in X County during participant recruitment. This is the reason I started the recruitment in five counties in Maryland.

The homogenous sampling technique was used to recruit the participants that met the adjusted critical research standard. The seven participants in this study were NHAs (a) who were currently administrators of record in five counties in Maryland with 5 years or more experience, and (b) who had turned over at least one time in 5 years. The research questions and subquestions focused on the turnover experience of the participants as they described what the NHAs accounts are in regard to their turnover impact on residents, how NHA turnover influences resident QOL, what way the turnover of NHAs influences residents' physical needs, residents' rights, residents' relationships, and residents' meaningful activities, and what the connection is between a high turnover among administrators and a low QOL for residents. The findings from the interview data showed that NHA turnover influences resident QOL. Four participants believed that turnover influence on resident QOL could be positive or negative.

Interpretation of Findings

The objective of this case study was to explore how NHAs connect their departure with resident QOL. By revealing the description of NHAs of how their turnover influences resident QOL, I attempted to address the gap of knowledge. All the participants in this study agreed that NHA turnover influences the resident QOL.

According to the participants, the degree of the positive or negative influence depends on several factors such as the leadership style, resident mental status, building condition, and facility regulatory status. The findings also showed that NHA turnover

influences resident QOL by creating absent leadership presence, facility-wide connection break, and facility transformation phase. There is also an aura of uncertainty in the nursing homes when there is leadership turnover, and these areas should also be considered when interpreting the findings of this research. Comments were made on the stated issues by all the participants. The participants stated that facility-wide connection break, absent leadership presence, and transformational phase were the three issues that impact nursing home resident QOL when a NHA turns over.

Absent Leadership Presence

Research Question 2 asked participants how NHA turnover influences resident QOL. The turnover of NHA leads to no leadership presence in the facility according to the participants. Three participants stated that before they arrived at their nursing homes, there were interim administrators in the nursing homes. One participant stated that before she arrived at the facility, there was a 6 months period when the Executive Director off the CCRC was the interim administrator, and “nobody was directing the operations.” Another participant stated that a new administrator has to figure out what to do with the residents, staff, and family members. The lack of leadership presence often leads to no operational guidance or global focus, lack of focus on resident’s needs, lack of choices for residents, lack of connection with residents, no response to resident’s needs, no focus on staff performance and no visible NHA presence in the nursing home.

Facility-Wide Connection Break

Research Subquestion 1 asked the participants the ways NHA turnover influences residents' physical needs, resident's rights, residents' relationships, and residents' meaningful activities. The participants agreed that the way that NHA turnover influences residents' physical needs, residents' rights, residents' relationship, and residents' meaningful activities is by creating no advocate and no continuity of care for residents' needs, choices, rights, supplies and equipment. One participant stated that the administrator is responsible for approving orders for supplies, and addresses issues such as a resident need for wheelchair while another participant commented that administrators hold staff accountable.

Licensed NHAs are considered residents' advocate by the regulators. One participant stated "people have the right to make choices. If there is no one there keeping track of what is going on or are people being offered choices?" and that "your job as the residents' advocate is to make sure that they have the opportunity to have their needs accommodated. And that people are asking them what are their needs." The absence of an administrator creates a void in resident advocacy. Another participant stated "each administrator has a code of ethics" to ensure that residents needs are met by employees. When there is no resident advocate in a nursing home, there might not be choices offered to residents, no assurance of residents' rights, no visible leader, no decision maker, no one for residents to talk to and bond with, and there is a need for residents to develop and establish relationships.

When NHA terminates his/her employment with a nursing home, there is a connection break with the residents, family members and staff. The participants stated that NHAs build relationships with residents, family members and employees, which makes all parties comfortable, and when the relationship is severed, everyone affected is unsure about the environment. One participant commented on resident-administrator relationship after turnover as “they have to start over and develop relationships with the new NHA. The new NHA would learn what they want and who they are” and it takes time. The connection break leads to doubt, unsure of relationships, missing emotional and physical connection, lack of trust, loss of sense of comfort and security, no one to talk to and bond with, and no caring and responsive relationship.

Facility Transformational Phase

NHA turnover creates an environment of change and uncertainty that could adversely influence resident QOL. The employees might not focus on providing quality care to the residents due to nervousness and anxiety. The program changes could also impact the continuity of services provided to the residents. One participant stated that NHA turnover often leads to baseless or poor performance by employees. There was no connection between high NHA turnover and low resident QOL based on analysis of 2008 to 2013 NHs OSCAR files.

Theoretical Consideration

The theoretical proposition for this study was based on Donabedian’s (1988) health services quality model. This model stated that the QOC could be classified into three categories: structure, process, and outcome. Structure means what the organization

does, which is the settings of care which includes material resources, human resources, and organizational structure (p. 1745). Process means how the organization accomplishes its obligations, which are the activities, performed when care is provided and received. Outcome means what is achieved in the end, which are the results of the care provided. According to Donabedian, for QOC to be addressed, there must be an established system to connect structure to the process, and process should be linked to the expected outcome (p. 1745). The focus of this study is on how NHA turnover (structure) influences the services provided by nursing home employees (process) resulting in residents' QOL (outcome).

I showed that NHA turnover creates an absent leadership presence and facility-wide connection break (structure) which leads to an uncertain environment and break in continuity of care (process) resulting in low resident QOL (outcome). Results showed that administrator turnover leads to connection break between residents and administrators which affect residents' relationships. The significance of this research can serve as groundwork for more qualitative studies on resident QOL regulatory issues using Donabedian's model.

Limitations of the Study

There are some factors that limit the generalizability of the findings of this study, and they are associated with the methodology used in the research. The sample size used in the study, is small and the seven participants were purposefully selected. The instrument used for the study was created by me, so may be open to researcher bias. The researcher's bias exists in the study despite his/her effort to eliminate personal bias.

Researcher's bias could be reduced if the researcher is unaware of the study's expected outcome (Pannucci & Wilkins, 2010). My choice of 2008 to 2013 or 6 years was arbitrary, and so researchers who analyzed with other time frames may be valuable. The study only addressed specific resident QOL regulatory areas. Finally, I was unable to relate QOL citations to administrators of record, due to incomplete plan of correction provided to the researcher by the participants.

Recommendations

There is growth in scholarly studies relative to resident QOL associated with disease conditions and NHA turnover. Some recommendations were relative to nursing home resident QOL. These recommendations are based on the suggestions that QOL issues should be addressed during regulatory survey visits, healthcare organizations should include older adult QOL preservation and enhancement as one of its goals, and organizational outcome should be based on the achievement of QOL by residents and not on the clinical QOC provided to residents (Castle et al., 2009; Netuveli et al., 2008; Sloane et al., 2005). In order to achieve and improve resident QOL, there has to be a consistent leadership figure. Therefore, one recommendation is that nursing home owners should design systems that would enable them to recruit and retain effective NHAs. With appropriate recruitment and retention of NHAs, nursing homes would attain and maintain high QOL for residents.

Another recommendation is that NHAs should attempt to stay at each nursing home for a reasonable duration of service. The study findings showed that NHA turnover creates an adjustment time for everyone associated with the nursing home. Starting over

is stressful for everyone involved, especially in nursing homes where regulators often come for regulatory survey of each new administrator. Nursing homes with low turnover provide high quality of services which improves the QOC, and also reduces the cost of recruitment and training (Donoghue, 2010).

The literature I reviewed for this study revealed that NHA turnover has been a problem for decades. Scholars have discussed the impact of turnover on the QOC, leadership style and turnover, turnover and education, and factors that cause turnover (Castle et al., 2009; Decker et al., 2009; Donoghue et al., 2009; Kash et al., 2010). Studies have also been conducted on the QOL relative to disease conditions. There was a lack of literature that associated turnover with QOL. Further studies might be conducted to explore how residents connect NHA turnover to their QOL. There should be an effort to understand residents' perception of leadership turnover on them.

Implications for Social Change

Examining NHA turnover relative to resident QOL is crucial and could result in policy debate over resident QOL issues. The findings of this study have significant implications to the topic, providers and NHAs (practice in the field), policy makers (to define policy), nursing home consumers (implication for positive social change), and research. Relative to the topic, researchers have documented evidences of the effects of NHA turnover on resident QOC (Castle &Lin, 2010; Hunt et al., 2012; Thomas et al., 2012). Scholars have also conducted several studies on QOL related disease conditions (Abrahamson et al., 2012; Willemse et al. 2011). But, there is nonexistence of or limited qualitative evidence on the influence of NHA turnover on resident QOL. Therefore, I

explored the influence of NHA on resident QOL. This qualitative case study gave voice to the NHAs who have been ignored in resident QOL studies. Nursing home stakeholders could benefit from hearing the voices of these individuals as they connect their turnover to resident QOL.

The participants of this study shared that in their experiences, NHA turnover created an absent leadership presence, facility-wide connection break, and facility transformation phase, which could adversely influence resident QOL. This research included a voice that is lacking in the area of study, and the voice could offer insight into how nursing home stakeholders could address the issues.

Relative to providers and NHAs, this research adds to possible improvement in the hiring and retention of effective NHAs by owners of nursing homes. The research could also encourage NHAs to stay in their jobs for long duration. The findings of this research show that the turnover of NHAs creates conditions that could negatively affect resident QOL. Although several factors lead to low resident QOL, the ongoing tenure of NHAs is important in improving resident QOL. Therefore, the results of this research are critical to NHAs and owners of nursing homes.

In regards to policy makers, this study could provide data that illuminates resident QOL issues to policy makers. Federal and states regulations require nursing home owners to recruit licensed NHAs to manage their nursing homes, and also preserve and sustain residents' QOL in order to comply with Medicare and Medicaid payment for service requirements. Siegel et al. (2012) stated that since a significant amount of federal and state funds pay for the care provided to nursing home residents, there is a need to ensure

that services rendered are cost-effective and beneficial to the residents (p. 222). The retention of NHAs could improve the services that nursing home residents receive leading to high QOL. Policy makers could use the findings from this study to assist with decisions about policies, statutes and regulations to improve resident QOL in nursing homes.

Relative to positive social change, the results of the research will affect positive social change by providing data to help improve the quality of residents' life in nursing homes. This study is relevant and timely because of scholar and policy interest in resident QOL issues. Several scholars suggested that the QOL issues should be addressed during regulatory survey visits, healthcare organizations should include older adult QOL preservation and enhancement as one of its goals, and organizational outcome should be based on the achievement of QOL by residents and not on the clinical QOC provided to residents (Castle et al., 2009; Netuveli et al., 2008; Sloane et al., 2005). The significance of this study can serve as groundwork for more exhaustively controlled studies on resident QOL issues.

Researcher Reflections

I started my healthcare career 31 years ago as a registered nurse in my country of birth. I have been a registered nurse in the US for 25 years. I worked in acute care until 1992 when I started working fulltime in nursing homes. I held several leadership positions in nursing homes. I because a licensed NHA in 1998, at the urging of an administrator that I worked for as an Assistant Director of Nursing in 1994. It took 4

years for me to make up my mind about becoming an administrator. I am glad that I became an administrator of nursing homes.

I trained as an Administrator-in-training (AIT) in Maryland for 12 months. I trained with a preceptor unpaid 40 hours a week for 12 months, which enabled me to learn all aspects of nursing homes regulations. It was a tough training which indirectly prepared me for my doctoral studies. I took the licensing examination nine months into my training, and I passed the examination at the first time that I took it. I was still required to complete my remaining months of training before I was licensed as an administrator. Due to personal reasons, I have not used the license to practice.

I worked at two facilities as Director of Continuous Quality Improvement. I enjoyed the policy aspect of the job. Since I have been working in nursing homes, I noticed frequent turnover of administrators. I wondered what the reason for the turnover was. When I started my doctoral degree, I knew that my research topic would have to do with NHA turnover. I had wanted to find the causes of NHA turnover, but due to saturation of research on that area, my chair suggested that I should address turnover from the QOL angle. The suggestion was a great idea because it enabled me to learn and understand the regulatory aspect of resident QOL. The study findings also enabled me to understand how resident QOL could easily be affected by change. Because of my acquired knowledge in this area, my goal in life is to improve the QOL of older adults every chance I get.

The doctoral study was an arduous trip filled with hills and valleys. The data collection period was the hardest time, because of the difficulties that I had with

participant's recruitment. Most prospective participants did not respond to the letters at all. I wasted a lot of money on stamps and envelopes. I drove in the snow on the interstate highways to conduct interviews far from my house. I hate driving in the interstate highways. My father died a week before my proposal defense. He had been a steadfast supporter of my educational pursuit from birth. He always trusted and believed in my capabilities. He made me believe that the sky is my limit. His love guided me during this horrible time of my life after his death. I wish he were still alive today, but God knows better than a man. I almost dropped out of the program forever during the data collection phase. Thanks to my loving family and world-class beloved friends that cheered me on. I am glad that I am closer to the end than the beginning. I am very proud to have completed what I started.

Nursing home resident QOL was the focus of my dissertation study for almost 3 years after I completed my course work and residencies. Recruiting participants, collecting data, analyzing data, and interpreting data was a dream come through for me. I hope to make positive social change on older adults lives someday and always in my life.

Conclusion

Chapter 5 started with the summary of the key study findings, the purpose and nature of the study, and why the study was conducted. The interpretation of the findings was also presented in this chapter. Chapter 5 also contains the analysis and interpretation of the study results relative to the context of the conceptual framework. The study limitations to trustworthiness were also presented in Chapter 5. This chapter presented

the study recommendations and Implications for social change. Finally, my reflection was presented, where I reflected on my life's journey that led me to where I am today.

The participants in the study agreed that NHA turnover influences resident QOL. The results of the study showed that NHA turnover led to no leadership presence for residents and connection break for residents. The study findings also showed that NHA turnover led to a transformational phase which influenced resident QOC. There was no connection between NHA turnover and low resident QOL. None of the NHs was cited for participation in residents' and family groups (F-tag 243) for 2008 to 2013. The study findings could be applied to literature, practice, policy, leadership and social change.

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Appendix A: Dissertation Research Interview Questionnaire

Dissertation Research Interview Questionnaire

The Influence of Nursing Home Administrator (NHA) Turnover on Resident Quality of Life

Date:

Interviewer's Name: Juliet I. Madubata, Doctoral Student, Walden University

Location of Interview:

Interviewee's Name:

Age:

Sex:

Location of employment:

Bed Capacity:

Non-profit, profit or governmental facility:

Number of Years as a NHA:

Duration of service at the facility:

Introductory Protocol:

- My research study is to explore how the turnover of nursing home administrators influences residents' quality of life, from administrators' point of view.
- This project would focus on the meaning of nursing home administrators' turnover relative to residents' quality of life.
- The study would also explore how the turnover of NHAs influences the services provided to residents of nursing home.

You have been selected to participate in the research study because I would like to know what turnover means to you as a NHA with regard to residents' quality of life. The length of the interview would be sixty to ninety minutes, and there are twenty-one questions that we would cover during that time. To assist with note-taking, I would like to audio tape our conversation. I have your signed consent form. Is it still alright to audio tape the interview? My Professors and I would be the only individuals that would have access to the audio tapes and the field notes. The tapes would be destroyed after transcription. Your participation is voluntary, and you could stop the interview at any time for any reason.

Questions:

1. How long have you been a LNHA?
2. How many facilities have you worked as a LNHA?
3. How long have you been at this facility?
4. Have you changed facilities in the last five years?
   a. If yes, how many times did you change jobs in five years?
   b Why did you change facilities?
   c. If no, why did you not change job?
5. Tell me what happens in the facilities after an administrator leaves:
6. Do you think that administrators' turnover influences residents' quality of life?
7. How does administrators' turnover influence residents' quality of life?
8. How does administrators' turnover affect residents' physical needs (accommodation of needs)?

9. How does administrators' turnover affect residents' rights (self-determination and participation)?

10. How does administrators' turnover affect residents' relationships (resident and family groups)?

11. How does administrators' turnover affect residents' meaningful activities (Activities)?

12. How does administrators' turnover affect residents' family relationships?

13. Does administrators' turnover influence nursing home employees?

   a. If yes, why and how?

   b. If no, why not?

14. What groups of employees are mostly affected by turnover of administrators?

15. What are the reasons for frequent turnover in nursing homes?

16. Do you think that administrators turnover voluntarily or involuntarily?

Please explain your response:

17. How did you cope with your turnover?

18. What do you think are the effects of frequent LNHAs turnover on the nursing homes' outcomes?

19. Do you think that the nursing home administrators' turnover is a problem in the industry?

   a. If yes, why?

   b. If no, why not?

20. What do you think should be done to prevent frequent voluntary LNHAs'

turnover?

21. How could frequent involuntary LNHAs' turnover be prevented?

Post Interview Comments or Leads:

Thank you for participating in the interview. Your confidentiality would be maintained. I might contact you for clarification of some information during the transcription in the future. The draft of the interview would be provided to you for review.

Appendix B: Dissertation Study Cover Letter

July 25, 2014

Juliet I. Madubata, Doctoral Student

Xxxx xxxxx Street

Xxxxx, MD 20xxx

Dear Sir/Madame,

My name is Juliet I. Madubata. I am a doctoral student at Walden University. My proposed research study will explore how nursing home administrator turnover influences resident quality of life. Enclosed is a consent form for the study, “The Influence of Nursing Home Administrator Turnover on Resident Quality of Life”. I have also enclosed a copy of the Walden University Institutional Review Board’s approval, dated November 15, 2013.

I propose to conduct a study of nursing home administrators in Maryland. While the study will provide me with data regarding administrator turnover and resident quality of life for my dissertation, the study will also offer meaningful information to nursing home stakeholders.

I will appreciate your informed review and consent to the enclosed information. You could contact me at 301-219-0330 or at Juliet.madubata@waldenu.edu with any questions. I look forward to your comments and consent.

Sincerely,

Juliet I Madubata, Doctoral Student

Appendix C: Dissertation Study Consent Form

Dissertation Study Consent Form

You are invited to take part in a research study on the influence of nursing home administrator turnover on resident quality of life. The researcher is inviting nursing home administrators employed in the Prince George's County, Maryland to be in the study. The inclusion criteria of the participants will be nursing home administrators (a) who are currently administrators of record in the Prince George's County with 5 years or more experience, and (b) who have turned over at least two times in 5 years. There will be ongoing member check to guarantee that data collected and interpreted is without error. Information on the Plan of Correction will be included in data collection. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Juliet I. Madubata who is a doctoral student at Walden University. You may already know the researcher as a Registered Nurse and/or a Licensed Nursing Home Administrator, but this study is separate from that role.

Background information:

The purpose of this study is to explore how nursing home administrators connect their departure with resident quality of life.

Procedures:

- The length of the interview would be sixty to ninety minutes, and there are
- twenty-one questions that we would cover during that time.
- To assist with note-taking, I would like to audio tape our conversation.
- My Professors and I would be the only individuals that would have access to the audio tapes and the field notes.
- The tapes would be destroyed after transcription.
- Your participation is voluntary, and you could stop the interview at any time for any reason.
- There will be ongoing member check to guarantee that data collected and interpreted is without error.
- Information the Plan of Correction will be included in data collection.

Voluntary Nature of the Study:

This study is voluntary. The researcher will respect your decision of whether or not you choose to be in the study. The researcher will not treat you differently if you decide not to be in the study. If you decide to join the study, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of minor discomforts that can be encountered in daily life, such as stress or becoming upset. Being in this study would not pose a risk to your safety.

The proposed study will effect positive social change by providing data to enable lawmakers to implement nursing home initiatives which will address the retention of nursing home administrtors, and to generate continuous quality improvement measures to ensure that residents achieve and preserve high quality of life.

Payment:

There is none.

Privacy:

Any information that you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be saved in paper copies and pack-up disks, and secured in locked cabinets. Data will be kept for a period of at least five years or as required by the university.

Contacts and Questions:

You may ask any questions you have now. If you have questions later, you may contact the researcher via [redacted] and/or Juliet.madubata@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden university representative who can discuss this with you. Her phone number is at 1-800-925-3368, extension 3121210. Walden University's number for this study is

11-15-13-0200184, and it expires on November 14, 2014.

The researcher will give you a copy of this form to keep, or, please print or save this consent form for your records.

Statement of Consent:

I have read the above information, and I feel I understand the study well enough to make a decision about my involvement. By signing below or replying to this email with the words “I consent”, I understand that I am agreeing to the terms described above.

Participant’s Name:

Date of consent:

Participant’s Signature:

Researcher’s Signature: Juliet I. Madubata

Appendix D: Pilot Study Cover Letter

Juliet I. Madubata, Doctoral Student

Dear,

My name is Juliet I. Madubata. I am a doctoral student at Walden University. You are invited to take part in a pilot study on the influence of nursing home administrator turnover on resident quality of life as an Expert Reviewer. You are not a participant of the study and your suggestions will enable me to produce appropriate interview questions for the research questionnaire. I will contact you upon receipt of your acceptance via email to schedule a time to e-mail the sample questions for your review, response, and suggestions.

While the study will provide me with data regarding administrator turnover and resident quality of life for my dissertation, the study will also offer meaningful information to nursing home stakeholders. Participation in the pilot study is voluntary and confidential. The expert reviewer could withdraw his/her consent at any time for any reason.

I will appreciate your informed review and consent to the enclosed information. You could contact me at [redacted] or Juliet.madubata@waldenu.edu with any questions. I look forward to your comments and consent.

Sincerely,

Juliet I. Madubata, Doctoral Student

Appendix E: Observation Data Collection Form

Date of Observation:
Time of Observation:
Location of Observation:
Participant Name:
Observer Name:

Observation Criteria:	Field Notes	Researcher Reflections
Unusual Occurrence:		
Physical Settings:		
Participants:		
Activities and Interactions:		
Conversations:		
Nonverbal Factors:		
Researcher Behavior:		

Comments:

Curriculum Vitae

Juliet I. Madubata

EMPLOYMENT OBJECTIVE:
To obtain a leadership position in Healthcare

Goal: To be a leader of positive organizational change through departmental teamwork, collaboration and cooperation, and continuous proactive evaluation of performance improvement initiatives to enhance the quality of outcomes.

Skills Summary:

- Proven ability to evaluate and interpret regulatory and organizational policies, and develop and provide recommendations relative to practice outcomes.
- Demonstrated strong reading, listening, writing, analytical, organizational, communication, and decision-making skills.
- Positive social change/outcomes focused, proactively address issues through strategic planning.
- Managed personnel and resources to ensure quality care/service is practiced.
- Advocate for expert consultation as needed to ensure quality organizational outcome and prevent liability.
- Learned the ability to design, complete, and publish research materials.
- Proven ability to collaborate, cooperate and coordinate with other disciplines in practice opportunities.
- Comfortable working in a team based environment.
- Developed and implemented policies and procedures.
- Demonstrated ability to work independently and collaboratively on several organizational projects.
- Established and maintained respectable working relationships with a diverse population of multidisciplinary faculty, students and staff.
- Strong commitment to quality teaching, practice and research.
- Promoted student success, quality assurance and effective teaching.
- Participated in the ongoing curriculum development and assessment.
- Maintained up-to-date student and program records.
- Provided high quality instruction and supervision of students in the classroom, laboratory and clinical settings.

- Proven ability to liaison between employer and regulators and/or other agencies.
- Demonstrated ability to apply critical thinking and sound judgment to address emergent situations.
- Completed and submitted required documents such as MOUs as required.

EDUCATION:

Walden University
Degree: Ph.D Candidate
Public Policy and Administration
December 2009 – December 2014
GPA: 4.00

Chamberlain College of Nursing
Degree: Bachelor of Science in Nursing
GPA: 3.90
Award: President's Honor

University of District of Columbia
Degree: Master of Business Administration

Southern University in New Orleans
Degree: Bachelor of Science in Accounting.
Honors: Honor Roll Fall 1983 to Spring 1986.
Dean's List Spring 1984.
Award: Cum Laude

School of Nursing
Queen Elizabeth Specialist Hospital
Umuahia Imo State, Nigeria
Degree: Diploma in Nursing

EMPLOYMENT EXPERIENCE:

April 2006 to January 2014
University of the District of Columbia Community College
Nursing Certificate Program

May 2010 to May 2011
Title: Interim Clinical Coordinator
Duties: Contacted new healthcare organizations and established clinical affiliation between the program and the new clinical sites. Assured that ongoing relationships with

the current clinical affiliates were maintained. Developed new memorandum of understanding (MOU) and updated expired MOU for all clinical affiliates. Guaranteed that all clinical schedules were delivered to appropriate clinical sites as requested. Recruited experienced clinical instructors for employment. Addressed faculty and student clinical issues. Maintained inventory of clinical supplies. Assigned clinical instructors to clinical sites. Reviewed students' files for regulatory and clinical compliance. Compiled clinical rotation rosters. Inquired of clinical opportunities for students. Maintained clinical records of students. Oriented new clinical faculty to the Nursing Certificate clinical requirements and to the clinical sites.

Title: Nurse Educator
Duties: Taught didactic, laboratory skills and practicum to practical nursing students in Fundamentals of Nursing, and Gerontological Nursing. Taught laboratory and clinical skills to practical nursing students in Mental Health Nursing and Adult Health Nursing when assigned. Taught nursing assistant and home health aide students didactic, laboratory skills and practicum. Membership in the Curriculum Committee and the Admission, Progression and Graduation Committee. Address students concerns and refer students' issues to the appropriate channel. Participated in staff development activities.

2003 – March 2006
Radiance College, Washington DC

Title: Clinical Instructor
Duties: Taught laboratory skills and practicum to practical nursing students in Fundamentals of Nursing, Mental and Community Health Nursing, Gerontological Nursing, and Medical/Surgical Nursing to Practical Nursing students. Addressed students' issued. Participated in staff development programs. Participated in graduation activities.

1998-2003
VMT Education Center, Washington DC

2002- 2003
Title: Admission Manager
Duties: Administered and mailed pre-entrance examination for prospective students. Analyzed pre-entrance examination results to enable selection of appropriate students for the available classes. Interviewed, recruited, selected and admitted students based on regulatory and the school's admission requirement. Oriented new students to the school and student's handbook. Provided admission forms to prospective students and collected required documents for admission from admitted students. Maintained up to date and accurate students' records. Prepared and mailed admission letters to selected students. Participated in staff development programs. Participated in graduation activities.

Title: Instructor
Duties: Taught didactic, laboratory skills and practicum to practical nursing students in Maternal and Child Health Nursing, Mental Health Nursing, Gerontological Nursing, Community health Nursing, Fundamentals of Nursing, and Medical/Surgical Nursing. Taught didactic and skills for Cardiopulmonary Resuscitation classes.

Aug. 2000-Aug. 2002
Rock Creek Manor Nursing Center, Washington, DC

Title: Director of Quality Assurance.
Duties: Responsible for reviewing all admission referrals for acceptance or rejection. Organized and directed Mock Survey for the organization. Assisted department directors with the plan of correction for survey deficiencies. Retrieved monthly quality indicators for the facility from the Internet to enable the facility to identify problem quality of care areas and to address the issues accordingly. Performed on site Continuous quality assessment and improvement inspections for the facility to identify situations that may deviate from established standards and / or regulatory compliance. Designed, implemented and modified as necessary, CQA & I program, Systems, policies and procedures in conjunction with the facility's CQA & I committee. Continuously evaluated the quality of care/services provided. Acted as liaison in the coordination of CQA& I activities among the committees and departments. Prepared annual CQA&I Calendar. Developed and maintained plan of action in response to identified problems and opportunities to improve care. Maintained CQA&I data in an organized manner. Worked closely with the staff educator to identify staff development needs and plan how to address the needs. Made recommendations to the Administrator relative to programs, activities, and care/service delivery issues that could improve the quality of services and/or assure the maintenance of regulatory compliance. Educated staff about the facility's quality indicators as they related to the nation and provided the strategies to stay within the normal level.

Apr. 1999 to Aug. 2000
Medlink Hospital and Nursing center, Washington DC

Title: Director of Continuous Quality Improvement & Infection Control.
Duties: Ensured that the facility is maintained in a sanitary environment. Reviewed isolation techniques and procedures to ensure that all personnel, resident, and visitors are following established procedures/precautions. Made changes in isolation procedures when necessary. Notified appropriate regulatory agencies of contagious or infectious diseases. Monitored all findings from any resident care quality assessment activities that related to infection control. Educated staff about the facility's quality indicators as they related to the nation and showed the ways to stay within the normal level. Organized and directed Mock Survey for the organization. Assisted the department directors with the plan of correction for the survey deficiencies. Retrieved monthly quality indicators report

for the facility from the Internet, which enabled the facility to identify problem quality of care areas and to address them proactively. Performed on site Continuous quality assessment and improvement inspections for the facility to identify situations that may deviate from established standards and/or regulatory compliance. Designed, implemented, and modified as necessary, CQA&I program, Systems, policies and procedures in conjunction with the facility's CQA & I committee. Continuously evaluated the quality of care/services provided. Acted as liaison in the coordination of CQA&I activities among the committees and departments. Prepared annual and monthly CQA&I Calendar. Developed and maintained plan of action in response to identified problems and opportunities to improve care. Maintained CQA&I statistical data in an organized, user-friendly, and accessible manner. Collaborated with the staff educator to identify staff development needs. Made recommendations to the Administrator relative to programs, activities, and care/service delivery issues that could improve the quality of services and/or assure the maintenance of regulatory compliance.

1998- 1999
Adventist HealthCare, Fairland Nursing and Rehab. Center

Title: Director of Nursing.
Duties: Responsible for the 24 hour nursing care of the eighty-two bed facility. Managed the overall operation of the nursing department in accordance with the company's policies, standards of nursing practices and governmental regulations. Evaluated nursing department needs and addressed issues accordingly. Recruited new employees as needed and dismissed poor incorrigible care givers. Conducted performance appraisal of nursing staff. Ensured a culture of resident safety within the facility. Assessed facility and nursing practices for compliance. Developed and implemented new programs and policies for the nursing department to improve quality. Participated in the monthly Profit and Loss managerial meetings. Evaluated, supervised and directed the activities of the nursing department. Ensured an ongoing continuous quality improvement activities. Monitored nursing department's performance relative to the regulatory quality indicators, and made changes to improve performance as needed.

June 1997- June 1998
Gladys Spellman Specialty Hospital & Nursing Center, Cheverly Maryland & Livingston Health Care Center, Fort Washington, Maryland

Title: Administrator -In -Training
Duties: Completed the scheduled AIT course outline rotation. Attended seminars on Prospective Payment System, CCAC accreditation, Health Care Policy forum, Creating a Culture of Quality, The Fair Labor Standards Act, Collective bargaining, Managed Care Models, and Effective Quality Assurance for Nursing Facilities. Participated in several survey processes, which involved JCAHO for Long Term Care and Chronic Hospital, Prince George's County and State of Maryland. Assisted with residents' initial and

quarterly activity and social service assessment. Rotated to departments to learn how each department operates in reference to the state and federal regulations. Trained in MDS, PPS, and Consolidated Billing.

1992-1998
NorthWest Health Care Center
Washington, District of Columbia.

Title: Patient Care Coordinator to Nursing Supervisor
Duties: Responsible for ensuring quality nursing care of a three hundred and fifty - five bed facility in the absence of all administrative staff. Ensured that all licensed nurse, certified nursing assistants, and non-nursing staff are providing their care in accordance with the policies and procedures of the facility. Participated in the quality assurance evaluation of the facility by outside agencies. Responsible for adequate staffing of all the units of the facility during my shift. Contributed to the interdisciplinary resident care plans. Acted as the ADON in their absence and oriented ADONS, PCCS and floor RNS. Trained staff in CPR, IV Therapy and computer skills.

Membership: Pi Alpha Alpha, Golden Key International Honor Society, The Gerontological Society of America, The Washington DC Area Geriatric Education Center Consortium (WAGECC), American Society on Aging (ASA), and American Society for Public Administrators (ASPA).

Fellowship: WAGECC Fellow

LICENSE: Licensed Nursing Home Administrator for State of Maryland and the District of Columbia.
Registered Nurse for Maryland and Washington DC.

COMPUTER SKILLS: Microsoft word, Microsoft Excel, Microsoft PowerPoint, Word Perfect, Lotus 123 and Basic.

Research Software: NVivo 9 & 10 Qualitative software and SPSS Quantitative software

REFERENCES: Will be furnished upon request.