

The Consequences of Having a Bad Administrator

During the many years I have lived in a nursing facility we have had several administrators. One stands out in my thoughts.

When he first arrived he clearly knew little about nursing homes - criticizing CNAs for not washing floors. He was unaware of what tasks CNAs do and what is the responsibility of housekeeping. He also asked nurses to do CNA work. Clearly, he was ignorant of what constitutes direct care.

Personally, this administrator abused me in multiple ways. He accused me of refusing needed medications when my physician at a Boston teaching hospital had taken me off them. His comment was outside his scope of practice. He also told me I was not allowed outside for as long as I wanted - but rather for no more than 2 hours at a time. A violation of resident rights.

This administrator tried to take essential medical supplies away from me - for which I had had a physician order for years. These included foam patches and barrier cream to protect me from developing pressure sores - from sitting in my wheelchair for hours at a time. He told me my medical supplies were too expensive - and that I had to use the same ones as other residents - which would not have worked for me. At one point he didn't want even to let me keep my skin-protective cream in my room. I called DPH and the state called our DON and told her I could.

Our corporate office disagreed with him, telling him to provide the supplies I requested. He had a childish temper tantrum - while informing me of what corporate had told him - saying that he would never speak to me about anything again!

At one point during this supply saga the situation had become so dire someone one of my medical providers sent me some supplies. Two lawyers were willing to represent me, as he was neglecting me. One actually called and spoke to him.

A troublesome event occurred - when he asked an aide to remove my electric wheelchair from a nook in the hall outside my room - and put it into a common area nearby for a fire drill. Luckily, she refused. If the chair had been charging in the electrical outlet in the nook - and it had not first been unplugged - the controller on the chair would have been damaged and the chair would not have worked.

Also seriously, the room - where other wheelchairs had been moved to - was a complete mess of tables and chairs all pushed together. It was an unsafe place for an electric chair with a control panel that could have been broken making my chair unusable. My local fire department had actually previously told me it was safe for me to leave my chair in the nook - not only for fire drill, but also for an actual fire - as the chair was not in the path of travel there.

This administrator objected to my having canvas bags with personal belongings in them on the windowsill of my room next to my bed. He wanted a staff person to put my bags and their contents into plastic tubs in storage somewhere - when we don't actually have any storage space for residents in the building. Most importantly, everything in the bags were things I needed access to on a daily basis. Snacks, Styrofoam cups with lids the facility should have been buying but wasn't. Office supplies and files of notes for my writing. Seasonal gear - like in winter scarves, arm warmers, hoods and gloves. These are all items I use to have a full life.

Being close by, my belongings also benefit aides. Everything is easily accessible so an aide has only to go to the bag I designate and hand me what I want. This is especially helpful when we are short staffed. Putting my belongings elsewhere - without my having easy access to them - would have violated my right under the CMS Regulations of Participation to care and services to achieve my highest practical physical, mental and psychosocial well-being. This would also have violated my right to activities of my choice.

Once, when a technician from my wheelchair company came to make some adjustments to my chair this administrator interrupted us. He asked the technician if he would later come speak to another resident who has a wheelchair she actually didn't want repaired! The technician was clearly annoyed at being interrupted and told him to call the office for an appointment.

A serious area of contention between this administrator and me was that he told me I had no right to know in advance who would provide care for me. He told me the schedule is operational information. I disagreed, as I have specific needs including having staff who can safely move and charge an electric wheelchair. His refusal violated my federal nursing home resident right to right to self-determination - which includes the right to choose providers of care.

Relatedly, he told me that everyone with a CNA license can do me. Here is an example showing he was incorrect. One evening I had two agency CNAs, neither of whom had done me before. They transferred me with a lift to my bed. I was then hanging high in the air over it in the sling. Frighteningly, the control panel did not respond when the button to lower the lift was pushed.

I explained to the CNAs that they had only to pull out the red button on the back of the lift - as the lift was now locked. Neither CNA had any idea what I was talking about. The situation was dangerous so I screamed for help. A nurse - who knew the lift - came into my room and pulled out the button. I was then able to be lowered safely to bed.

This incident underscores that having a CNA license is insufficient. The problem here was that neither CNA was familiar with the equipment in my facility. This is also another example of the fact that this administrator had no understanding of direct care. Clearly, my need to check the schedule in advance - to see if the aides assigned to me know my routine - is essential.

Here is another example of a serious incident. One night I was safely transferred to bed but was not positioned properly. I was left in bed too far on the right of my mattress and I was not completely flat. As a result, I was hanging over the right side of my bed with my right leg starting to slide off the mattress. To protect myself from sliding onto the floor I grabbed the side rail on my bed to hold myself onto the bed - and turned on my call light for assistance. No one answered. So I reached for my cell phone and called dispatch at my local police station to ask for help.

An officer called my facility and asked a nurse to come check on me. She repositioned me properly. I was lucky not to have slid onto the floor and been injured. The two CNAs I'd had were agency. Neither understood the importance of positioning me completely flat in bed - as I'm paralyzed and cannot reposition myself to be safe.

Having the schedule of CNAs in advance is also important as it gives me time to contact our DON so she can schedule at least one CNA who knows me and how to provide my care. I note this administrator was the first administrator to refuse to give me the schedule in advance, putting me at risk.

Personally, I ignored the administrator. I went out for as long as I wanted. I got the medical supplies he tried to deny me. I got our DON to make sure I had CNAs on the schedule who could provide safe care for myself and for my chair.

As for staff, this administrator also mistreated them - some of whom resigned completely from working in our facility because of the way he treated them. Other staff resigned because of the working conditions he created for them. Conditions that didn't exist before his arrival here. A couple staff resigned from their positions and switched to other jobs in the facility - so as to avoid him, by no longer being directly supervised by him.

Here are the specifics. A DON resigned because she was fearful she'd lose her license - given the conditions he created for her staff who did not have the medical supplies they needed for residents. These included briefs, wound dressings, nutritional supplements, cups with lids that fit for hydration, soap to wash residents with, shaving cream and razors, and a lack of over-the-counter medications like Tylenol.

Two staff who were in charge of our Central Supply office resigned completely. One resigned because this administrator accused him of not delivering PPE to units - when this responsibility comes under nursing, not Central Supply. This administrator told him to go home - which he did. He then refused to come back.

The second resigned because she tired of having to listen to complaints from staff who needed supplies for their residents she wasn't able to give them. Our administrator actually accused the staff of being the problem, telling her that "Staff are unforgiving." - implying staff do not forgive not having supplies they need for residents - when actually

he was the problem. He wasn't ordering the needed supplies. So they weren't available for her to deliver.

Our Medical Records person resigned because this administrator pressured her unrealistically to do two jobs for one salary - Medical Records and Central Supply. She went back to being a CNA in our facility - no longer working in a position directly under him.

Our scheduler - who he criticized without cause for the work she was doing excellently - resigned. She was replaced with someone who did not know either staff or resident needs. The one who resigned went back to being a mental health counselor in our facility - which the administrator likewise didn't supervise directly.

I was told he upset an activities assistant by requiring her to participate in the morning meeting of management - when her supervisor wasn't here to attend. I was told she was upset first because she had no management experience. And she was also unhappy because the mornings she was in a meeting she was unable to provide activities for residents during that shift. She felt bad because she knew residents really enjoyed the activities.

This administrator clearly did not support staff nor make them feel valued. He did not know how to talk to them. He chose to utter platitudes instead like "Thank you for everything you do for us." - when he did not know what they did. He should instead have acknowledged specific contributions.

Emotionally, he was erratic. It was reported to me that he had actually cried one day during a morning meeting of management - when he had asked staff to do something and they refused.

He lacked personal boundaries. When he first came to us he put his hand on my arm or shoulder when talking to me. I put an end to that telling him I didn't want him touching me. One day he complained to me about his personal problems - that he's diabetic, afraid of needles, and has to have someone else give him his insulin injection. More than I need to know, as I'm not interested in being his therapist.

I didn't like the language he used in a public area such as "fucking jackass", "holy crap", and the phrase "SOL" - which was explained to me means - shit out of luck. A new one for me. He referred to our DON as "My DON", overly possessive, when she is the DON for the whole facility.

I filed complaints with our corporate office, MA DPH and the MA Board of Registration of Nursing Home Administrators about the problems we were having because of him. My complaints to our corporate office were most successful. Our regional supervisor came - and spent a couple days a week for several weeks with us - addressing a lot of the problems.

This supervisor also told us when he came that DPH would soon send surveyors for our annual recertification survey. Indeed, a couple weeks later the surveyors came. They were here for almost two weeks. We had 6 or 7 surveyors most days. One day 5. A colleague of mine pointed out to me that since DPH usually only sends 3 surveyors, the increased numbers - in her opinion - indicated the state was paying serious attention to the complaints I had filed about conditions in the facility he had created.

Overall, I feel this administrator lacked leadership skills. He was not knowledgeable about nursing homes - nor staff job descriptions and resident care. He had poor communication skills. He lacked empathy. He was unable to get along with many staff and residents, creating conflict between himself and others. He thought he knew better than everyone. He lacked good judgment. He made poor decisions.

In my opinion, he had neither the personality nor competencies to be an effective administrator. Staff and residents suffered every day because of him. Not a single staff person had anything positive to say about him.

Because of the ways he had treated me personally I'd had enough - so I stopped speaking to him - even when he addressed me. One day he saw me having a conversation with another staff member. I think he was jealous because he said to him "I'm a nice guy. Tell her that I'm a nice guy. She should talk to me."

Interestingly, in the summer when he first came to our facility he wore shorts to work. Our corporate office told him he could not wear them to work - as they were unprofessional. That word sums up our problems with him. He was unprofessional. I feel he was the worst administrator we ever had.

To avoid having a problematic administrator like this one - I suggest that all administrator-applicants' backgrounds and personal references should be fully researched. Then if the person is hired - and serious problems occur with the individual - s/he should be fired and replaced.

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