The Operational Layer Gap

Why skilled nursing administrators are running facilities without the data layer — and what changes when they finally get it

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Executive Summary

Skilled nursing administrators are managing facilities without the operational data layer that operators in every other service industry — hospitality, food service, retail, logistics — have had for a decade or more. The clinical layer of the SNF is digitized. The billing layer is digitized. The staffing layer is digitized. But the non-clinical operational layer — facility rounds, maintenance tracking, issue escalation, and compliance documentation — is still being managed on paper, whiteboards, end-of-day debrief meetings, verbal handoffs, and sticky notes.

This is not a small gap. It is the largest unaddressed operational gap in the SNF industry, and it shapes every administrator's day. The cost shows up in administrator time consumed by coordination instead of leadership, in compliance evidence reconstructed from paper at survey time rather than retrieved from a system, in operational decisions made on instinct rather than data, in institutional knowledge lost when a department head leaves.

This paper argues that closing the gap is now possible — and that doing so changes what kind of operator the administrator gets to be. It examines what running on paper costs facilities today, what becomes possible when the operational layer is finally instrumented, and where RoomRounds fits in this newly emerging category.

> *RoomRounds is as much about empowering administrators with actionable data as it is about automating the rounds process. The administrator becomes a data-informed operator instead of an instinct-driven one.*

The Skilled Nursing Industry Today

A digitized clinical layer, an undigitized operational layer

The U.S. SNF industry has 14,745 CMS-certified facilities serving approximately 1.24 million residents, generating roughly $120 billion in annual revenue under Medicare's Skilled Nursing Facility Prospective Payment System and Medicaid reimbursement.

Over the past two decades, the industry has invested heavily in clinical software. Electronic Health Records (PointClickCare, MatrixCare, American HealthTech, and others) capture clinical documentation, medication administration, MDS assessments, care plans, and resident records. Billing and revenue cycle tools handle claims, denials, and reimbursement. Staffing and scheduling platforms manage shifts, certifications, and Payroll-Based Journal reporting. Analytics overlays surface data from these systems for facility leadership.

The operational layer of the same facility, however, has received almost none of this investment. Rounds are still walked with paper checklists. Maintenance issues are still tracked through whatever channel happens to be convenient. Issue escalation still depends on verbal handoff and memory. Compliance documentation still lives in a patchwork of paper folders, personal phone photos, and disconnected spreadsheets.

The administrator at the center

The skilled nursing facility administrator sits at the operational center of the building. Their role spans regulatory compliance, departmental coordination, financial performance, family relationships, and the workforce challenges below them — line-staff turnover at 36-42%, persistent staffing shortages, ongoing CMS survey pressure. Industry sources note that administrators "often work non-standard hours, and/or more than forty hours per week," with "most time spent in meetings."

Administrator turnover, by contrast, is approximately 22% — the lowest of any major SNF role. The administrator is the stable buyer in the facility, typically in role for four to five years on average. They are also the only role with budget authority for operational software at independent and most regional-operator facilities.

> *If software is to address SNF operations meaningfully, the administrator is both the user and the buyer. Yet the operational workflows the administrator manages every day remain the least-instrumented part of the facility's technology stack.*

What Running on Paper Costs You

Facilities running their non-clinical operations on paper, whiteboards, and verbal handoffs operate without four foundational capabilities that every other service industry treats as basic. Each absence has measurable consequences for administrators and the facilities they run.

Cost 1: Operational efficiency lost to coordination overhead

When operations run on paper, the administrator's day is consumed by coordination. The morning meeting to assign rounds. The mid-day check-ins to gather status from department heads. The end-of-day debrief to compile what was found and decide what to do about it. The verbal handoffs that move information from one shift to the next, when they happen at all.

Across a typical leadership team — administrator plus three to seven department heads, depending on facility size — operational coordination consumes 15 to 100 hours per week of team time. This is time the administrator is not spending on what their role actually needs: line-staff retention initiatives, family relationships, quality improvement, financial performance management. The administrator of a paper-driven facility spends more time coordinating the workflow than leading the facility.

> *The line-staff retention crisis is happening below the administrator. The administrator is in a position to address it — but only if the time and data exist to do so. Paper operational workflow takes both away.*

Cost 2: Communication that moves at the speed of meetings, not the speed of work

In a paper-driven facility, information moves at the speed of the next debrief meeting, the next shift change, the next phone call. A maintenance issue found in room 207 at 9am may not reach the maintenance lead until the management meeting at 4pm — seven hours later. A family concern raised on second shift may not reach the administrator until Monday morning, two days after it was first heard.

This is not a failure of effort. Department heads and floor staff are doing their jobs. It is a failure of system — there is no infrastructure that moves operational information at the speed it is generated. Information accumulates in heads, on paper, in text messages between specific people, in the gaps between meetings.

The administrator cannot see what they cannot see. When status updates live in heads, the question "did anyone get to that?" produces a shrug or a guess. When the administrator wants to know what is actually happening across the facility, they ask someone, who asks someone else, who maybe asks a third person.

Cost 3: Decisions made without real-time data

In every other service industry, operators run on real-time data. A hotel general manager opens a dashboard and sees occupancy, housekeeping completion, open maintenance work orders, guest complaints, and revenue per available room. A restaurant operator sees table turn time, prep-line throughput, ticket times, and labor cost as a percentage of revenue. A retail operator sees foot traffic, conversion rate, stock levels, and shrinkage. These metrics are not aspirational; they are how those businesses are run.

The SNF administrator running on paper has no equivalent. They do not have per-room rounds completion data. They do not have time-to-fix metrics on maintenance issues. They do not have ticket aging visibility, response time trends, or employee performance comparisons. They are running a complex facility with multiple departments and significant operational complexity using the same tools their predecessor used in 1995.

The cost is operational decisions made on instinct rather than data. The administrator who suspects but cannot prove that one department head is responsive while another is not. The maintenance backlog that is felt but not measured. The compliance gap that is suspected but not visible until the surveyor finds it.

Cost 4: Compliance evidence reconstructed instead of retrieved

Survey deficiencies in SNFs frequently involve non-clinical departments — dietary services, sanitation, life safety, environmental services. These are exactly the operational areas where evidence is most likely to be on paper, in personal phones, or in someone's memory. With 27% of facilities receiving at least one serious deficiency per survey cycle and an average of 9.5 deficiencies per cycle overall, the cost of poor compliance documentation is not hypothetical.

In a paper-driven facility, compliance evidence accumulates in a patchwork of locations: inspection logs in the maintenance director's office, signed acknowledgments in HR files, photos on personal phones, vendor receipts in a drawer, fire drill records on a spreadsheet someone last updated three months ago. When the state surveyor asks for documentation of last quarter's fire alarm tests, the maintenance director excuses himself to look through paper folders. Sometimes successfully, sometimes not.

A facility that ran its compliance work well but documented it poorly is functionally equivalent at survey time to a facility that did not run it at all. The cost is corrective action plans, follow-up surveys, potential fines, and in the most severe cases denial of Medicare and Medicaid payments — costs that can run from tens of thousands to hundreds of thousands of dollars per deficiency period.

Cost 5: Institutional memory that walks out the door

When a department head leaves a paper-driven facility, the operational knowledge they accumulated leaves with them. What was tried in room 207 and didn't work. Who is responsible for the third-floor

leak that keeps recurring. Why the kitchen freezer keeps tripping the breaker. The next manager picks up without context and re-learns lessons the facility had already learned.

In an instrumented facility, operational knowledge persists in the system independent of any individual. The work history, the resolutions tried, the patterns visible across months of activity — all of it inherits to the next person in the role. Given the realities of SNF management turnover, the loss of institutional memory in paper-driven facilities is a recurring tax on operational performance that disappears entirely when the operational layer is instrumented.

What Changes When the Operational Layer Is Instrumented

If the cost of running on paper is real and measurable, the question becomes: what changes when the operational layer is finally instrumented? The answer is not a list of features. It is a transformation in what kind of operator the administrator gets to be.

From coordination overhead to operational visibility

With the operational layer instrumented, the administrator no longer spends the day coordinating workflow. The morning rounds assignment happens through templates assigned to department heads on mobile. The mid-day status check happens through a dashboard that shows rounds completion, open tickets, urgent items, and scheduled work in real-time. The end-of-day debrief meeting becomes optional, because the administrator already knows what happened today.

The leadership team's 15 to 100 hours per week of coordination overhead does not disappear entirely, but a meaningful portion of it does — and what remains shifts from coordination to leadership. The administrator's time, freed from chasing status, becomes available for retention work, family relationships, quality initiatives, and the financial performance discussions that actually move facility outcomes.

From paper-driven communication to real-time visibility

Information stops accumulating in heads. A maintenance issue found in room 207 at 9am becomes a ticket the moment it is found, routed to the right department, visible on the administrator's dashboard, and acted on without waiting for the 4pm management meeting. A family concern raised on second shift becomes a tracked item the administrator can see Monday morning rather than discovering at the family meeting.

Every operational observation — by department managers walking rounds, by floor staff noticing issues during their work, by maintenance staff completing scheduled tasks — flows into a single system the administrator can see. Every conversation about that work happens inside the ticket where the work lives, rather than in scattered text threads, phone calls, and hallway encounters. The conversation moves at the speed of the work.

From instinct-driven operations to data-informed leadership

With the operational layer instrumented, the administrator finally has the metrics that operators in other industries take for granted. Per-room rounds completion. Per-manager response time. Time-to-fix on maintenance issues. Ticket aging trends. Resident-experience patterns. Employee performance comparisons. The operational data layer that did not exist in paper workflows becomes the foundation for performance management.

The administrator who suspected but could not prove now has the data. The maintenance backlog that was felt but not measured now has time-to-fix metrics. The compliance gap that was suspected but invisible is now surfaced before the surveyor finds it. Decisions get made with data rather than with instinct, and the administrator becomes the kind of operator their peers in hotel chains, restaurant groups, and retail organizations have been for years.

> *Better data → better decisions → better operations → better line-staff retention → better resident and family satisfaction → better facility P&L → better survey outcomes. Each loop reinforces the next.*

From compliance scramble to documentation as a byproduct

When the operational layer is instrumented, compliance documentation stops being a separate effort. Every action — rounds completion, maintenance task closure, issue resolution, ticket chat — generates a timestamped, attributable, searchable record automatically. The state surveyor asks for documentation of last quarter's fire alarm tests, and the administrator searches the dashboard, opens the relevant tickets, and produces the photo evidence with timestamps.

The end-of-month or pre-survey scramble to reconstruct compliance evidence becomes unnecessary because the evidence has been accumulating naturally all along. Survey readiness becomes a byproduct of operational discipline rather than a separate workstream. Audit defensibility — for post-incident reviews, insurance claims, and regulatory inquiries — becomes a structural property of the facility rather than something that has to be built up retroactively.

Is There an Incumbent?

Before arguing that the operational layer is uninstrumented, we examined the SNF software market in detail. The 2026 best-of-class listings from industry publications and analyst aggregators consistently surface the same categories of software:

- Comprehensive EHR platforms: PointClickCare, MatrixCare, American HealthTech, SigmaCare, Netsmart MyUnity, Yardi Senior Living, COMET

- Analytics overlay platforms: SNF Metrics, CareWork, Senior IQ
- Revenue cycle automation: ValueDX, AR Max, specialized billing tools
- Workforce management: OnShift, Smartlinx, Apploi, Connecteam
- Therapy management: Net Health Optima, others
- Compliance audits (point tool): MyFieldAudits

None of these tools spans the four non-clinical operational workflow categories — rounds, maintenance tracking, issue escalation, and compliance documentation — at the architectural level. The EHR vendors and analytics platforms describe themselves as comprehensive, but their definition is bounded by what generates clinical or financial data. They handle the workflows that drive reimbursement and clinical compliance. They cannot handle, without expanding HIPAA scope and absorbing the deployment delays that come with it, the operational layer.

Adjacent point tools exist for specific subtasks. MyFieldAudits offers mobile compliance audits but does not span the broader operational architecture. Generic computerized maintenance management systems cover maintenance scheduling without understanding SNF context. Generic team communication tools handle messaging across industries but do not integrate with the operational workflow categories specific to long-term care.

> *The category of "non-clinical operational workflow platform for skilled nursing facilities" has no dominant incumbent. The SNF industry has been operating without it for two decades.*

Why no incumbent has emerged

Two structural reasons explain the absence of an incumbent. First, existing software vendors targeted clinical workflows because that is where reimbursement and regulatory documentation lives. They built deep clinical capability and inherited HIPAA scope as a structural constraint, which means they cannot deploy fast, cannot charge $0 setup fees, and cannot serve the operational layer without expanding into clinical scope and losing the architectural advantages that come with staying outside it.

Second, operational workflow software has historically been built for other industries. Generic maintenance management tools serve factories, hotels, and offices. Generic operations management platforms span retail and hospitality. None were purpose-built for SNFs, and none integrate the four operational categories specific to long-term care. SNF administrators evaluating these tools find they have to assemble four separate point solutions, none of which understand the operational context they actually live in.

The result is a market that, despite being one of the most software-saturated in healthcare for clinical workflows, has remained essentially uninstrumented at the operational layer.

RoomRounds' Position in This Category

RoomRounds is a non-HIPAA SaaS platform that automates the four operational workflow categories described in this paper — facility rounds, maintenance tracking, issue escalation, and compliance documentation — for skilled nursing facilities. The product runs on an administrator desktop dashboard and a mobile app for department managers and floor staff. Every operational action generates an auditable digital record automatically, producing the operational data layer the industry has lacked.

The architectural choice to stay outside HIPAA scope is deliberate. By handling only non-clinical operational workflows — never patient health information — RoomRounds avoids the IT review, legal review, BAA infrastructure, and compliance burden that slow clinical software deployments. Facilities deploy in days, not months. Setup fees are $0 across all tiers. The procurement cycle is operational, not clinical.

The market is large, the gap is structural, the pain is measurable, and the buyer is accessible. The platform that instruments the operational layer well — at the right deployment speed, the right price point, and the right scope — has the opportunity to define a category that has been waiting for definition.

Conclusion

For SNF operators

If you are an administrator, owner, or executive at a skilled nursing facility, the question to ask is no longer whether the operational layer needs to be instrumented. The case for that has become increasingly clear. The question is what to look for when you evaluate the platforms that propose to instrument it.

Five criteria matter:

- Architectural scope: does the platform unify rounds, maintenance, escalation, and compliance in a single workflow, or does it require integrating multiple point tools?
- Deployment time: does it deploy in days, or does it require months of IT integration, legal review, and consulting engagement?
- HIPAA scope: does it stay outside HIPAA scope (allowing fast deployment and broad operational access), or does it pull operational workflow into clinical compliance scope?
- Administrator usability: is the administrator the user (with a desktop command center) and the buyer, or is the platform designed around a different user with different priorities?
- Auditability: does every operational action generate a timestamped, attributable, searchable record by default — or does the platform require additional configuration or discipline to produce defensible documentation?

For the industry

The SNF industry has spent two decades digitizing the clinical layer. The clinical layer is largely solved. The operational layer is the next frontier — and the case for solving it is no longer ambiguous. The cost of running facilities on paper operational workflow is measurable, the alternative is technically straightforward, and the buyer is in role to make the decision.

> *The SNF industry has a structural gap: no purpose-built non-clinical operational workflow platform exists at scale. The consequences are measurable. The opportunity is to close the gap — for facilities, for administrators, for residents and families who benefit when operations run well, and for the next decade of SNF software innovation.*

Learn more about RoomRounds and the operational data layer for skilled nursing facilities at www.roomrounds.com.

Methodology and Sources

Industry statistics cited in this paper:

Facility universe (14,745 CMS-certified SNFs, 1.24M residents, ~$120B industry revenue): CMS public data, Nursing Home Compare, 2025.

Turnover rates (CNAs 42%, RNs 36%, Administrators 22%): 2025-2026 Nursing Home Salary and Benefits Report, HCS/LeadingAge/AHCA.

Survey deficiency rates (9.5 average per cycle; 27% with serious deficiencies): KFF reporting on CMS survey deficiencies, July 2025.

Competitive landscape verification (May 2026):

Reviewed 2026 best-of lists from Capterra, GetApp, MyFieldAudits, Connecteam, and analyst aggregator WifiTalents. Cross-referenced with vendor websites for PointClickCare, MatrixCare, American HealthTech, SigmaCare, Netsmart, Yardi, SNF Metrics, CareWork, ValueDX, OnShift, Smartlinx, Apploi, MyFieldAudits, Connecteam, and others. Identified no platform that unifies non-clinical operational workflow across the four categories (rounds, maintenance, escalation, compliance) at the architectural level. Adjacent point tools exist but none span the operational layer comprehensively or specifically for SNF context.

Authorship and intent:

This paper is authored and published by RoomRounds, Inc RoomRounds is a non-HIPAA SaaS platform for skilled nursing facilities. For inquiries about this white paper, or to evaluate RoomRounds, visit www.roomrounds.com.