SeniorCRE®

Operating Infrastructure for Senior Housing & Care

WHITE PAPER · CONCEPTUAL OPERATING MODEL

From Siloed AI to Organization-Wide Intelligence

Why vertical AI tools have value, why horizontal decisions are different, and what an Operator-Controlled Operating Record makes possible

> The next leap in AI value is not making each department smarter. It is helping the whole organization make better decisions across departments, with clear authority and accountability.

PUBLISHED
October 16, 2026

PREPARED FOR
Operators · Owners · Clinical, technology and finance leaders

PUBLISHER
SeniorCRE, LLC

CONTENTS

— Key terms 2

01 The change already under way 3

02 Vertical optimization and horizontal integration 4

03 The problem lives between departments: two examples 5

04 A governed decision follows a complete chain 7

05 The operator chooses the deployment 8

06 Why each vendor cannot govern it alone 9

07 What organization-wide AI is intended to enable 10

08 The practical rule for deploying AI 10

R Sources and next step 11

THE THESIS

Vendors can govern their agents. The operator must govern the decisions those agents make on its behalf.

EVIDENCE STANDARD

This paper describes a conceptual operating model. The Operator-Controlled Operating Record is designed and not yet implemented in any community. The example is illustrative, not a customer case; outcomes are targets to be tested in a pilot, not measured results; and no live named third-party connector is claimed.

KEY TERMS

KEY TERMS **Five terms used throughout this paper**

Term	Meaning
System of record	The software that officially holds one kind of information: clinical records, staffing, therapy, billing or assessments.
Governance	The organization's rules for which evidence to trust, what decisions are allowed, and who is accountable.
Authority chain	A clear path showing who can recommend, approve, act, escalate or override a decision.
Operator-Controlled Operating Record	The durable account of a cross-functional decision: evidence, disagreements, authority, rationale, action and outcome.
AI assistant and AI agent	An assistant helps people find, draft and analyze. An agent can also carry out multi-step work or initiate permitted actions.

SECTION 01

The change already under way

Software vendors are attaching AI to the systems they already serve. Each tool handles a defined task with a limited view of the organization, and each is useful on its own terms.

A clinical documentation tool may review charts or identify an MDS coding issue. A staffing tool may find overtime. A finance tool may analyze payer performance. These are valuable point solutions, and senior housing & care operators are adopting them: more than a third of clinical leaders report AI fully implemented or in pilots in their communities.[1]

The stakes rise as AI assistants become AI agents that can use tools and start workflows. Separate recommendations then carry more weight. The clinical, staffing and finance agents might each be right within their own lane, yet together recommend actions that pull a community in different directions.

EXHIBIT 1 **Why the gap between systems is already a problem**

77%

of surveyed operators, executives and technology leaders cite interoperability between software tools and access to data as a top challenge

Source [2]

63%

of clinical leaders believe resident acuity is underreported in their communities

Source [1]

36%

of clinical leaders report AI fully implemented or in pilots

Source [1]

The question is no longer whether AI will reach every department. It is who decides when departmental AI disagrees, and what record that decision leaves behind.

THREE QUESTIONS **Every cross-functional AI decision has to answer**

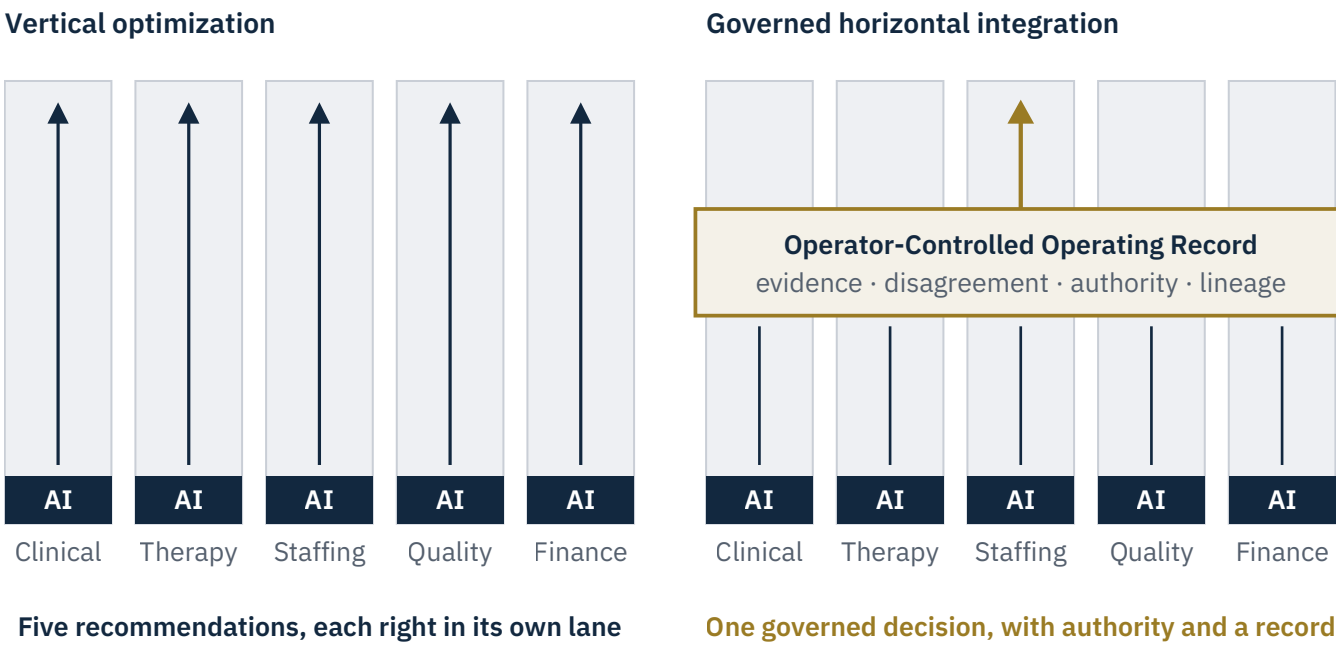
What is true?	Which evidence governs when clinical, therapy, staffing, quality and finance systems disagree.
Who decides?	Which accountable person or rule may approve, act, escalate or override, and within what limits.
What is kept?	A durable record of what was known, what was chosen, why, by whom, and what happened next.

SECTION 02

Vertical optimization and horizontal integration

Vertical describes AI working inside one department or system. **Horizontal** describes a decision that spans several departments. The difference is the scope of the problem and the authority behind the decision, not the sophistication of any one model.

EXHIBIT 2 **Five smart lanes, or one governed decision**



Source: SeniorCRE conceptual operating model. Illustrative.

EXHIBIT 3 **How the two approaches differ**

Dimension	Vertical optimization	Governed horizontal integration
Focus	One workflow or department	An organization-wide outcome
Inputs	Data from one source or lane	Clinical, therapy, workforce, finance and quality together
Decision	Local tool or department rules	Shared evidence plus explicit decision rights
Example	Flag an MDS coding inconsistency	Coordinate function, staffing, documentation and care

A note on terms: in business strategy, “vertical integration” means owning more stages of a supply chain. Here, “vertical AI optimization” means AI attached to departmental systems.

Both matter. Vertical tools make each lane better; the governed horizontal layer makes sure their combined advice serves the community as a whole.

SECTION 03

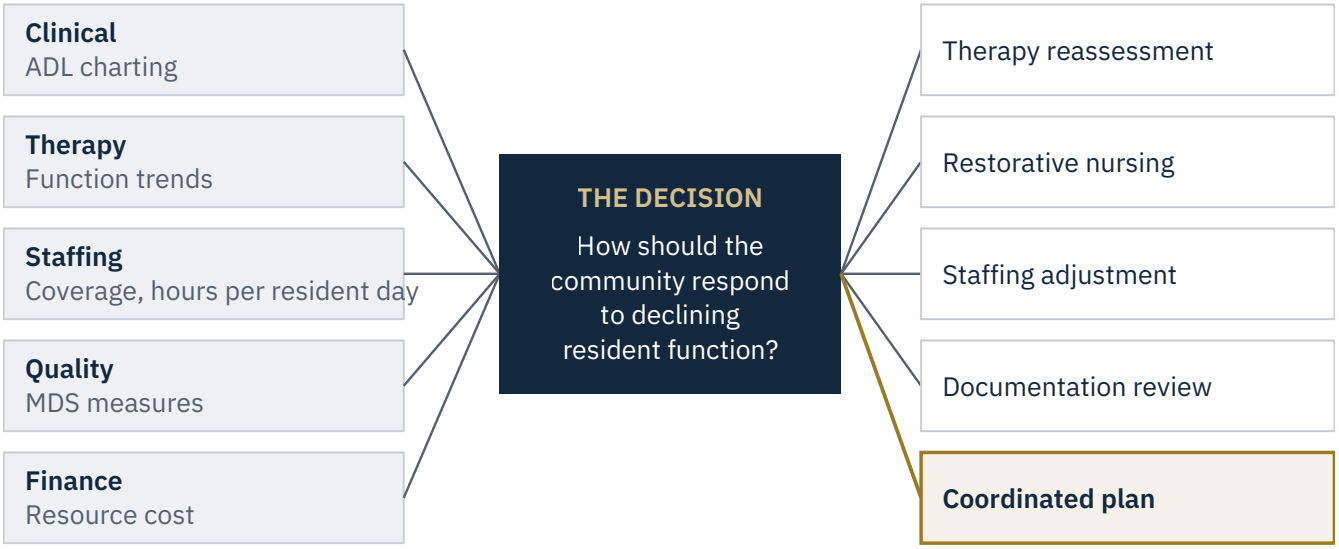
The problem lives between departments

Two illustrative examples, neither a customer case, show the same pattern in different settings.

Example 1 · Skilled nursing: declining resident function

More residents in a skilled nursing community need increased help with walking and daily activities. Leadership wants to improve functional outcomes and the related Five-Star quality measures while managing staffing and financial constraints.

EXHIBIT 4 **Five systems hold part of the answer; none holds the decision**



Illustrative. The right response is often several coordinated steps, which no single system can recommend on its own.

A VERTICAL ANSWER

One system flags decline

A therapy or clinical tool flags functional decline. That helps, but it does not tell leaders whether the response should be a therapy reassessment, restorative nursing, a staffing adjustment, a documentation review, or several coordinated steps.

A GOVERNED HORIZONTAL ANSWER

The organization decides

The evidence from all five areas is combined, their disagreements are shown, the owners of clinical and staffing changes are named, and the chosen response is recorded with its rationale, so its results can be observed and learned from.

EXHIBIT 5 **What each lane's AI might recommend on its own**

Lane	What its AI sees	What it might recommend
Clinical	More residents need help with walking and daily activities	Increase assistance and update care plans
Therapy	Declining function scores	Add therapy evaluations and minutes
Staffing	Overtime rising against budgeted hours	Hold or reduce hours
Quality	Function-related measures trending down	Review MDS documentation
Finance	Resource cost rising faster than revenue	Limit added services

Illustrative. Each recommendation is reasonable in its own lane; together they conflict. Resolving that conflict needs shared evidence, named authority and a record of the decision.

Example 2 · Assisted living: a care-level change and the bill

An assisted living resident's updated service assessment shows needs consistent with a higher care level: more help with transfers and bathing, and added medication reminders. Three systems now tell three different stories, and the resident's fee, staffing and care plan all depend on which one governs.

EXHIBIT 6 **One resident, three systems, three care levels**

Source	Shows	Why
Assessment	**Level 3**	The updated service assessment reflects the resident's current needs
Billing	**Level 2**	The fee change has not been approved, and notice has not been given
Scheduling	**Level 2**	Care minutes still follow the prior care plan

Illustrative. Billing at the old level means unrecovered cost for care already being given; staffing at the old level means care the plan says is needed may not be scheduled. Raising the fee by inference, without clinical confirmation and proper notice, creates a different risk.

Each system is behaving correctly. What is missing is the decision: who confirms the assessment, who approves the change, when the resident or family is told under the residency agreement and state rules, and when billing and staffing follow. Section 04 shows the record that decision leaves behind.

SECTION 04

A governed decision follows a complete chain

EXHIBIT 7 Six steps from evidence to execution



#	Step	What happens
1	**Evidence**	Combine permitted clinical, therapy, staffing, quality and finance information.
2	**Disagreement**	Surface differences in definitions or observations instead of hiding them.
3	**Authority**	Specify who owns clinical changes, staffing changes and escalation.
4	**Operator-Controlled Operating Record**	Preserve what was known, why a choice was made, and who approved it.
5	**Intelligence**	Let AI compare appropriate scenarios and competing constraints.
6	**Execution**	Act only within permissions, then observe functional and operating results.

Source: SeniorCRE conceptual operating model. The Record sits before intelligence: coherence before intelligence.

What the Record looks like

For Example 2, the Operator-Controlled Operating Record would hold one governed decision like the one below. Every field is preserved, so anyone can later see what was known, who decided and why.

EXHIBIT 8 **A sample governed decision: care-level change**

Decision	Change Resident A's care level from 2 to 3
Evidence	Updated service assessment (Level 3); billing record (Level 2); care schedule (Level 2 minutes); residency agreement notice terms
Disagreement	Three sources show two different care levels; the assessment is the newest, and the other two follow the prior plan
Authority	Wellness director confirms the assessment (clinical owner); executive director approves the change; business office applies the fee after notice
Rationale	Assessed needs exceed the current level; the care plan and staffing must match the care being given
Actions	Notice to resident and family under the agreement; care plan and schedule updated now; fee effective at the end of the notice period
Follow-up	Reassess in 30 days; confirm that billing, schedule and care plan all show Level 3

Illustrative and simplified. Roles, notice periods and approvals follow each operator's policies, residency agreements and state rules. AI may surface the mismatch and draft the record; it does not confirm the assessment or change the fee.

SECTION 05

The operator chooses the deployment

Governance never requires replacing a system, and replacement is never prohibited. Either way there is one authoritative record per function, and the operator decides what governs.

ROAD 1

Govern what you have

Keep the clinical, workforce, therapy and finance systems you run today. SeniorCRE governs the decisions that depend on more than one of them.

ROAD 2

Run on SeniorCRE

Select SeniorCRE as the system of record for chosen functions, each once its gates clear. Medication administration and eMAR are on the roadmap and outside the starting scope.

SECTION 06

Why each vendor cannot govern it alone

Vendors should govern their own tools, and the best do. Those safeguards matter, but they do not by themselves settle organization-wide trade-offs.

EXHIBIT 9 **Two layers of governance, both necessary**

What each vendor governs	What only the operator can govern
Identity and access to its tool	Which evidence governs when departments disagree
The actions its agent may take	Trade-offs between resident outcomes, labor and margin
Security and audit logs for its system	Who owns a cross-functional decision, and who may override it
The quality of its own recommendations	The durable record of what was decided, why and by whom

A staffing agent cannot decide how much resident-function risk is acceptable to save labor expense. A reimbursement agent does not own clinical discharge readiness. Those calls belong to accountable people inside the operator, working from shared evidence.

Where standards are heading

Operator-level governance is not only SeniorCRE's view. The NIST AI Risk Management Framework makes governance a core function, calling for documented accountability, roles and responsibilities across the AI lifecycle.[3] Federal health IT rules now require certified systems to make the sources and logic behind predictive decision support transparent to users.[4] And in skilled nursing, CMS builds Five-Star quality ratings on MDS assessment data, so how assessment evidence is reconciled has direct consequences.[5] Each points to the same requirement: decisions that can be traced to evidence and to an accountable person.

> *Interoperability moves data. An Operator-Controlled Operating Record makes enterprise AI possible.*

Four questions to ask any AI vendor

1	Which of our systems does your AI read, and which can it change?
2	When your recommendation conflicts with another department's, who decides, and where is that recorded?
3	Can we see the evidence, rule and approver behind every action your agent takes?
4	If we leave, do we keep the decision history in a usable form?

SECTION 07

What organization-wide AI is intended to enable

These are targeted outcomes, not measured results. Each would be tested in a pilot.

EXHIBIT 10 **Targeted outcomes and how the Record is designed to support them**

Targeted outcome	How	Status
Better-supported functional care decisions	Connect function trends to care interventions, staffing capacity and follow-up.	Target
Smarter workforce decisions	Compare labor expense with acuity, resident needs, quality and coverage.	Target
Better skilled-stay flow	Connect clinical readiness, therapy, payer rules, discharge planning and bed demand.	Target
More defensible financial decisions	Evaluate reimbursement and margin in the context of care and operating constraints.	Target

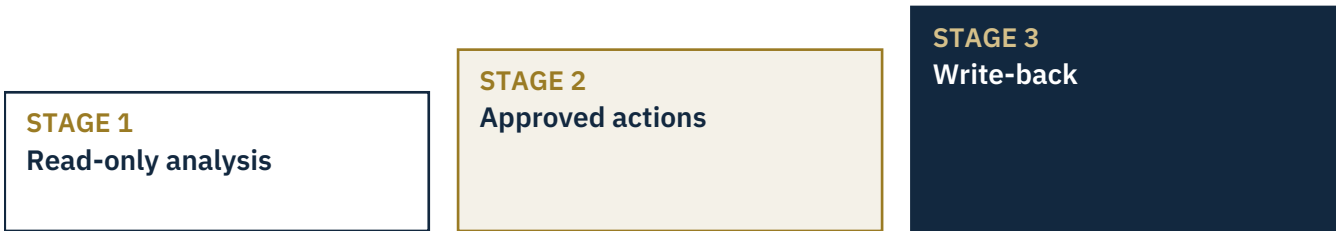
The Operator-Controlled Operating Record is designed and not yet implemented in any community.

SECTION 08

The practical rule for deploying AI

Start with one cross-functional decision, define the data it needs, establish whose authority governs, and give AI narrowly permitted work.

EXHIBIT 11 **Earn each level of autonomy**



Stage 1 · Read-only analysis	AI compares, explains and recommends from governed evidence; people decide and act.
Stage 2 · Approved actions	AI starts permitted workflows after an accountable person approves.
Stage 3 · Write-back	Only when integrations, validation, controls and responsible people are in place.

IMPORTANT QUALIFICATION

Not every AI assistant or one-off tool needs an enterprise governance layer. The case is strongest when AI draws on several systems, affects competing objectives, or starts consequential workflows. This is a proposed operating model: no live named third-party connector is claimed, and specific integrations and performance gains must be validated.

NEXT STEP

Bring us one decision that crosses departments

We will map the evidence, the disagreement and the authority it needs before any AI touches it.

Request an Executive Briefing at seniorcre.com/contact?briefing=executive

Definition · Authority · Reconciliation · Lineage

The four that make data governable.

SOURCES

[1] "Senior Living Resident Acuity Rising and Underreported, New Survey Finds," *Senior Housing News*, December 10, 2025, reporting the American Seniors Housing Association and August Health Clinical Leaders Report (68 respondents). seniorhousingnews.com/2025/12/10/senior-living-resident-acuity-rising-and-underreported-new-survey-finds/

[2] Argentum and A Place for Mom, "The State of Technology Adoption in Senior Living," as reported by *Senior Housing News*, July 1, 2025. seniorhousingnews.com/2025/07/01/argentum-technology-survey-identifies-top-trends-barriers-in-senior-living/

[3] National Institute of Standards and Technology, Artificial Intelligence Risk Management Framework (AI RMF 1.0), January 2023. nist.gov/itl/ai-risk-management-framework

[4] Assistant Secretary for Technology Policy / ONC, Health Data, Technology, and Interoperability (HTI-1) Final Rule, decision support intervention requirements. healthit.gov/topic/laws-regulation-and-policy/health-data-technology-and-interoperability-certification-program

[5] Centers for Medicare & Medicaid Services, Five-Star Quality Rating System for nursing homes. cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system

Conceptual operating model; not a claim of production results. SeniorCRE is not a healthcare provider. © 2026 SeniorCRE, LLC, a HavenCo company. SeniorCRE® is a registered mark of SeniorCRE, LLC.