Managing Decline in Assisted Living: The Key to Aging in Place

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Objectives. This study investigates the process of aging in place in assisted living facilities (ALFs) and seeks to gain an in-depth understanding of the factors influencing this phenomenon in a variety of ALF contexts.

Methods. Qualitative methods were used to study five ALFs for 1 year. Data collection methods included participant observation; informal and in-depth interviewing of providers, residents, and residents’ families; and review of resident and facility records. Analysis was conducted using the grounded theory approach.

Results. The ability of residents to remain in assisted living was principally a function of the “fit” between the capacity of both residents and facilities to manage decline. Multiple community, facility, and resident factors influenced the capacity to manage decline, and resident–facility fit was both an outcome and an influence on the decline management process. Resident and facility risk also was an intervening factor and a consequence of decline management.

Discussion. Findings point out the complexity of aging in place in ALFs and the need for a coordinated effort by facilities, residents, and families in the management of resident decline. Findings further highlight the necessity of residents being well informed about both their own needs and the capacity of a facility to meet them.

Traditionally, the term “aging in place” has referred to individuals growing old in their own homes with the emphasis on modification of home environments to compensate for limitations and disabilities (Pynoos, 1993). Although few would argue that most older persons prefer to age in place at home, recently the concept has been expanded to include assisted living facilities—a type of midrange supportive housing generally considered less restrictive and more “home-like” than nursing homes.

Assisted living facilities (ALFs) are the fastest-growing type of senior housing in the United States (Citro & Hermanson, 1999). According to a recent report by Mollica (2002), the United States in 2001 had 36,399 licensed facilities with 910,486 units, representing a 14.5% increase in capacity since 2000. Despite variations across states in name and definition, for the most part, these facilities are nonmedical, community-based living environments that provide shelter, board, 24-hr oversight, and personal care services to a predominantly elderly population (Hawes, Rose, & Phillips, 1999). The promotion of aging in place by maximizing resident independence and providing services to accommodate residents’ changing needs is often one of the key philosophical tenets of ALFs (Citro & Hermanson, 1999). Twenty-eight states include such a philosophy of assisted living in their statutes or regulations (Mollica & Jenkins, 2001).

Whether or not aging in place is a reality for AL residents depends, to a certain extent, on how the concept is defined. Recent studies indicate that, although AL residents are increasingly older, are more functionally impaired, and have greater care needs than those described in earlier research (Dittmar, 1989), for the most part, residents are not able to “fully” age in place, that is, remain in the facility until they die (Chapin & Dobbs-Kepper, 2001; Hawes et al., 1999). In fact, a recent national study reported an average length of stay of only 18 months (American Seniors Housing Association, 1999), and most providers view a resident’s stay as temporary, that is, designed to stave off, not prevent, nursing home placement (Frank, 2002). A four-state study by the U.S. General Accounting Office (GAO, 1999) also found that most facilities did not provide adequate information to consumers to determine whether their needs could be met and for how long. Some ALFs, however, do subscribe to a true aging-in-place model. In a study of 366 ALFs, the National Center of Assisted Living (1998) found that 65% allowed hospice services. Depending on the extent to which they promote aging in place, facilities have been described as following “retention” versus “transfer” (Bernard, Zimmerman, & Eckert, 2001) or “extended care” versus “lite” (Carder, 2002) models.

Although research addressing aging in place in ALFs is limited, several studies shed light on factors influencing how long residents remain in these settings. Probably most significant are state regulatory requirements for admission and retention, which establish the parameters for aging in place by specifying the characteristics of residents who may be served and the types of services that may be provided (Mollica & Jenkins, 2001). States vary significantly with regard to these requirements, and facilities’ specific admission and retention policies often are more restrictive than stipulated by regulations (Chapin & Dobbs-Kepper, 2001; GAO, 1999; Hawes et al., 1999). Although many states include a general statement that facilities must have the capacity to meet the needs of their residents, only a few allow residents who need continuous skilled nursing care, are bed bound, or require a two-person transfer.
Service availability in ALFs typically parallels admission and retention policies, and limited service availability is why most residents leave (Hawes et al., 1999; Mollica & Jenkins, 2001). Because most ALFs are private pay, residents’ financial resources are a significant factor in their ability to stay (Hawes et al., 1999). Forty-one states have some method of Medicaid reimbursement for ALFs, but the number of beneficiaries served in this setting is still low—about 102,000 (Mollica, 2002). Almost no Medicaid reimbursement is available for high-end facilities.

Design elements also influence aging in place. Accessible features such as entrances at grade, single-story construction, or presence of an elevator, handrails, wider doorways, lever handles, walk-in showers, and grab bars reduce excess disability and enable those with gait, balance, grasp, and mobility impairments to function more independently and safely (Mollica & Jenkins, 2001). ALFs housed in older structures built for other purposes typically have fewer types of accessible features, and accessibility is less extensive throughout the facility than that found in purpose-built ALFs.

A conceptual model presented by Bernard and colleagues (2001) describes aging in place in ALFs in terms of the interplay of a “constellation” of factors, some alterable and some not, at the individual, facility, and community levels. These authors emphasize, as others have (Callahan, 1993; Pynoos, 1993), the importance of person–environment fit and the need for ongoing assessment of a facility’s capacity to meet residents’ changing needs.

To date, no research has examined the process of aging in place in ALFs in depth and longitudinally. This qualitative study in a small sample of ALFs addresses this knowledge gap. We define aging in place simply as the process of residents growing older in this setting, and we explore the pathways of residents who leave these homes and those who stay. The specific research aims are to gain understanding of (a) the process of aging in place in ALFs and (b) the factors influencing this phenomenon in a variety of AL contexts.

**Methods**

The data for this research came from a larger study exploring independence and autonomy in ALFs. Because the goal of the study was to gain an in-depth understanding of a complex phenomenon within the sociocultural context of assisted living, a qualitative research approach was used (Sankar & Gubrium, 1994).

**Research Setting**

The study was conducted in five ALFs in Georgia, where ALFs are termed “personal care homes” and are defined broadly in statute to include a wide range of facilities with no limitations on size and only the specification that residents be at least 18 years old. The Georgia Long-Term Care Ombudsman Program (2003) reports 1720 licensed facilities in the state with 25,096 beds. Approximately two thirds of homes fall into the family-model category (two to six beds). Limited data indicate that residents of Georgia’s personal care homes resemble the national profile of an increasingly impaired population (Ball et al., 2000; State Health Planning Agency, 1993).

The strategy of purposive, maximum variation sampling (Patton, 1990) was used to select a small but diverse sample of five ALFs serving primarily elderly residents and varying along the dimensions of race and socioeconomic status of residents and size, level of resources, and geographic location of facility (Table 1). This strategy produced a sample of homes that reflected the variation among ALFs found in Georgia. Homes were studied both for the in-depth understanding of unique situations that emerged from the thick description (Geertz, 1983) of each case and for the breadth of understanding of common themes that derived from the team analysis of multiple types of data from all homes.

Two homes were small. Sleepy Hollow was a modest three-bedroom home with an attached manufactured housing unit in a rural mountain setting. It had been operating as an ALF for 2 years. Six residents lived in the home with the owners and their teenage son. Victorian Lane was a two-story, single-family home, built in the late 1800s, with a more recent one-story annex. All bedrooms were single occupancy. It was located in a small town in a rural county, had been in operation for 12 years, and was licensed for nine residents. Both small homes had low to moderate fees (ranging from $870 to $1500), and all residents were Caucasian.

Camellia Court was a medium-size ALF located on the edge of town in an exurban community. The home was adjacent to a nursing home owned by the same corporation and consisted of three buildings (one of which had two stories), built as apartments and clustered around a courtyard. Units had two bedrooms and a shared living room and bathroom. It had operated as an ALF for 17 years and was licensed for 48 residents. Monthly fees ranged from $1200 to $2000. Oak Manor and Park Place were large, relatively new, purpose-built ALFs in urban locations. Oak Manor had 42 suites and Park Place 57, and both offered numerous floor plans. They had the highest fees of sample homes and were the only homes with dementia special care units (not included in the study). At Oak Manor, all residents were African American. Almost all were Caucasian at Camellia Court and Park Place.

**Data Collection**

The primary methods of data collection were (a) participant observation, (b) informal and in-depth interviewing, and (c) review of resident and facility records and marketing materials. Data were collected simultaneously in each home for 1 year by a team of 11 researchers. A lead researcher was responsible for data collection at each site, and the number of researchers per site varied with the size of the home, ranging from one at Sleepy Hollow to four at Park Place.

Participant observation took place throughout the study period in each home, allowing for observation of the range of routines of these homes, the introduction of new residents, and how decisions were made regarding residents leaving. Researchers made a total of 457 visits, resulting in 1436 hr of observation. Visits ranged in length from 1 to 8 hr (but typically lasted approximately 3 hr) and took place on all days of the week and at different times of the day. Researchers recorded observations through field notes, following a detailed guide (developed by the key investigators), which addressed the range of facility activities (planned, unplanned, formal, and informal) and included where and when activities took place, who was involved, how they were carried out, what people said (paying attention to the informants’ language), and how participants reacted to the world around them.
The role of the researcher was essentially that of an observer with moderate participation in the activities of the home, including watching television, sharing meals, and taking walks with residents, accompanying them on group outings or to physician’s appointments, and attending organized group activities in the home. In the smaller homes, researchers also assisted with meal preparation and serving. Informal interviewing, though guided by theoretical sampling of data and the observation guide, was comparatively unstructured. It was carried out by the researchers assigned to each home typically as part of participant observation.

Purposive sampling was used to select residents, family members, and direct-care staff workers for in-depth interviewing. Residents were selected to represent maximum variation in age, disability, race, and gender to better understand the effect of resident characteristics on aging in place. Only cognitively intact residents were included in the sample. Decisions about cognitive ability were made subjectively by the researcher, often in consultation with facility personnel. Family members were those individuals most involved in and knowledgeable about residents’ care and included relatives of both residents who were interviewed and those with cognitive impairment. Staff members were selected to include those involved in administration and direct care, including in each home the owner or executive director as well as at least one hands-on caregiver. A total of 39 residents, 28 family members, and 39 staff members were interviewed. Researchers (typically the lead researcher in each home) conducted interviews following a detailed guide. The interview guide was semistructured and addressed a variety of topics related to aging in place, including residents’ health status, care needs, self-care practices and attitudes, finances, relationships, and informal support and facilities’ policies and procedures, services, fees, care practices, and staffing. All interviews were tape recorded and transcribed verbatim.

Social and medical data (e.g., health status, personal characteristics, medications, and family contacts) were extracted from the records of residents and used to establish a profile of a resident’s medical condition and resources, to track changes in status, and to clarify and verify interview data. Only records of residents who had given informed consent were reviewed, which included most residents at Sleepy Hollow, Victorian Manor, and Camellia Court and only interviewed residents at Oak Manor and Park Place. Facility documents reviewed included the formal admission agreement, written policies and procedures, and marketing materials.

Data Analysis

The grounded theory approach (Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1998) was used to analyze all types of qualitative data: interview transcripts, field notes from informal interviews and participant observation, and notes from resident and facility records and marketing materials. This approach involved the use of coding—the discovery and naming of categories—a procedure extensively described in qualitative research (Miles & Huberman, 1994). In coding, data first were scrutinized for emergent categories based on both questions asked by the researcher and issues raised by informants, an analytical process called open coding. Codes then were developed in terms of their properties (attributes and characteristics) and dimensions (location along a continuum) and applied to both interview and observational data. In the second type of coding—axial coding—initial categories were related to other categories, or subcategories, through what Strauss and Corbin (1998) refer to as a paradigm model. This model links subcategories to a category in a set of relationships denoting causal conditions, context, intervening conditions, action–interaction strategies, and consequences. Finally, categories were integrated and refined to form a larger theoretical scheme in the third type of coding—selective coding—in which the major categories were organized around a central explanatory concept, or core category (Strauss & Corbin, 1998).

In open coding, many of the initial categories were linked to our two research aims. For example, in examining factors that influence aging in place, a code that emerged was “resident monitoring.” This code then was developed in terms of properties (e.g., frequency and dimensions (e.g., often to never) and examined in relation to staff training and continuity, community health care resources, and resident health status—axial coding. Major categories (e.g., managing regimens, health promotion, balancing needs with resources) next were organized around a core category (Strauss & Corbin, 1998), “managing decline,” in selective coding. Researchers also created theoretical notes or memos throughout the coding process. These memos, containing insights, observations, interpretations, and questions about the data, facilitated linkage between data collection and analysis and helped identify recurring patterns and themes (Strauss & Corbin, 1998). The software package Ethnograph 5.0 (Qualis Research Associates, Denver, CO) was used to facilitate analysis, primarily as a means of sorting coded segments of data for ease of comparison across facilities.

The challenges of conducting research with multiple researchers and data sites, varied procedures, diverse sources of information, and an enormous volume of data were addressed by taking a coordinated team approach. The research team met biweekly to discuss data collection, analysis, and interpretation. These discussions ensured identification of missing data,

### Table 1. Facility Characteristics

<table>
<thead>
<tr>
<th>Study Home</th>
<th>Capacity</th>
<th>Location</th>
<th>Years of Operation</th>
<th>Monthly Fees</th>
<th>Facility Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleepy Hollow</td>
<td>6</td>
<td>Rural</td>
<td>2</td>
<td>$870–1500</td>
<td>One-story single family</td>
</tr>
<tr>
<td>Victorian Manor</td>
<td>9</td>
<td>Small town</td>
<td>12</td>
<td>$870–1500</td>
<td>Two-story Victorian with annex</td>
</tr>
<tr>
<td>Camellia Court</td>
<td>48</td>
<td>Small town</td>
<td>17</td>
<td>$1200–2000</td>
<td>Converted apartment</td>
</tr>
<tr>
<td>Oak Manor</td>
<td>53^b (75)^c</td>
<td>Urban</td>
<td></td>
<td>$2095–3645</td>
<td>Purpose built</td>
</tr>
<tr>
<td>Park Place</td>
<td>68^c (100)^c</td>
<td>Urban</td>
<td>3</td>
<td>$2300–5650</td>
<td>Purpose built</td>
</tr>
</tbody>
</table>

^aAll residents at Oak Manor were African American. Other homes had all or majority Caucasian residents.
^bCapacity of assisted living section.
^cTotal capacity, including dementia unit.
collection of data on all specified topics and new topics that became relevant, concordance and reliability in development of categories, and solution of procedural problems.

RESULTS

Resident Pathways

The process of aging in place varied considerably, both qualitatively and quantitatively, in these five homes, but here we are concerned mainly with its duration and evolution—and the factors that influence these aspects—and will speak of residents’ pathways as they left or as they aged in place.

A total of 185 residents lived in the five homes at least 1 month during the study year. Whereas the majority (61%) of the 125 residents living in the five homes at the beginning of the data collection period remained at the end of the year, in each home, resident populations were in a state of flux: Sixty residents moved in, 43 moved out, 14 were transferred to dementia units, and 7 died, either in the home or after a brief hospital stay. Turnover varied across homes. Five of the original eight Victorian Lane residents moved out. None moved in. At Oak Manor, which was relatively new and still marketing to fill its units, 26 residents moved in, and 14 moved out. Sleepy Hollow and Park Place had the most stable populations. Residents’ length of stay ranged from 1 month to 16 years. The resident with the longest tenure lived at Camellia Court, the oldest home. In all homes, pathways of residents who stayed, as well as those who left permanently, often included temporary stays in hospitals or nursing homes. As a director at Park Place said: “We have hospitalizations and emergencies here all the time. When you are dealing with frail older persons, anything can happen, anything.”

Factors Influencing Resident Pathways

Resident pathways were influenced by multiple factors relating to the wider community outside the home, the physical and social environment of the facility, and the individual resident. The relationship between these factors was complex and dynamic, and the phenomenon of aging in place represented a balancing act that depended on how various factors acted and interacted in the context of each ALF. Central to a resident’s ability to age in place was ultimately the “fit” between the capacity of both the facility and the resident to manage resident decline. (By “facility,” we mean the facility as a whole, including management, staff members, policies and procedures, and environment.) Strategies utilized by facilities and residents to manage decline were aimed at both preventing and responding to decline. In discussing how factors affect aging in place and the management of resident decline, we will note the effect of community factors as they operate at both the facility and the resident levels.

Facility Factors

Size, location, ownership, and age.—Structural characteristics of each ALF affected both the physical and the social environment and influenced the facility-level factors discussed below. For example, small size and small-town and rural locations fostered closer personal relationships. Independent ownership permitted more flexible policies, yet corporately owned homes had greater financial resources. Newer facilities had more accessible physical environments. The effect of these factors will be noted throughout this section.

Admission and retention policies.—Each home’s owner or administrator articulated a general philosophy that guided admission and retention policies. These policies, as well as consistency of policy adherence, were influenced by community factors (largely regulatory and economic), other facility factors (e.g., ownership, design, and staffing), and, in some cases, an owner’s personal values and relationships with residents and their families.

Park Place was the only home with a clear “aging-in-place” policy, as stated by the marketing director: “We serve the most frail and difficult-to-care-for resident, and we want this home to be the resident’s last home.” We found that Park Place residents had a reasonably good chance of achieving this goal. An example was Paul, who, in his 3 years at Park Place, declined to where he was wheelchair bound, had an in-dwelling catheter, and needed help transfilling and performing all activities of daily living (ADLs), including eating. Only 2 of a total of 81 residents moved from Park Place during the study because of care needs, and 7 stayed until death. Georgia regulations stipulate that residents may not be bed bound or require continuous medical care, and only at Park Place did policies push regulatory limits. The director named “the kind of resident one can take” as “the biggest [most significant to facility operation] regulation” and indicated that, had regulations permitted, residents requiring skilled care would have been retained.

The policy at Victorian Lane represented the opposite end of the spectrum: “We don’t take people that are bedridden or that need a whole lot of care because then we can’t really do what we’re supposed to be doing, and what I feel like we’re doing is trying to keep everybody as oriented to life and having our meals and [being] more like a family environment, and you can’t really have that with a whole lot of sickness in a house.”

Informal codes as well as regulations guided policy, especially in the two small homes. When questioned about the criteria for admission, the owner of Sleepy Hollow stated: “They are supposed to be ambulatory, to act in case of emergency.” She then added a personal caveat: “We don’t want anybody that don’t blend in with the other residents. That’s one of the main things we are looking for.” In the closer quarters of a small home, particularly when the owner lived in the facility, personality and cultural similarity helped determine who was admitted and retained. Even at Park Place, whether residents “fit in” socially (i.e., their behavior did not differ overtly from the norm) did influence transfers to the dementia unit there. Several residents were moved from assisted living to the dementia unit when other residents began to ostracize them.

Although Georgia has neither an assisted living licensing category nor a philosophy promoting aging in place, facility personnel may obtain a waiver from certain care requirements that limit residents’ stays. This process was used at two study homes. The owner of Sleepy Hollow received a waiver to pulverize and administer medications to the one resident with dementia. Park Place administrators regularly obtained waivers for hospice care, even though the staff RN pointed out that the
rigor of the process limited its usefulness: “The state requires that we get a waiver when we have a hospice [resident], but by the time we have a waiver, the person is no longer with us. It takes forever to get one. You fill out about 20 pages.” The director of Oak Manor indicated facility management was open to using the process, but, in her view, liability risks were a consideration: “You have a waiver to do it [administer insulin], but, God forbid, [if] something happens, you’re liable.”

Competition in the AL market affected admission and retention in each home. The retention philosophy at Park Place was developed largely to secure a marketing niche among other high-end facilities, and the facility’s ongoing waiting list verified the success of this strategy. Oak Manor, which sought the more affluent African American market and was unique in the community when it opened, was only one third full at the start of the study and still had vacancies at the end. The other homes competed with newer homes in their areas, but the availability of other community options facilitated discharge of unwanted residents. All of the residents leaving Camellia Court went either to the adjacent nursing home owned by the same corporation or to nearby ALFs, and those discharged from Victorian Manor also found placement in the local community.

Financial resources, staffing, and services.—The source, level, and distribution of a facility’s financial resources were critical, primarily because they determined staffing and services, in large part the basis of admission and retention policies and practices for managing resident decline. A facility’s overall resident profile and resident census at various points in time also played a role.

Georgia regulations require that ALFs maintain staffing levels adequate to protect the health, safety, and welfare of the residents, with a minimum staff-to-resident ratio of 1:15 in the daytime and 1:25 at night. Staffing in the three larger homes tended to follow the minimum requirements. Although ratios were higher in the small homes where residents were fewer (i.e., fewer than 15), staff duties were more comprehensive—including cooking and household tasks in addition to resident care—and typically were carried out by one person. At Camellia Court, care staff members also served meals and performed cleaning and laundry duties. Care staff workers at Park Place and Oak Manor had meal service duties, but their primary focus was resident care.

At Oak Manor and Park Place, fees were high and commensurate with accommodations and services. Suites at Park Place ranged from $2300 to $4000 per month. ADL care was an additional $35 per day for the highest level, and the per-diem cost of incontinence products was $15.50. Transportation to the doctor also was extra: $20 per round trip plus $12 per hour for accompaniment. Although living at Oak Manor was slightly less costly, fees were based on a similar “à la carte” pricing system, which allowed these homes, at least in theory, to balance the care need “demand” with staffing “supply.” The strategy at Park Place was to hire extra part-time staff for mornings when care needs were highest, “to get them up and get them showered.” Fees at Oak Manor were lower than in other homes owned by the same corporation with majority Caucasian clientele, because, according to a corporate representative, “assisted living is very new to the African American community.”

In homes catering to a less affluent clientele, where fees were lower and not tied to services, the strategy of increasing numbers of staff members to meet care needs was not possible. When Red, a Sleepy Hollow resident, declined to the point that he needed total ADL care, his fee, as well as staffing resources, remained the same. What changed was the burden of care on the two primary caregivers: the owner and her mother. At Victorian Lane and Camellia Court, heavy ADL needs, particularly incontinence care, typically led to discharge. When this strategy led to a drop in the census at Victorian Lane to only three residents, the owner put all workers on unpaid leave and moved into the home to care for the remaining residents herself. At this point, she retained a resident with needs beyond those typically allowed.

In Georgia, Medicaid reimbursement in ALFs is available only through the Medicaid Home and Community-Based Services (HCBS) 1915 (c) waiver. Only 19% of these funds are allocated to ALFs, and only facilities with 15 or fewer beds are eligible. Reimbursement rates are low, approximately $14 per day for homes with 6 or fewer beds and $31 per day for homes with 7–15 beds. Although both small homes received Medicaid reimbursement for a portion of residents, and participation afforded a steady source of residents and fees, program participation did have drawbacks. At Sleepy Hollow, where the Medicaid reimbursement rate was significantly lower than the private-pay monthly fee ($870 versus $1200), the owner tried to maintain “a ratio of four private pays to two Medicaid.” Waiver clients were more profitable at Victorian Lane because of its larger capacity, but the owner disliked her loss of control over admissions: “If Medicaid gets involved, you have to take them whether or not they will be a good person in the home.”

Although care personnel in these homes were not allowed by regulation to provide skilled nursing or medical care, each facility had a significant role in residents’ health care and health promotion—both central to managing resident decline. These roles entailed direct provision of services and facilitation of access to other health care providers and included medication management, consulting with physicians and pharmacies, monitoring conditions and treatment regimens, responding to health crises, transportation to medical appointments, and arranging for home health care.

In the two small homes, the owners took most residents to appointments and stayed with those who needed help, increasing their own familiarity with residents’ conditions and need for follow-up care. Both also had developed long-standing relationships with the local physicians who attended their residents. On occasion, the physician tending to Sleepy Hollow residents made house calls. At Oak Manor, transportation was available only on specific days and on a first-come, first-served basis, and no staff members were free to accompany residents. As a result, residents sometimes missed appointments or returned lacking information essential to their care.

Assessment and monitoring of residents’ health status and care needs were important components of each home’s care role. Typically, it was ongoing and took place during everyday interactions. Both Oak Manor and Park Place conducted quarterly resident assessments, and Park Place caregivers also provided monthly “wellness” exams to check residents’ weight and vital signs. The owner of Sleepy Hollow kept a daily
“diary” of changes in residents’ conditions. Because of constant contact with fewer residents and greater continuity, care providers in the small homes tended to know residents’ routines more intimately. At the larger homes, where residents not receiving ADL care had minimal daily contact with staff members, problems sometimes were overlooked. Several days went by before caregivers at Oak Manor noticed significant swelling of a resident’s ankles because of her failure to take a prescribed diuretic. A staff person at this home noted that “becoming compatible” with a resident was necessary to be able to “pick up on their needs.” Such compatibility was elusive in the two larger, purpose-built ALFs where staff turnover was high, residents’ medical needs more complex, and, in some cases, contact was limited.

The education and training of facility workers affected their ability to monitor and respond to disease signs and symptoms and perform tasks such as insulin injections and blood sugar monitoring as well as their general understanding of health conditions. Georgia regulations require AL staff to have basic first aid, CPR, and 16 hr of continuing education annually, but facilities are given considerable latitude in fulfilling these requirements. Though facilities are not required to have skilled personnel available or on-site, both Park Place and Oak Manor had at least one professional staff person (RN or LPN) on duty in the daytime. Other staff members at these two ALFs, on the whole, had more training and formal education than workers in the other homes. For example, Oak Manor staff members were specially trained to manage the 14 diabetic residents, but at Victorian Manor, where both caregivers and residents were less educated, a diabetic resident was discharged.

Access to community health care resources affected facility management of resident decline. Each home utilized temporary skilled or rehabilitative services from home health agencies. At Oak Manor, one agency provided daily monitoring and medication administration to insulin-dependent diabetic residents for a portion of the study year. The two small homes received bimonthly RN visits through the HCBS waiver program. These RNs monitored participating residents and provided health information, training, and assistance with record keeping. Both Oak Manor and Park Place had formal relationships with a university geriatric hospital, which gave staff members regular access to knowledgeable professionals for consultations about resident care and was available for resident evaluation and treatment. Oak Manor arranged for one resident to receive inpatient treatment for Valium addiction and for several others to attend outpatient therapy to treat depression. Each home had a hospital with emergency care and physicians nearby, although only general practitioners were available in Sleepy Hollow’s rural community, contributing in two cases to delays in illness diagnosis.

Managing resident decline also involved health promotion, and each home had strategies to maintain and improve residents’ physical and mental health. The three larger homes had planned activities, including regular exercise sessions and educational programs. Two events at Oak Manor, a half-day “healthy eating” program and a physician presentation on urinary incontinence, were both effective in changing some residents’ behaviors. Such events reflected the corporate philosophy, which, as stated by the staff RN, equated personal care with “preventive care, just seeing someone able to stay healthy as long as possible.” Informal health promotion was ongoing in all homes through encouragement of beneficial behaviors such as staying active, curtailing smoking, drinking water, and eating healthily.

**Physical environment.—**The physical environment affected management of decline in each home, in some more directly than others. Regulations required homes to have grab bars and nonskid surfaces in bath areas and secure handrails on stairways and ramps, but the two purpose-built ALFs were designed to accommodate resident disability and decline. Both had handrails in hallways, were wheelchair accessible, and had emergency call devices in all bed- and bathrooms. Camellia Court and Victorian Lane, both older and designed for other purposes, had some resident rooms on the second floor and other areas with steps. In addition, bathrooms were small, making it difficult to maneuver with a walker. Neither home admitted residents in wheelchairs, and inaccessibility was a key factor in resident discharge.

The front doors in all homes remained unlocked, in large part to preserve the homelike nature. As the owner of Victorian Lane stated, “This isn’t a jail. It’s a home.” This practice, however, increased opportunities for wanderers to exit, and in each of the large homes, residents were discharged or transferred to the dementia unit because of exiting. Monitoring fewer residents in the small homes proved more manageable.

Opportunities for privacy also affected aging in place. The private suites at Park Place facilitated retention of residents with hospice services. On the other hand, retaining Wilson, a Sleepy Hollow resident with a number of offensive habits (e.g., blowing his nose on his clothes), was even more problematic because he had to share his living space.

**Resident Factors**

**Health status and strategies.—**Residents’ health status and conditions had obvious effects on the management of decline and their ability to age in place. Only four residents improved in function and were able to move out. Three of these were individuals who had moved in after an illness or health crisis. For most residents, some decline was inevitable, although the rate of decline and the slope of the trajectory were not. Much depended on the idiosyncrasies of the disease and the capacity of the facility and others to provide care. Also of unquestionable influence was the level of function at admission. As the Park Place director admitted, “The first year we had residents who were very, very frail, and, of course, they waited too long to make their decision [to move in]. So they were not here very long.” Lily, who had lived at Camellia Court for 16 years, moved in when she was relatively independent and young (64 years old). Her discharge resulted from incontinence, kleptomania, and, ultimately, a fall breaking her ankle. A resident’s particular condition also influenced the ability to age in place. Slightly over one third of discharges were the result of confused, disruptive, or risky behaviors related to dementia or mental illness. Wanderers typically were dealt with speedily.

Residents’ attitudes, knowledge, and behaviors related to health promotion and treatment compliance were additional influences on their abilities to manage decline and age in place. Millie, a Sleepy Hollow resident, explained her strategy: “Here,
I take my medicines, and I eat right. I do what [my doctor] tells me to do because I don’t want to get down like I did before.” Each home had residents who made an effort to follow special diets, take medications as prescribed, and stay active, as well as others who continued to smoke and eat unhealthy foods. Frank, an Oak Manor resident with diabetes and congestive heart failure, was well informed about his condition and pro-active in treatment. He ordered and managed his medications, kept up with doctor’s visits and lab tests to regulate coumadin doses, and carefully followed prescribed regimens such as elevating his legs and wearing support hose. Despite the seriousness of his condition, two hospital admissions, and a lengthy nursing home stay, Frank remained in the home. Although such diligence was not possible for many residents owing, for example, to lack of knowledge or dementia, lesser roles were significant in decline management.

Managing decline for many residents included continuing to take care of their personal needs as best they could. Carrying out tasks such as basic ADLs, medication management, and laundry allowed some residents to exercise their value for independence, enhance function, and avoid additional fees and care burden to facility caregivers.

**Family support.**—In all homes, support from families, mostly daughters, was a key component of the management of resident decline and often tipped the balance between retention and discharge. One daughter came nightly to Camellia Court to help her mother get ready for bed. Another visited Oak Manor each morning to assist with bathing and dressing, telephoned facility workers later to be sure her mother was at meals, and took her to dialysis three times weekly when her kidneys began to fail. Other relatives paid bills, managed medications, monitored conditions and care, encouraged compliance, and provided assistive devices. Many offered critical emotional sustenance. Such support extended residents’ AL tenure and maybe their lives. As one Sleepy Hollow resident said, “They [my family] are the reason I am alive.” Support from spouses enabled ladder partners to stretch their stays, and at Oak Manor, the mutual assistance of two sisters—one visually impaired and the other wheelchair bound—had a similar effect.

**Other relationships.**—Relationships between residents and providers also affected management of decline, retention, and, in some cases, admission. Both past and present bonds were important. Although influence seemed greater in smaller homes and communities because of closer contact and long-standing ties (as well as the absence of corporate control), the reality of aging in place, in fact, contributed to building valuable connections in all homes. Red stayed longer at Sleepy Hollow because of the owners’ attachment to him, and Wilson would not have been admitted or his behavior tolerated without the owner’s life-long friendship with his son or the feeling among residents that he was “family.” Fees were reduced and discharge delayed for a Camellia Court resident because her daughter had “grown up with” the director. Support from other residents helped compensate for decline. At Sleepy Hollow, two residents “watched over” the resident with dementia to keep her from wandering from the yard, and a Park Place resident awakened her confused friend of 3 years every morning to make sure she went to meals.

**Financial resources.**—Financial resources were a key factor in residents’ ability to age in place. Five of the 43 residents who left the study homes did so primarily because of lack of money. For several others, difficulty in paying fees was a contributing factor. All lived in the large homes where Medicaid reimbursement was unavailable. Residents ran out of money over time even when fees remained stable, but such departures usually also were related to functional decline and the corresponding higher care fees or to across-the-board increases. Residents who refused to accept care deemed necessary by the facility were subject to discharge. The director at Oak Manor named “denial [of need for additional care] and money” as the biggest barriers to aging in place. Although the majority of Oak Manor residents had been successful professionals, their status as African Americans had limited their lifetime economic level. The three residents who left this home for financial reasons relocated to a neighboring all African American ALF (opened 1 year after Oak Manor) where fees were several hundred dollars per month lower. The one resident leaving Park Place because of inadequate funds also was African American. Fiscal problems were less common at Park Place, where most residents and their families were more affluent. The home, however, had been open only 3 years, and the director indicated that as residents age in place, money, or lack of it, likely will play a bigger role. Long-term care insurance allowed some residents at both of the high-end homes to extend their stays, as did the Medicaid reimbursement available to certain residents in the small homes.

**Attitudes toward assisted living.**—Only five residents moved out of these ALFs because of dissatisfaction with services or simply with being in an ALF: one from Oak Manor and four from Park Place. Most residents, once settled, wanted to stay. They appreciated care and security, and some felt the pull of new social bonds. Millie looked upon Sleepy Hollow as home and its owners as family: “They are like our kids, but they take care of us. I praise God everyday that I get to be here.” Alice said of Oak Manor, “I couldn’t be happier anywhere else.” Even those less satisfied preferred staying to the option of nursing home placement. Millie expressed this common fear: “If the Lord knows I am going to get worse, I hope He takes me on from here so I don’t have to go to the nursing home.” Families, too, were happier, and less guilty, if residents could avoid this alternative. These attitudes influenced some residents and families to work harder to manage decline or even mask its existence.

**Outcomes of Aging in Place**

Aging in place had both positive and negative outcomes. On the positive side, most residents were satisfied with the homes and the care they received and preferred staying to the alternative of nursing home placement or even moving to another ALF. By staying, they avoided the stress of leaving a familiar place and adapting to one unknown, and some developed meaningful roles and relationships. Facilities benefited from full beds and avoided discharge and new admission costs.

But keeping residents as they declined also had negative outcomes—for residents and for facilities. When care needs were especially high, some residents experienced physical and
social neglect. At Park Place, Paul’s routine cries of “Somebody, please help me” revealed a need for emotional care. Providers, too, suffered harmful effects. Sleepy Hollow's owner registered the physical strain of Red’s extended stay: “As much as I loved Red, I won’t take anyone else who needs that level of care. It was just too much.” And her mother described the emotional stress of his death: “When I worked in a nursing home, it was so big, and we never really got close to nobody, so when they died, it didn’t hurt so bad. But, law’, I’ve been with this man everyday. Why, I knewed him as good as anybody in my family. He was my family.”

Keeping very frail or confused residents also altered the physical and social environment, sometimes affronting or creating barriers for more functional residents. One Park Place resident said of Paul, “I just feel this isn’t the place for him. It doesn’t interfere with the attention I am getting. It’s maybe not quite the atmosphere I expected.” Increased wheelchair use in this home also made it difficult for residents to maneuver in common spaces and increased the “institutional” look of the facility.

Managing Decline

This research indicates that the cornerstone of aging in place in ALFs is the managing of resident decline. Most residents entered ALFs because of decline related to chronic disease, and staying in this setting hinged on the capacity of both residents and facilities to manage further decline. The capacity to manage decline was influenced by multiple interactive, and sometimes fluctuating, community, facility, and resident factors. Also central to aging in place and managing decline was the “fit” between the resident’s and the facility’s capacity to manage decline. The resident–facility fit was both an outcome of decline management and a factor influencing the process. Figure 1 depicts the action and interaction of factors in the management of resident decline.

Managing decline was approached in two ways: (a) preventing decline and (b) responding to decline. Strategies to prevent decline primarily involved health promotion (e.g., education of residents and staff caregivers, exercise, nutrition) and adherence to treatment regimens (e.g., medication management, dietary compliance). Strategies for responding to decline included balancing needs with resources, overextending resources to meet needs, and acceptance of the fact that some residents’ needs will be unmet. Balancing needs with resources was the principal response to decline. For example, an increase in a resident’s need typically resulted in the facility increasing the resident’s fees and hiring additional workers, sending the resident temporarily to a skilled facility, or discharging the resident. Resident and family strategies included paying for additional services, seeking further medical treatment, leaving voluntarily, or expanding the family’s care role. In other situations, when balancing was not possible or acceptable, both facilities and residents chose the alternative strategies of overextending resources or accepting unmet resident needs. These alternative strategies created risk for both residents and facilities. Staff and family members who increased care experienced stress. Residents who refused additional services or masked decline experienced unmet needs or were discharged. But all types of strategies had risk potential. Treatment adherence (e.g., purchasing medications and taking them as prescribed) could stretch residents’ financial resources. Discharging heavy-care residents to create balance with facility resources could lead to reduced census and facility financial strain. Assessment of potential risk guided selection of resident and provider strategies for managing decline. Resident and facility risk, thus, were both intervening conditions and consequences of the process of managing decline. Although each of these ALFs carried out risk management, none utilized formal written agreements with residents or families.

Discussion

This research explored the process of aging in place in assisted living and the factors that influence this phenomenon in a small sample of ALFs. The ability of residents to remain in these ALFs was principally a function of the “fit” between the capacity of both residents and facilities to manage decline. Although some residents did improve in function and some even returned home, most residents continued on a pathway of inevitable decline.

Multiple community, facility, and resident factors influenced the capacity of residents and facilities to manage decline. At the community level, though regulations set the parameters for admission and discharge, as found in other research (Hawes et al., 1999), only rarely were they critical to these decisions. Medicaid reimbursement in small homes clearly helped fill beds, gave some residents access, and extended the stay of others, but, owing to low reimbursement levels and limited program funding, the role of this factor in supporting aging in place is likely to remain minimal in Georgia. As in many other states (Mollica, 2002), the power of the nursing home industry to influence state long-term care policy continues to impede passage of legislation promoting aging in place and reallocation of Medicaid dollars. Community health care resources (e.g., physicians and home health care agencies) were an integral component of each home’s capacity to care for residents over time.

The effect of community factors was influenced by intervening conditions at the facility level, such as a facility’s use of health care resources or an owner’s strategy regarding waiver clients. Factors at the facility level interacted. Admission and retention policies were influenced by a facility’s size, age, ownership, design, fees, and staffing resources. The interplay of factors was dynamic. Together such factors helped determine what Bernard and colleagues (2001) have referred to as a facility’s “aging-in-place capacity.”

Both community and facility features affected the operation of resident factors. Medicaid payments stretched residents’ finances, and community long-term care resources influenced their options for alternative placements. A facility’s size influenced personal relationships, and its health care services affected residents’ functional status. Resident factors also interacted and influenced factors in the facility. The action and interaction of resident factors suggest that residents, as well as facilities, have an “aging-in-place capacity.”

These findings support the research of Bernard and colleagues (2001) explicating the role of community-, facility-, and individual-level factors in AL residents’ ability to age in place. Additionally, our research extends the explanatory power of their model by illuminating how and why various factors operate as they do both within and between levels. The
increased understanding of the aging-in-place process and of the effect of causal and intervening conditions also suggests that the interplay of community-, facility-, and individual-level factors is even more complex and dynamic than depicted by their model. Our findings also point out the importance of factors not addressed by Bernard and colleagues, particularly at the individual level, such as residents' personal relationships and attitudes and their own strategies for managing decline.

Residents and facilities employed two types of strategies to manage decline: those aimed at preventing further decline and those focusing on response to decline. Strategy selection was based on each resident’s and facility’s capacity to manage decline and the fit between the two. In addition, when choosing strategies, residents and facilities weighed the amount of risk the decision might incur and the degree of risk, if any, that was acceptable. Managing decline thus often became a question of managing risk.

Other research has found risk management to be a key element of aging in place (Kane & Wilson, 2001). Carder (2002) describes two kinds of risk: risks to residents’ health and safety and risks to operating the ALF. Resident risks include risks to an individual because of her or his own behavior as well as risks from other residents. Provider risks involve customary liability concerns regarding residents’ risky behaviors and risks associated with balancing occupancy goals with a desirable level of resident impairment. Frank (2002) notes that most residents hope to stay a long time yet do not want to associate with more frail residents, including those with dementia. In our study, resident and facility risk influenced how both groups managed decline.

These findings support research in other AL (Ball et al., 2000, in press) and home care (Ball & Whittington, 1995; Gignac, Cott, & Bradley, 2000) settings, demonstrating how impaired elders developed strategies to compensate for disability and optimize function to enhance independence and stay in place. Other studies also have highlighted the role of families in keeping residents in their own homes (Silverstone & Horowitz, 1993) as well as in ALFs (Ball et al., 2000).

In their study of chronic illness, Strauss and Glaser (1975) outline a framework for living with chronic disease that supports our model of decline management in ALFs. The framework presents chronic illness as follows either certain
or uncertain trajectories and as having key problems that one must develop strategies to handle. Strategies determine important consequences, and many call for assistance from agents who act in various capacities: rescuing, protecting, helping, and controlling. These authors also note that coping with key problems often required organizational arrangements, essentially coordination of agents’ efforts. Our findings point out the importance of the coordination of efforts in this task—not only of facility and family agents but of residents themselves.

Our findings regarding resident–facility fit corroborate the work of others (Bernard et al., 2001; Heumann & Boldy, 1993; Lawton, 1980; Moos & Lemke, 1994) emphasizing the importance of person–environment fit in AL residents’ ability to age in place. They underscore the need to view the environment broadly—in terms of both the physical and social dimensions and the resident, facility, and community factors. Findings further highlight the need for prospective residents to be well informed about their own needs and the facility’s capacity to meet them. Facilities also should provide comprehensive information about their philosophy of care and retention policies as well as the specific services and amenities offered.

Finally, for most AL residents and their families, aging in place is an appealing goal. Although avoiding nursing home placement may be a significant reason for this pursuit, we have found here and in earlier research (Ball et al., 2000), as others have (Namazi, Eckert, Rosner, & Lyon, 1991), that the assisted living setting can provide meaning to residents’ lives, and it even can assume the characteristics of home. Rowles (1993) argues that as society becomes increasingly mobile, technological, and global, both personal and societal images of the relationship between aging and place are evolving and taking on new forms. That is, the role of place in personal images of aging is changing, as is society’s image of the meaning of aging in place. These changes increase the potential for a transferability of a sense of place. For aging in place to be most beneficial, AL providers must strive to develop programs that build on that potential. Such programs would enable older persons to hold on to their former identities so that, as Rowles cautions, separation from place does not become separation from self.

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