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ADMINISTRATORS IN ASSISTED LIVING: WHO THEY ARE AND WHAT THEY DO

by

AILIE M. GLOVER

Under the Direction of Mary M. Ball

ABSTRACT

The assisted living industry is predicted to experience considerable growth due to the simultaneous aging of the baby boom generation and their subsequent need for long-term care. This study investigates individuals' pathways to administration in assisted living and the ways in which assisted living administrators define and carry out their roles. The study contributes to the understanding of the knowledge, skills, and personal traits needed by those who assume these vital leadership roles in an industry poised to care for the bourgeoning population of older adults. The sample for this study is 44 administrators who work in a random sample of 45 assisted living facilities in Georgia. Qualitative methods were used to analyze the data. The data revealed that multiple multi-level factors not only facilitate an administrator's pathway to AL administration, but these factors also help to shape how an administrator experiences his or her role within an ALF.

INDEX WORDS: Assisted living, Administrator, Role, Pathway, Education

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AILIE M. GLOVER

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2009

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2009

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August 2009

To Ida and Willard Long & Jean and Leslie Olson

ACKNOWLEDGEMENTS

I am extraordinarily grateful for the wonderful advice and support I received from my talented thesis committee, Dr. Mary Ball, Dr. Karen Giber, and Dr. Candace Kemp. They all went above and beyond to help me finish this thesis and I am very thankful for their help.

I want to specifically acknowledge Dr. Mary Ball, the chair of my committee, who worked endlessly – days, nights, weekends, even while on vacation – on this project with me. I learned so much about writing and research from Mary and I am truly appreciative of her unwavering patience and encouragement.

I would like to express special thanks to my wonderful husband, Bryan, for being so incredibly supportive throughout this entire graduate school experience. Of course, a big thank you goes to Peanut, my constant companion, who was by my side from page one.

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CHAPTER I

CONCEPTUAL FRAMEWORK

Introduction

The demographics of the United States are on the verge of profound change. The aging of the baby boom generation will accelerate the growth of the number of older adults in the country, resulting in what some refer to as the “graying of America” (Estes, 2001, p. 140). Today, 12.4% of the U.S. population is 65 years old or older ("U.S. Department of Health and Human Services: A statistical profile of older Americans," 2008). This percentage will increase to over 20% by the year 2030 (Cahan & Lancashire, 2008). The baby boom cohort is unique because they, unlike generations past, experienced great gains in health and financial security which will subsequently extend their longevity. Accordingly, the population of the oldest old (those aged 85+) is expected to nearly double to over 8.9 million by the year 2030 (DHHS, 2008).

Despite these statistics, older adults are not necessarily living longer with improved health. As Estes (2001) notes, “a longer life does not inevitably mean a healthier life” (p. 160). The increasing numbers of older adults in our country will place tremendous responsibility on federal and local budgets and on health, housing, and social services. The long-term care (LTC) sector will be a major component of the projected cost increases to governments and families alike (Estes, 2001). Assisted living facilities (ALFs), in particular, are expected to experience considerable growth because the current and future population of older adults will likely have a greater demand for assisted living’s (AL’s) premise: privacy and independence combined with various forms of social and recreational options in a personal care setting (Hawes, Phillips, Rose, Holan, & Sherman, 2003; Utz, 2003).

ALFs are currently the most rapidly expanding type of residential care setting for older persons in the country; the number of ALFs is expected to nearly double over the next twenty years ("ALFA: Overview of assisted living," 2009; Zimmerman et al., 2005). In light of these statistics, it is important to consider AL's current organizational and managerial capacities to determine whether this particular industry is prepared to care for not only the burgeoning population of older adults, but also a population of older adults who have increased impairment levels and comorbidity rates (Golant, 2008) .

Research suggests that management practices within an organization have the capacity to influence organizational culture and commitment, which is predictive of the quality of care provided to residents (Anderson, Corazzini, & McDaniel, 2004; Bishop et al., 2008; Castle, 2005; Eaton, 2000). Interestingly, there is little, if any, data about the individuals who occupy ALF management roles and what, exactly, their roles entail. The purpose of this study is to examine an AL administrator's work and educational background to better understand who is facilitating the care of an older adult within an AL community and what their job entails. Such information could help guide policy and practice regarding appropriate qualifications and training for those who occupy this key AL position.

Literature Review

History of Assisted Living

AL as commonly thought of today is extraordinarily young. Prior to 1965, the only residential settings for older adults with health problems were limited to philanthropically funded organizations commonly referred to as "homes for the aged" (Wilson, 2007, p. 8) or state-sponsored mental hospitals (Morgan, Eckert, & Lyon, 1995). The enactment of Medicare and

Medicaid helped to transform most of these homes for the aged into what can be considered today's version of a nursing home (Wilson, 2007).

The deinstitutionalization movement of the mid-1960's also helped transform the LTC industry. Advancements in the treatment of mental illness and the development of antidepressant drugs allowed for institutionalized adults who were previously deemed "mentally ill" to be discharged from state mental hospitals into the community (Morgan et al., 1995). The Community Mental Health Act (1965) funded outpatient care for this unique population (Morgan et al., 1995). Unfortunately, communities across the country found that they were not prepared to house the recently discharged residents. As a result, non-ambulatory individuals were moved into nursing homes and the younger, healthier older adults were placed in "board-and-care facilities" or became homeless (Morgan et al., 1995). Accordingly, board-and-care homes became increasingly prevalent across the country.

Morgan, Eckert, and Lyon (1995) define "board-and-care homes" as "nonmedical, community-based residences for unrelated dependent adults requiring in-home care and services" (p. 3). The term "board-and-care" is, thus, a generic term to describe a wide range of noninstitutionalized residential care arrangements. Other terms used to describe similar housing options include: "domiciliary care," "adult foster care," and "shared housing," among other labels (Morgan et al., 1995). Historically, these group residential care facilities had institutional features with between two to four residents sharing a bedroom and up to ten residents sharing a bathroom (Mollica, 2007).

The actual term "assisted living" was not introduced to the LTC repertoire until 1985 when it appeared in a pilot study proposal to the State of Oregon to care for twenty Medicaid recipients with impairments in a new, more flexible residential setting (Wilson, 2007). By 1991,

many residential communities were referring to themselves as “assisted living” and a nationwide study on LTC conducted by Hawes, Wildfire, and Lux (1995) included AL as an “explicit subset of residential care” (Wilson, 2007, p. 9). This new licensing category was desirable to consumers because it provided to residents what board-and-care facilities typically lacked: “a philosophy of care that emphasized privacy and the ability to have greater control over daily activities such as sleeping, eating, and bathing” (Mollica, 2007). Therefore, the commonly accepted philosophical principles of AL are: “to meet residents’ scheduled and unscheduled needs; promote independence, autonomy, dignity, and quality of life; and enable residents to age in place in a homelike environment” (Maas & Buckwalter, 2006, p. 14).

Today, AL is considered an alternative for older adults who need more assistance than is available in independent living communities, yet do not yet require the skilled care provided in nursing homes. Most ALFs provide or arrange for 24-hour staff, housekeeping, at least two meals per day, and some level of personal care (usually assistance with at least two activities of daily living (ADLs) (Hawes, Phillips, & Rose, 2000; Sikorska-Simmons & Wright, 2007). While the characteristics of ALF residents can vary, approximately two-thirds of AL residents are women, with the average age being 82 for women and 84 for men. The average AL resident has two or more chronic illnesses, and 60% of residents need assistance with one to three ADLs. The majority of AL residents need assistance with medication management, and two-fifths of residents consider themselves to be in fair or poor health (Hawes et al., 2000).

Assisted Living Regulation

Despite AL’s overarching philosophy of resident autonomy and privacy, its lack of federal regulation allows states to have many different interpretations about how ALFs operate and who they care for and for how long. In other words, definitions of AL vary across states and

it can be difficult to distinguish an ALF from other types of LTC facilities (Hawes et al., 2000; Mollica, 2007). Additionally, increased consumer demand for the AL model has prompted facilities to market themselves as “assisted living” even if they do not comply with the philosophy of privacy and autonomy upon which AL is based (Mollica, 2007).

The lack of a universal AL regulatory definition also means that there is substantial variation among ALFs regarding the size of the facility, ownership, resident characteristics and disability levels, staffing patterns, employee job expectations and training requirements, and overall administrative philosophy. It is important to explore these differences to fully understand how an AL administrator experiences his or her job.

The regulation and licensure of AL is variable by state and, as a result, provides a flexible operating environment for administrators. The lack of a one-size-fits-all approach to care (Mollica, 2007; Zimmerman et al., 2005) allows for a wide variety of licensing categories and terminology to describe ALFs. Although more than two-thirds of states use the licensure term “assisted living,” many states use different terminology (Polzer, 2008). The State of Georgia, for example, refers to ALFs as “personal care homes” in statute ("Secretary of State: Rules and regulations for personal care homes," 2008). Other states use “boarding home,” “basic care facility,” “community residence,” “enriched housing program,” or “home for the aged,” among other classifications (Polzer, 2008).

The approach states use in licensing ALFs is also variable. Mollica (2007) identified five licensing and regulatory models that are commonly used across the country. While these models are not mutually exclusive and the various approaches may be combined (Mollica, 2007), the models can help to exemplify how an AL administrator’s role can be highly influenced by state regulations. First, the “Institutional Model,” utilized by North Carolina (among other states),

prohibits individuals who have disabilities that require skilled care from residing in an ALF. However, some states who utilize this model have relaxed their standards to permit their residents to age in place by allowing skilled home health agencies to provide services within the facility for a limited period of time.

Second, the “Housing and Services Model” licenses and certifies ALFs to provide a wide variety of care services for persons with a diversity of needs – even those who are nursing home eligible. Under this model, AL providers may choose to offer skilled nursing services to their residents and set their own admission and retention policies. States that utilize this model have a specific licensing category for AL to distinguish it from board-and-care facilities.

Third, the “Service Model” licenses the service provider, which may be an outside agency or the residence itself. The rationale for this model is that focusing on the services that are delivered to the residents versus the physical structure of the facility will simplify regulatory standards. States that utilize this model, like Minnesota, can specify the type of building, apartment, or living space that can qualify as an ALF.

Fourth, the “Umbrella Model” allows one set of regulations to cover two or more kinds of housing or service arrangements. In other words, an ALF can be licensed to provide AL services as well as adult family care services. Fifth and last, some states have multiple licensing requirements for facilities within one single category. States with this type of model license facilities based on the characteristics of the residents they serve. Maryland, for example, categorizes residents based upon low, moderate, and high levels of need for care. Waivers are often granted to facilities who wish to serve residents outside their level of need licensing category to allow residents to age in place. The state of Georgia exemplifies the umbrella model.

While AL's regulatory flexibility may allow for high levels of consumer choice, it may also make it difficult for individuals to determine which kind of AL setting may best meet their current and future care needs (Mollica, 2007). The industry's lack of uniform regulations has also raised concerns about the quality of care provided to residents (Zimmerman et al., 2005). State regulators across the country made a concentrated effort to address these concerns between the year 2000 and 2002 by establishing more stringent policies on important issues such as staff training, record keeping, infection control, medication management, dietary standards, resident rights, emergency preparedness, and the regulation of dementia and Alzheimer's disease units (Polzer, 2008). Despite the good intentions that form the basis for the surge of new regulations, providers continue to believe that the new regulatory policies "stifle the variability that is fundamental to AL" (Zimmerman et al., 2005, p. S195). Accordingly, each state has a unique policy environment and consumer preferences for LTC that makes a universal definition and regulatory structure of AL problematic and unlikely (Mollica, 2007).

Facility Types and Characteristics

The definitional and regulatory variations of AL have resulted in multiple forms of AL, as evidenced in the LTC literature. The only existing national AL study, which examined 2,945 ALFs across the country with ten or more beds, has shed considerable light on this variation and the factors that influence ALF differences (Hawes, Rose, & Phillips, 1999). This study found that whether or not an administrator identified a facility as an ALF (an attitude expressed by 72% of administrators) was predictive of certain characteristics. Facilities self-described as ALFs generally had lower occupancy rates, had been in business for less time, and were more likely to offer apartments and private units, and admit and retain residents who used a wheelchair or

received help with locomotion, and tended to have higher monthly fees compared to facilities described in other terms.

This national study also elucidated the general structural variation of ALFs, which influenced other characteristics (Hawes et al., 1999). The majority of study facilities (55%) were free-standing (independent and unaffiliated with another entity). The remaining 45% were located on a campus which housed multiple levels of care or other care settings, such as a nursing home or an independent living community. Facilities embedded within a multi-level of care campus were more likely to have higher occupancy rates, higher monthly prices, private units and apartments, higher levels of service, higher staffing levels, and were more likely to both admit and retain residents who required higher levels of care. These facilities, however, did not have heavier-care residents than their free-standing ALF counterparts.

As previously mentioned, ALFs across the country often differ in their interpretation of the AL principles of privacy and autonomy. Hawes and colleagues (1999) classified an ALF as "high privacy" if at least 80% of the AL units were private (single-occupancy). Of the 2,945 facilities, 31% met the definition of "high privacy." Twenty-eight percent were classified as "minimal privacy," meaning that one or more rooms in the facility housed at least three residents. The remaining 41% of the facilities were classified as "low privacy."

Likewise, according to study criteria, an ALF is considered "high service" if it has a Registered Nurse (RN) on staff and provides nursing care as needed. Thirty-one percent of the facilities in the study met the "high service" criterion. Sixty-five percent of the ALFs provided low levels of service, but were willing to arrange for higher levels of service through an outside agency, and 5% provided minimal service (assistance with less than two ADLs). Thus, combining service and privacy, the most common type of ALF in the study was low privacy/low

service (59%), which, as Hawes and colleagues note, is quite similar to traditional board-and-care homes. Eighteen percent of the facilities were high privacy/low service; 12% were high service/low privacy; and 11% were high service/high privacy.

Aside from providing some much needed descriptions of ALFs nationwide, the data from this national study also offer some interesting insight into the realities of the AL industry and the difficulties associated with creating a private living environment that allows for both autonomy and the ability to age in place (Hawes et al., 1999). The authors conclude that while residents of ALFs had significantly more privacy and choice than residents of nursing homes or even board-and-care homes, many ALFs do *not* appear to provide environments that are consistent with the AL philosophy of privacy and autonomy. Furthermore, study findings show that ALF policies limit one's ability to age in place; the majority of residents in ALFs who experience severe declines in physical and cognitive health are typically discharged from the facility and placed in a skilled care environment.

Using data from their comprehensive-four-state (Florida, Maryland, New Jersey, and North Carolina) study ("The Collaborative Studies of Long-Term Care" or CS-LTC), Zimmerman, Sloane, and Eckert (2001) have classified ALFs into three models: 1) small; 2) new-model; and 3) traditional. This categorization is important in that it helps to define the size, character, and administrative structure of an ALF, which can have significant repercussions for the AL administrator's role and for facility policies. The data from the CS-LTC were derived from 2,078 residents in 193 diverse ALFs over a one-year period (Zimmerman et al., 2005).

Small facilities include those with fewer than sixteen beds, and they often resembled board-and-care homes. New-model facilities are purpose built, contain more than 16 beds, and have at least one of the following components: at least two monthly private pay rates; more than

20% of residents with disabilities requiring help with transferring; 25% of residents who are incontinent daily; and either a Registered Nurse (RN) or Licensed Practical Nurse (LPN) on duty at all times. Traditional facilities also have more than 16 beds, but do not meet New Model criteria (Zimmerman et al., 2005). The AL industry's growth in the mid-1990's produced a surge of the purpose-built/new-model facilities that developed out of the hospitality industry. New-model facilities cater mostly to affluent individuals, are privately financed, and can be selective in their admission policies (Leroi et al., 2006). These three facility types vary significantly by the type of residents they serve and the administrative structure by which they operate.

Administrative issues associated with facility size. A number of studies indicate that small ALFs are unique in many ways. One way concerns their resident populations. For example, small ALFs typically serve a more vulnerable adult population (Ball et al., 2005; Morgan et al., 1995; Sikorska-Simmons & Wright, 2007). Many of the residents in such facilities are poor, lack family and social support networks, and have life-long conditions such as mental illness, mental retardation, and other developmental disabilities (Ball et al., 2005; Leroi et al., 2006; Morgan et al., 1995). Further analysis from the CS-LTC showed that small facilities house a higher proportion of minorities (primarily African Americans), residents with lower educational attainment, residents who need greater assistance with ADLs (37% versus 15% in traditional facilities and 25% in new model facilities), and residents with more severe cognitive impairment (42% versus 23% in traditional facilities and 35% in new model facilities). Nearly half of residents in small facilities have behavioral impairments, compared with 37% of residents in traditional facilities and 39% of residents in new model facilities (Zimmerman et al., 2003).

Small ALFs are also unique in their administrative structure. They are typically less institutional than their larger counterparts and have lower fees, fewer private rooms, and fewer,

less-specialized staff (Ball et al., 2005; Morgan, Eckert, Gruber-Baldini, & Zimmerman, 2004). Small ALFs also tend to have a "hierarchical facility administration" (Morgan et al., 2004, p. 3) with staff/resident relationships that often seem familial. It is not uncommon for the owner to co-reside in the home and fulfill various duties ranging from direct care work to cooking meals for the residents, resulting in a "mom-and-pop" model of operation (Ball et al., 2005, p. *x*; Morgan et al., 2004, p. 3; Morgan et al., 1995, p. 5).

Ball and colleagues (Ball, Lepore, & Hollingsworth, forthcoming) examined variation in organizational/administrative structure in their study of 45 facilities in Georgia (upon which this secondary study is based). They found that small facilities typically had only one management position (a director) who, in one-third of the study facilities, was also the owner. One small facility also employed an activity director and, as such, had higher-fees. Ancillary personnel – staff other than direct care workers (DCWs) – were also limited in small facilities; of the 19 small facilities in the study, only eight had a cook and just four had a dedicated housekeeper.

The staffing dynamic changed in medium-sized facilities; all but one of the 13 medium facilities in the study had management positions in addition to the director. Ten facilities had an activity director; eight had dedicated housekeepers; and three had dietary aides.

All the large facilities had multiple management positions in addition to the administrator, including an activity director, food service director, marketing director, maintenance director, and business director. Large facilities also usually had a manager who supervised DCW and, if applicable, one for the dementia care unit (DCU). All of the large homes had housekeeping staff, but only one had dietary aides and one had a dedicated laundry person.

Similar to management roles, the number and type of DCW positions also were found to vary by facility size. The common labels for DCW positions included care aide, resident

assistant, personal care technician, care manager, and caregiver. Many facilities employ a medication technician (or “med tech”) which was often combined with the lead caregiver role. About 53% of the facility samples employed either an RN or LPN.

Some distinct policy issues also are associated with the operation of small ALFs. As previously mentioned, smaller facilities developed from board-and-care homes, which typically have very flexible admission criteria. As such, small ALFs have traditionally housed individuals with long standing mental illnesses and problem behaviors as well as individuals from a lower socioeconomic status (Leroi et al., 2006). However, small facilities are often less capable of handling residents’ problem behavior by virtue of their size alone; small ALFs do not have adequate space or staffing levels to insulate difficult residents from the rest of the group (Morgan et al., 1995). Accordingly, the CS-LTC data shows that small ALFs scored lower on “environmental quality, privacy, resident control, resident choice, tolerance for variant or problematic behaviors, availability of services, and medical care services” (Morgan et al., 2004, p. 13).

Resident privacy, autonomy, and choice are issues that affect all ALF types and have been extensively studied in the LTC literature (Ball et al., 2000; Morgan et al., 1995; Utz, 2003). These factors can be recognized in administrative policies about how meals are served, the strategies by which personal care and daily routines are facilitated, how resident social relationships are viewed, and how the ALF environment is structured (Ball et al., 2005). Ball and colleagues examined the barriers to resident autonomy utilizing Kane’s (1990) “four R’s” in LTC: routine, regulation, restricted capacity, and resource constraints (Ball et al., 2005).

Routines are commonplace in LTC, particularly in nursing homes, because a rigid schedule accommodates staff needs and improves efficiency. However, the medical model of

care, which emphasizes the use of routines and is often used in nursing facilities, has been shown to greatly restrict resident autonomy (Lidz, Fischer, & Arnold, 1992). Ball and colleagues (2005) found that routine affected the autonomy of residents in all six of the ALFs that participated in their study.

State regulations can also impact an ALF resident's autonomy. Ball and colleagues (2005) found that some facilities may use regulations as a way to justify certain policies, such as maintaining a chilly room temperature or the use of restraints. Regulation adherence can be variable in smaller facilities because there is less likelihood that they will get caught; most facilities are only inspected by state regulators or the LTC ombudsman program on an annual basis (Ball et al., 2005). Larger facilities, on the other hand, have greater numbers of residents and family members who are more likely to report regulation violations (Ball et al., 2005).

Policies which support a resident's restricted capacity (impairment) can also be difficult for administrators to implement and maintain. Individuals with cognitive impairment are often unable to express their needs and wishes and, thus, are forced to "acquiesce to authority figures" (Ball et al., 2005, p. 207). Furthermore, individuals with cognitive impairment may make choices that are incongruent with their health and safety. How the facility decides to accommodate residents' decisions are also variable; some facilities may seek strategic alternatives if a resident is pursuing a harmful decision, whereas other facilities may simply use sedating medication to solve the problem (Ball et al., 2005).

Lastly, resource constraints can have a profound impact on residents' autonomy – particularly in small ALF because they have lower fees and tend to serve low-income residents. As a result, small facilities are typically unable to offer amenities that allow for privacy and choice such as private bathrooms, recreational activities, meal choice, transportation, and

adequate staffing levels (Ball et al., 2005). Larger facilities are able to offer residents unique amenities that are well beyond the capacities of small ALFs, such as on-site banking, religious services and health and wellness centers. Larger resident populations also allow for greater resident control through the implementation of resident councils and resident-written newsletters (Morgan et al., 2004). As such, larger facilities elicited higher scores in the CS-LTC in its measure of services. Small ALFs are particularly affected by resource constraints. Ball and colleagues (2005) found, though, that all types of ALFs in their study struggled to adequately care for residents while still maintaining a profit.

It is important to note, however, that small ALFs did not fare worse on the CS-LTC in terms of "core" services such as meals, medications, personal care, and housekeeping (Morgan et al., 2004). Morgan and colleagues suggest that small ALFs are a very distinct and important component of the AL spectrum that is often looked at unfavorably when compared to its larger, new model counterpart. The qualitative component of the CS-LTC highlights some of the benefits of small ALFs that are overlooked by the quantitative scoring. For example, small ALFs emphasize interpersonal relationships, are more homelike and familial, and residents are less likely to feel isolated and lonely (Ball et al., 2005; Morgan et al., 2004). Furthermore, small facilities are beneficial for individuals with dementia because the physical environment is manageable. As such, small ALFs continue to be an important, lower-cost option within the ALF market.

Additional factors influencing facility variability. ALFs also vary by their funding source, ownership status, and location within a state (urban versus rural). While some studies (Konetzka, Stearns, Konrad, Magaziner, & Zimmerman, 2005; Weech-Maldonado, Shea, & Elmendorf, 2007) have researched these factors as a way to examine employee turnover and

staffing shortages in LTC, these dynamics also can help to further define an administrator's role within an ALF.

It is useful to identify the differences between for-profit (FP) ALFs and not-for-profit (NFP) ALFs because such statuses have implications for the administrator's role. Facilities that receive public money through Medicaid or SSI are expected to run a cost-effective operation. Not-for-profit facilities are under equal scrutiny because they are publicly subsidized through tax exemptions; NFP facilities have a responsibility to provide community benefits as a result of their tax-exempt status (Aaronson, Zinn, & Rosko, 1994). Hawes and colleagues found that the ALFs in their national study were almost equally likely to be operated by FP (49%) as by NFP (50%) entities; 1% of facilities in the study were jointly operated as both FP and NFP (Hawes et al., 2000).

Ullman (1987) (as cited by Aaronson et al., 1994) examined behavioral differences between FP and NFP nursing home administrators. Ullman proposed that "FP nursing home administrators have an incentive to maximize facility profits subject to minimum quality constraint. However, NFP nursing home administrators may pursue objectives that enhance personal prestige by increasing the quantity and quality of services of the facility" (p. 776). NFP administrators may accomplish this objective by increasing staffing levels, thus producing higher quality care. FP administrators, on the other hand, may view staff as simply a cost to be controlled (Aaronson et al., 1994). The authors further suggest that NFP status is associated with better resident care outcomes, likely due to its inclination for higher staffing levels.

Hawes and colleagues (2005) found in their study of rural ALFs that 85% of ALF residents resided in facilities in metropolitan environments, 15% lived in nonmetropolitan areas, and just 1% lived in facilities in counties with populations less than 2,500. Three specific issues

about rural ALFs are commonly reported in the LTC literature. First, there is a definite undersupply of ALFs in rural areas (Hawes et al., 2005; Weech-Maldonado et al., 2007). Second, ALFs in rural areas were typically "low service, low privacy" and were not in congruence with the philosophy of AL (Hawes et al., 2005). Third, rural ALFs were largely unaffordable for moderate-to lower-income older adults (Hawes et al., 2005; Weech-Maldonado et al., 2007). These three issues exemplify a unique operating environment for administrators and necessary source of focus for policymakers.

Assisted Living Administration

Aside from Allen's (1999) comprehensive book examining the AL administrator role, there has been scant research on this particular topic. Allen's data is restricted to a large facility, corporate model. Other research has focused primarily on small facilities or board-and-care homes. Therefore, there is a need to examine the administrator role in all facility types.

Profile of administrators. An examination of the characteristics of ALF administrators and their motivations for entering the LTC field would help to further define the administrator role. Morgan, Eckert, and Lyon (1995) examined the characteristics of small board-and-care home providers in two cities (Cleveland and Baltimore). They found that the small board-and-care home providers in their sample were mostly women (over 90%) whose demographic traits parallel those of individuals who are typically involved in caregiving work. The providers were, on average, in their 50's and most were minorities – 30% of the providers in Cleveland and over 69% of the providers in Baltimore were African American. Most of the providers had limited education, but had experience in other types of health care settings (mostly in nursing homes). This information advances knowledge of providers, but, such data are not available for other facility types in the literature.

Components of the role. The administrative process of an ALF begins with a governing body (Allen, 1999). The governing body is considered the designated person(s) legally responsible for the policies and procedures associated with the management and operation of the ALF (i.e. a Board of Directors for a NFP facility). The governing body appoints the administrator who is responsible for the day-to-day management of the facility (Allen, 1999).

Exploring basic concepts of management and business sheds light on the administrator role. Allen (1999) specifies certain components of the administrator's job, including: planning, organizing, staffing, directing, marketing, and budgeting. In larger ALFs, many these activities can be assigned to other levels of management (i.e. department heads) and only overseen by the administrator. Small ALF administrators typically are solely responsible for each of these functions. It is important to note, however, that many small ALF administrators may not fulfill these specified components of their job with as much forethought as Allen (1999) suggests. As Ball and colleagues (2005) found in their study of small ALFs, small providers are under extensive financial constraints and they typically do not have the resources to market their facility or consider certain staffing matters, such as benefits. Furthermore, a common criticism of small facility administrators has been their lack of training in areas such as bookkeeping, records management, and the interpretation and implementation of regulations (Morgan et al., 1995) As such, the administrator role is variable by facility size (Ball et al., 2005).

Allen (1999) notes that a plan – the establishment of the framework for all ALF activities – is essentially a statement of the organizational goals of the ALF and is thus an important component of an administrator's job. The ALF industry is rapidly changing and an administrator must be able to forecast industry trends and plan accordingly. Potential issues that also may be

pertinent in planning include changes in governmental regulations, local competition, and changes in the economy and housing markets.

Organizing is the administrator's first step to implementing a plan. This component entails a careful examination of the facility's budget, job descriptions, and materials so that decisions can be made based on available resources. Most ALF administrators organize based on some sort of theoretical framework, which may be a well thought-out process for some, yet, as noted above, more perfunctory for others (Allen, 1999).

Ensuring adequate staffing is a critically important component of an administrator's role within an ALF. The interactions between residents and staff – particularly DCW – can influence the residents' quality of life and satisfaction within the facility (Allen, 1999; Sikorska-Simmons, 2006). The decision on *how* to staff a facility depends upon multiple variables, such as the level of care required by the residents and the type of ALF (i.e. small, traditional, new model) (Allen, 1999). As in any organization, hiring the right person and subsequently retaining the employee can be one of the most difficult tasks for an administrator. This is particularly true for the LTC industry, in general, because DCWs are typically low-skill/low-wage employees (Ball et al., 2005). Small facilities are at a particular disadvantage because they typically cannot afford to pay staff more than minimum wage or offer benefits. As a result, the pool of quality personnel is limited (Morgan et al., 1995; Perkins, Ball, Whittington, & Combs, 2004). Further complicating staffing efforts is the fact that many DCWs lack experience, training, and education, resulting in various problems, such as difficulty reading medicine labels, substance abuse, mental illness, or incarceration (Perkins et al., 2004). Administrators are often forced to deal with problems of theft, drug abuse, and absenteeism (Perkins et al., 2004). As such, high rates of turnover persistently plague ALFs.

Ideally, an AL administrator must be able to communicate and direct his or her staff to implement the organization's established policies and procedures. Staff must be made aware of the facility's plan for issues ranging from fire safety to food preparation standards (Allen, 1999). The direction and communication of these ideals is influenced by the type of leadership style the administrator employs, which will be examined in greater detail later.

Despite the country's growing number of older adults and already long waiting lists for AL apartments, the influx of ALFs into the LTC market requires that an AL administrator consistently promote his or her facility to maintain occupancy rates. This task can be complicated because, as Hawes and colleagues (2000) noted, ALFs have difficulty allowing residents to age in place due to nursing home or hospital placement or death. Furthermore, ALFs must rely heavily on private paying residents due the limited availability of public reimbursement through the Medicaid program (Mollica, 2007). As such, ALFs are seeing their profit margins narrow, subsequently creating a significant need to keep rooms full (Allen, 1999).

An administrator is responsible for the entire financial operation of the ALF, which likely is one of the administrator's most important roles because a facility's overarching success depends on its ability to maintain a profit. The administrator must select and hire competent financial personnel, such as a bookkeeper, accountant, or business manager and have knowledge about these types of positions not only to successfully hire and supervise such people, but also to be able to assess their performance. The administrator may also have to understand complicated tax issues; corporately owned chain-facilities will often use individual facilities to balance cash flows and tax affairs of the corporation through the network of facilities. All in all, administrators must have a keen understanding of the entire budget process because they are responsible for the effective operation of the facility to not only the residents, but also to their families, to

employees, owners and stockholders, and the governing body. Any questions regarding the mismanagement of facility finances are directed immediately to the administrator (Allen, 1999).

Administrator management style. While Allen (1999) provides an in-depth examination of the tasks and responsibilities associated with an AL administrator's role, there is relatively little research on the management styles utilized by AL administrators. These data would provide an important perspective into the administrator job experience and even potentially help to explain why some administrators experience managerial success and others do not. A review of the literature on nursing home administrators and directors of nursing (DONs) can also provide an effective starting point for understanding these issues.

Allen (1999) suggests an effective leadership style for AL administrators called "Leadership By Walking Around" (LBWA) (p. 62). This style is useful because it allows the administrator to walk around the facility and personally observe staff, residents, families, and volunteers so they can evaluate first-hand how services are being rendered. Furthermore, the administrator can examine the integrity of the structure itself to ensure the facility is clean and in good repair.

Ball and colleagues (2005) examine an administrator's leadership style from another perspective in what they call a "provider's way" (p. 134). The provider's way refers to the management style by which the administrator operates the facility and cares for residents, and is shaped by the administrator's personal style and care ethic. For example, an administrator in one facility may be especially meticulous about the residents' appearance and may discourage staff from allowing resident self-care. Another administrator may adopt a more lenient philosophy and encourage resident self-care, resulting in residents wearing unmatched clothes with messy hair. The provider's way is particularly evident is small ALFs where the administrator has a more

substantial influence on resident care versus administrators in larger facilities where the corporate doctrine dictates how an administrator should manage the facility (Ball et al., 2005).

Another way administrators govern a facility is through a process of negotiating risk (Ball et al., 2005; Perkins et al., 2004). The process of negotiating risk is the way in which an administrator provides care to residents despite competing influences such as physical, emotional, and financial stress; heavy care and administrative responsibilities; low financial compensation; regulatory and licensing requirements; and inadequate support from residents' families and the wider community (Ball et al., 2005). Administrators are forced to devise creative strategies to manage residents' care needs while simultaneously maintaining their business, often at the threat of regulatory sanctions. Incidentally, this process can jeopardize both the residents' care and the business itself (Ball et al., 2005). Negotiating risk is particularly common in small ALFs because of their constant financial constraints. For example, an unusually high utility bill may force the facility to operate at a deficit, thus requiring the administrator to balance low revenues in other (potentially illicit) ways (Perkins et al., 2004).

Anderson, Corazzini, and McDaniel (2004) examined the dynamic between nursing home administrators' communication patterns and their effect on caregiver turnover. Perceptions of administrative climate and communication were gathered from 3,449 employees in 164 randomly sampled nursing homes in Texas. From these data, the authors revealed two "administrative climates" which occurred most frequently: reward and laissez-faire climates. Reward climates emphasize interaction between management and employees and provide merit based rewards. Laissez-faire climates, on the other hand, are unorganized and disputes are left unrecognized, and employee rewards are status-based (Anderson et al., 2004).

Interestingly, Anderson and colleagues (2004) found that caregiver (certified nursing assistants (CNAs) only) turnover was highest in perceived reward climates. They suggest that administrator concern for employee welfare and open feedback seen in reward climates may actually be seen by the CNAs as more "paternalistic" than supportive. Conversely, the CNAs in the laissez-faire climate may view the administration more positively because it seems more "hands off." Anderson and colleagues' findings also suggest that nursing home administrators have specific intentions of creating a particular type of administrative climate within a facility, but employee perceptions, reactions, and communication patterns ultimately help to shape the resulting climate.

Banaszak-Holl and Hines (1996) also examined employee outcomes of managerial strategies. They found that an employee's job satisfaction increases as the employee gains greater involvement in choosing work tasks. Furthermore, managerial emphasis on training and schedule flexibility were also associated with greater employee satisfaction. Despite the fact that greater employee autonomy improves employee satisfaction, it rarely occurs in LTC settings. Resident care plans are mostly created by an administrator and personal resident information is often not shared with employees. Furthermore, direct-care staff are frequently alone with residents, which requires the employee to take on considerable amounts of responsibility without clear authority and accountability (Stone & Yamada, 1998). This practice forces the employee to be caught in the middle of demands by his or her employer and the needs of the resident, which can create uncertainty, confusion, and ultimately employee burnout. Therefore, an additional managerial dilemma thus becomes how to enforce both formal rules and performance requirements for employees (Stone & Yamada, 1998).

Schein (1996) asserts a different perspective in his exploratory essay on organizational studies. He states that CEOs should utilize both reward (e.g. financial incentives) and control (e.g. rules and procedures) systems as a way to manage large numbers of people. Additionally, an administrator must be able to "minimize the human factor" (p. 238) by keeping subordinates at a distance and always recognizing that financial certainty is the most vital component of an organization. It is unclear if such business values are compatible with the field of long-term care. Many employees in LTC facilities are not participating in caregiving work for compensation alone. Research suggests that the altruistic return of caring for older adults is the primary motivating factor for caregivers' work (Feldman, 1993; Morgan et al., 1995). Furthermore, employees in LTC respond well to non-monetary rewards (i.e. autonomy, empowerment, "employee of the month" recognition)(Lepore, 2008; Stone & Yamada, 1998). Long-term care administrators therefore struggle between the philosophies of providing quality care for their residents and running a business where financial gain is the utmost concern, potentially sacrificing important staffing considerations such as higher pay and benefits and employee involvement in decision making.

Administrator education and training. States' regulations about training and education for AL administrators are as varied as the many definitions of AL. For the most part, states' education requirements may be outdated; they often reflect what might be needed for someone to manage small board-and-care-homes that were common before the increase in modern ALFs (Allen, 1999).

Despite the fact that training is a key component to quality assurance, AL administrators and other staff are often insufficiently trained to handle the growing social and medical needs of AL residents (Mollica, 2007). Mollica (2007) notes that very little training is required in ALFs:

> Three-quarters of unlicensed personnel were required to attend some type of pre-service training or orientation, most commonly lasting between 1 and 16 hours. Only 11% of the staff who received required training completed it prior to the start of work; the remainder received on-the-job training or a combination of pre-service and on-the-job training. In contrast, nursing homes aides are required to have a minimum of 75 hours training (10 days) and pass an exam before they can work on a unit providing direct personal care (p. 29).

As a result of both an administrator and employee's lack of training, a sizeable number of older adults are relocated from ALFs to nursing facilities, subsequently contradicting AL's principle to allow residents to age in place (Hawes et al., 1999; Maas & Buckwalter, 2006).

In the State of Georgia, an administrator must be at least 21 years old and receive work-related training within the first sixty days of employment in the facility ("Secretary of State: Rules and regulations for personal care homes," 2008). The State of Oregon, on the other hand, requires that administrators: 1) be at least 21 years old; 2) possess a high school diploma or equivalent; AND 3) have two years of professional or management experience in a health or social service field or program; OR 4) have a combination of experience or education; OR 5) possess an accredited Bachelor's Degree in a Health or Social Service field. Additionally, all administrators must also: 1) complete a state-approved training course of at least 40 hours; OR 2) complete a state-approved administrator training program that includes both a classroom training of less than 40 hours and a state-approved 40 hour internship with a state-approved administrator (Polzer, 2008).

Allen (1999) asserts that the education requirements of the AL administrator will be market driven, citing hospital administrators as an example. "Fifty years ago few hospital administrators held a master's degree in health care administration. Today, without at least a master's degree, one need not bother to get into the long line of applicants for the position of hospital administrator" (p. 123). Today, nursing home administrators are the only health care

administrators required to hold a license (Allen, 1999). It is still unknown if the AL industry will follow suit.

Administrator tenure. Castle (2005) investigated the correlation between the turnover of top managers and subsequent caregiver turnover in nursing homes. His analysis found that top management turnover is significantly associated with high nurse aide turnover. A 10% increase in top management turnover rates was associated with a 21% increase in nurse aide turnover rates. Furthermore, top management turnover rates in general are high, with percentages ranging from 20% to 50% annually (Castle, 2005).

Most research on staff turnover has focused solely on the caregivers because they are the front-line workers and provide the majority of resident care. Castle argues that management turnover not only has a "destabilizing influence within the facility" (p. 187), but it can also alter employees' commitment to the workplace and erode the quality of care provided. The longer tenure an administrator has within a facility, the better he or she can connect with staff and promote employee commitment (Anderson et al., 2004).

Further exacerbating the turnover problem is the fact that some front-line staff may choose to leave with a departing administrator to the new facility, or potentially see the leadership transition as a good time to also leave their position (Anderson et al., 2004). There is an increased burden of transition costs associated with both management and caregiver turnover that is also frequently reported in staffing literature (Castle, 2005; Kash, Castle, Naufal, & Hawes, 2006; Konetzka et al., 2005; Sikorska-Simmons, 2005). Singh and Schwab (2000) suggest possible interventions for this particular dilemma, such as hiring only top managers with a low turnover profile.

Training also has been shown to affect an administrator's tenure. Research suggests that top management professional development (training) is associated with a 45% likelihood of lower administrator turnover (Castle & Shugarman, 2005).

Research Aims

This review of the literature shows that there is little known about the personal characteristics, management styles, work history, education, motivations, attitudes, and training of ALF administrators, despite a growing consumer demand for this LTC model. This study will fill this gap in the literature. Establishing a knowledge base about administrators and their roles in a wide variety of AL settings can help to provide understanding of the qualities needed to assume these critical leadership roles.

An examination of an AL administrator's work and education background and attitudes about his or her job also will help to provide a better understanding of who is facilitating the care of an older adult within an AL community. It is important to consider AL's current organizational and managerial capacities to determine whether this particular industry is prepared to care for the burgeoning population of older adults in this country. This information could help guide policy and practice regarding appropriate qualifications and training for those who occupy this key position within the realm of LTC. My specific research aims are as follows:

1) To learn about individuals' pathways to AL administration;
    a. What are individuals' motives?
    b. What are individuals' educational backgrounds?
    c. What are individuals' work histories?
2) To understand how individual-, community-, and facility-level factors influence pathways to AL administration;

   a. How do individual factors (e.g., gender, race, age, education, family situation) influence pathways to AL administration?
   b. How do facility factors (e.g., size, hiring policies, ownership) influence pathways to AL administration?
   c. How do community factors (e.g., AL regulations, local economy) influence pathways to AL administration?

3) To learn how AL administrators define and experience their roles;
   a. How do they view their jobs?
   b. What tasks does their job entail?

4) To understand how individual-, community-, and facility-level factors shape how AL administrators define and experience their roles in the assisted living setting.
   a. How do individual factors (e.g., education, employment history, age) influence how administrators define and experience their role?
   b. How do facility factors (e.g., size, resources, ownership, resident profile) influence how administrators define and experience their role?
   c. How do community factors (e.g., AL regulations, local economy) influence how administrators define and experience their role?

CHAPTER II

RESEARCH METHODS

The Primary Study

This study is a secondary analysis of data from a larger study entitled "Job Satisfaction and Retention of Direct-Care Staff in Assisted Living," funded by a grant from the National Institute on Aging (R01 AG021183-03, Mary M. Ball, principal investigator). The goal of the larger study was to learn how ALFs could maximize job satisfaction and retention of direct-care staff. The three research aims were as follows:

1) To gain an understanding of the meaning of job satisfaction for direct-care staff in the ALF environment;
2) To better understand how individual, sociocultural, and environmental factors influence job satisfaction and retention of direct-care staff in ALFs and the relationship between these variables; and
3) To learn the strategies that direct-care, managerial, and administrative staff could develop to support job satisfaction and retention of direct-care staff in ALFs.

Research Sample

The facility sample used in this study included ALFs in the state of Georgia with 16 or more beds and located within 150 miles of the city of Atlanta. ALFs in Georgia are defined in statute as "personal care homes." In 2007, Georgia had 1,968 licensed personal care homes with 26,985 beds ("Georgia Long-Term Care Ombudsman Program - 2007 Annual Report," 2007). ALFs in Georgia are similar to ALFs in other states in terms of staffing levels, training requirements, job descriptions, and employee pay (Ball et al., 2005; Hawes et al., 2003). Characteristics of ALF residents in Georgia also resemble the national resident profile on the

levels of frailty, race, gender, and socioeconomic status (Ball et al., 2005). This resemblance improves the study's generalizability to ALFs nationwide.

The regulatory definition of AL in Georgia is broad and the facilities in this sample represent a wide range of sizes and types. As such, the facilities in this sample are consistent with many of the facility types described in the literature. While Zimmerman and colleagues (2001) refer to facility types as "small, traditional, or new model," the facilities in this study are classified as "small, medium, and large" because this sample includes only homes with 16 or more beds, which do not meet the "small" criteria as described by Zimmerman and colleagues (Ball & Perkins, forthcoming). However, the facilities in this sample do meet the classifications of facilities as outlined by Hawes and colleagues (1999).

Forty-five ALFs were selected as the study sample using stratified random sampling. Based on the study's research aims and questions, sample homes were stratified according to facility size and geographic area. This resulted in three categories by size: 16-25 beds; 26-50 beds; and 51+ beds. Stratifying by size helps to include facilities which differ in both ownership and resident characteristics. Homes were also stratified into three geographic areas to account for differences in local economies and in socioeconomic status, race, culture, and ethnicity of facility staff and residents.

Area 1, which is the most populous, includes 10 counties in metro Atlanta. Area 2 is located within 150 miles south, southwest, southeast, and east of Atlanta. Area 3 contains the rural mountain area of north Georgia and is located within 150 miles northeast, northwest, and north of Atlanta. Table 2.1 shows the distribution of sample homes by facility size and geographic locations.

Table 2.1 Distribution of Homes by Facility Size and Geographic Location

Size Location	Small 16-25 Beds	Medium 26-50 Beds	Large 51+ Beds	Total
Area 1	2	4	8	14
Area 2	6	4	4	14
Area 3	11	4	2	17
Total	19	12	14	45

Employee participants in the study included administrative and care staff. Administrators were selected based on their knowledge of overall facility operation and of policies and procedures regarding the hiring and management of direct care staff. Generally, one administrator was selected in each home. In the case of three facilities that were under one ownership, only one administrator was selected. In one large facility, two administrators were selected. The final sample of administrators totaled 44. Direct care staff selection varied according to interview type (either "Type 1" or "Type 2" interviews). Those participating in Type 1 interviews (N=370), which contains both open and closed-ended questions and a job satisfaction scale, were selected by stratified, random sampling according to shift and employment status (full time versus part time). In addition, 41 staff were selected for in-depth, qualitative interviews. Purposive sampling was used to choose individuals that represented conceptual dimensions relevant to the research questions. Eleven direct care staff participated in both types of interviews, yielding a final sample of 400.

Data Collection Methods

The primary method of data collection included: 1) face-to-face interviews with administrative and direct-care-staff, 2) limited participant observation and, 3) review of the facility's written policies and procedures related to staffing. Administrator interviews addressed the facility's organizational structure, policies, and procedures and the administrator's personal

characteristics, background experiences, and attitudes related to staffing. Interviews lasted about 1.5 hours and were recorded verbatim.

Relevant features and routines in the ALF setting were observed and recorded in extensive field notes. The researchers observed what was going on in the facility; who was involved; what people said; where, when, and how activities took place; and how participants reacted to the activities.

The Secondary Study

Research Sample and Data

This study utilized data from the in-depth interviews with 44 administrators, representing the 45 facilities as outlined in Table 2.1. In these interviews, administrators provide information about their employment and educational background, reasons for entering the LTC field, typical roles and responsibilities, and attitudes toward their jobs. Table 2.2 describes selected personal characteristics of the 44 administrators. These data show that the large majority of administrators are female (70%) and Caucasian (87%). Ninety-five percent have at least a high school education, and 45% have a college degree. Their years experience in LTC range from 3.9 to 22.4 with a mean of 13.2 and in AL from 2.5 to 14.9 with a mean of 8.7.

I also utilized facility data from the primary study, including the profiles and memos created for each home by the primary study's researchers, as well as data from the facility-level SPSS database. The SPSS database will provide descriptive information about the facilities (i.e. resident impairment levels, ownership, capacity). The 45 facilities represent a range in location, size, ownership, resources and fees, and resident and staff profiles, all factors that, based on the literature, I believe will have bearing on my research aims and questions. Table 2.3 shows selected facility characteristics by facility size. These data show that the majority of the facilities

in the sample are corporately owned (67%) and for-profit (87%) and located in urban environments (66%). Fees amongst the facility types ranged from $1,498 per month in small ALFs, to over $4,000 per month in large ALFs.

Table 2.2 Selected Demographic and Work Characteristics of AL Administrators (N=44)

Variable	%
Gender	
Female	70
Race	
Black	11
White	87
Other	2
Age (M)(± sd)	47 ± 10.86
Education	
Less than high school	5
High school diploma/GED	12
Trade school	5
Some college/Associates degree	33
College degree	22
Some post graduate	2
Graduate degree	21
Long-term care training	
CNA training	14
LPN	9
RN	17
AL administrator license	16
Employment history (years)	
LTC (M)(± sd)	13.2 ± 9.23
AL (M)(± sd)	8.7 ± 6.22
Facility (M)(± sd)	6.3 ± 6.17
Administrative experience (M)(± sd)	11.2 ± 8.46

Data Analysis

This study used a grounded theory approach to analyze the data (Strauss & Corbin, 1998). The advantages of using grounded theory are its systematical research procedures and its

Table 2.3 Facility Characteristics by Facility Size

	Small (N=18)	**Medium (N=13)**	**Large (N=14)**	**Total (N=45)**
Corporate (%)	50	92	79	67
For-profit (%)	78	77	93	87
Facility Tenure (years) (MD)	7.2	9.2	6	10.4
Urban (%)	56	77	100	66
Fee Range (M)	$1,498-1,983	$1,772-2,803	$2,097-4,037	$1,763-2,859
LPN/RN on Staff (%)	39	23	100	53

flexibility to address new findings and modify initial assumptions. The grounded theory approach involves two major procedures: coding and memoing.

Using the grounded theory approach, I analyzed the administrator interviews line by line and scrutinized the data for emergent categories based on my research questions. I grouped the emergent categories in an analytical process called open coding (Strauss & Corbin, 1998). Examples of these codes might include personnel tasks and fiscal responsibilities. The next step entailed axial coding which linked the initial categories to other categories (or subcategories) through a paradigm model (Strauss & Corbin, 1998). In this type of coding, the various administrative roles were analyzed with respect to individual, facility, and community-level factors. In this process, I linked sub-categories to a category in a set of relationships that showed causal conditions, context, and intervening conditions. The co-occurrence of these two categories was examined further in relation to factors such as a facility location, size and ownership. In addition, I sorted the data by looking for patterns, for example, administrator motives or training.

Memoing went hand-in-hand with coding. Throughout the process of analytical coding, I wrote notes and memos about my insights, interpretations, and questions about the data. I created charts to facilitate the process of axial coding. For example, one chart served to compare and contrast the components of the administrator role with respect to facility size. In addition, I

constructed diagrams to help analyze the influence of the various multilevel factors on administrators' pathways to their jobs and on how administrators define and enact their roles.

CHAPTER III

PATHWAYS TO ASSISTED LIVING ADMINISTRATION

This chapter will provide a context for understanding how and why administrators enter the AL field and the individual-, community-, and facility-level factors that influence their pathways to their designated roles. Understanding administrators' motivations and pathways can help to explain why these individuals choose and remain in AL.

Profiles of Administrators Illustrating Pathways

Below are profiles of nine AL administrators selected out of the total sample of 44. Three administrators were chosen from each of the facility types (small, medium, and large) because they represent a range of stories. Their stories exemplify the range of individuals found in this sample and will help to illustrate the many differences and similarities found among administrator's backgrounds (see Table 2.2 for characteristics of the full sample) and pathways to AL. The facilities where these administrators work will be referred to by the numerical codes assigned to them in the primary study.

Small Facilities

Bryan. Bryan is a 47-year-old, white male who has worked at facility 900 for about two and a half years. Facility 900 has a capacity of 24 residents, is for-profit, and is independently owned by Bryan and his sister-in-law, Emily, who recruited him into the business partnership. Bryan has a bachelor's degree in marketing and he spent a large part of his career working in real estate, property management, and heating and air repair. Bryan is new to the LTC field yet his work background allows him to successfully handle many of the facility maintenance and

personnel issues common in an ALF. Despite some role similarities, Bryan believes that working as an administrator in AL is more "emotional" than his previous jobs. He recalled the feelings of appreciation that he receives from the residents:

> The third day I was here, I went out front and there was a lady sitting out there, she was a retired school teacher, and she said, 'How are you liking it here?' I said, 'It is a little different, but I think it is going to be okay.' I will never forget. She said, 'Well, we really like you and we hope you stay here.' I worked in real estate [for] 14 years … I don't think anyone said anything that nice to me the entire time. She told me that in three days. I knew I was going to like it here.

Prior to this business venture, Bryan was living in metro Atlanta and was growing weary of the big city and its perpetual traffic congestion. Becoming part-owner of facility 900, which is located in a small town about 50 miles outside of metro Atlanta, allowed Bryan to live in a small community again – just as he did while growing up.

***Jean*.** Miss Jean is a 66-year-old, African American female who has been in the AL "ministry" for nearly a decade. She refers to facility 1500, which she owns and operates, as a "ministry, not a business" because it resulted from a vision from God. As a little girl, Jean dreamed of being a nurse and taking care of "people that weren't able to take care of themselves." Miss Jean's career in LTC started in 1989 when she opened a family-sized facility with only three residents in her own home. Just three years later she was operating at full capacity, so she opened another facility which could accommodate six people. Miss Jean then opened facility 1500 in the year 2000, which at the time of the study was at capacity with 24 residents. Jean recalls how her husband used to say, "Why can't you be like other people's wives? Other men's wives, they bring home dogs, birds, cats. You come in with people." Miss Jean's caring nature is further exemplified by the fact that all of her residents are very low-

income, participate in the Community Care Services Program (CCSP) - the state's Medicaid Waiver program, and require a relatively high level of care.

Jean's modest facility is located in a medium-sized city south of Atlanta in a primarily African American neighborhood, not far from an industrial area and railroad tracks. Miss Jean employs her son as both a caregiver and maintenance man and her brother as the assistant director, among other staff. Despite the additional help, Jean is very involved in resident care and is at the facility every day. Jean has Certified Nursing Assistant (CNA) training, and she completed one year of college. She worked in a factory prior to opening her facility.

***Kirsten*.** Kirsten is a 48-year-old, white female who has worked at facility 2600 for nine years – just two years short of the time she spent working at the local bank prior to her transition to AL. The owner of the for-profit facility, Patti, also a banker, convinced Kirsten to run 2600 and two other ALFs she owns. Facility 2600, which has a capacity of 16 residents, is located in a small southern town and is distinctive in that it used to be the beautiful home of an elderly woman who willed it to Patti, her respected friend. Patti converted the home into an ALF but was careful to preserve the original crystal chandelier, antique furniture, and the old dairy barn, among other unique characteristics (atypical considering the many facilities with institutional features). Kirsten had always wanted to be a nurse and had attended two years of nursing school before having her first child. Although she did not have experience in the field prior to taking on the administrator position, Kirsten understands the benefits of helping others: "They [the residents] appreciate you, they know you're here, they feel like you will help them. And when you go home you think: 'I helped somebody.'" Kirsten's role at facility 2600 inspired her to get her certificate in residential facility administration from the National Association of Residential Care (NARC).

Medium Facilities

Teresa. Teresa is a 58-year-old, white female who has been the administrator at facility 600 for over twenty years. Facility 600 has a capacity of 47 residents, is predominantly Jewish, and is located in an upscale suburban community just north of Atlanta. The facility is not-for-profit and is run by a 35 member board, which provides for a unique administrative operating environment. Teresa has a Bachelor's degree in Social Work, a field which she deems her calling. She later went back to school while working at 600 and received a graduate certificate in Gerontology and became certified as a Retirement Housing Professional (RHP). Prior to working at 600, Teresa owned a needlework shop with a friend, which proved to be a "troublesome venture." Eager to leave that business, Teresa next became a typist at an insurance agency, a job she soon felt that if given the chance she could move well beyond. Needless to say, she jumped at the opportunity to take the position at facility 600 when a board member approached her about interviewing for the job. Teresa believes she has found her "home" at facility 600 and believes that she has earned the equivalent of a "PhD in aging" after her long career as administrator there.

Anne. Anne is a 58-year-old, white female who is both owner and administrator of facility 2000, which has a capacity of 48 independent and AL residents and has been in operation for over five years. The facility is located in a rural county that suffered a major economic downturn a few years ago but has recently experienced positive growth due to the influx of money from "outsiders" who frequent a nearby lake resort. Despite the community's changes, Anne's facility continues to have a small-town feel – many of the staff have known the residents for a long time and vice versa. Anne has spent over thirty years working in LTC, specifically in nursing home administration. She has an associate's, bachelor's, and master's degree in nursing

and she is a registered nurse (RN). Anne utilizes her nursing background by providing direct care and distributing medications to residents, which allows her to be fully integrated into the lives and daily routines of her staff and the residents and their families.

Sharon. Sharon is a 30-year-old, white female who has been the administrator at facility 3300 for only four months. Facility 3300 is located just minutes off a major Georgia interstate in a mid-sized metro Atlanta county and is surrounded by subdivisions, car dealerships, a nursing home, and a wooded area with deer. Sharon is also responsible for overseeing another facility under the same ownership. Facility 3300 has a capacity of 50 residents and is for-profit and corporately-owned. Fortunately, the staff seems confident in Sharon during this time of transition. Sharon feels as though she has worked up the "corporate ladder" because she started volunteering in a nursing home (where her mother worked) when she was 14 years old. She eventually became a CNA, completed some graduate school, and then worked as a recreational therapist in a nursing home and as an activity/vocational director in a mental health group home. Sharon thinks that it is important for an administrator to have the hands-on perspective of a caregiver and a love and passion for working with older adults.

Large Facilities

Fred. Fred is a 34-year-old, white male who has worked at facility 500 for about one year. Facility 500 has a capacity of 81 residents, is for-profit and corporately-owned, and is located in the midst of a construction project, just minutes off a major Georgia interstate in one of the larger metro Atlanta counties. Shopping plazas surround the facility and a large supermarket is just across the street. Fred has a master's degree in gerontology and is a CNA and a certified ALF administrator through the Assisted Living Federation of America (ALFA). Fred's career in LTC started while in his late 20s after a stint volunteering at an ALF, where he "did a

little bit of everything" and developed a fondness for working with older adults – particularly those with Alzheimer's disease. Fred eventually became the activity director at the facility. Five years later and after finishing graduate school, Fred became the administrator of facility 500. Interestingly, Fred raced motorcycles for a living prior to becoming involved in LTC.

***Ashley*.** Ashley is a 38-year-old, white female who has been the administrator at facility 3100 for only six months. Although the facility was in the midst of a staffing transition when Ashley came on board, she soon began implementing many changes to facility policies. Facility 3100 has a capacity of 120 residents, is for-profit and corporately-owned and is located off of a heavily traveled road in a suburban community just north of Atlanta. Ashley's proclaimed philosophy of –"I think people want to be recognized for the good work they do"– is evidenced by her strong focus on staff appreciation. Ashley has a master's degree in psychology and her work history is entirely in elder care – she did housekeeping in a nursing home while in college, worked in the geriatric unit of a 500-bed hospital, and then became a regional manager of operations for her current company. In an effort to spend more time with her family and less time traveling in her corporate job, Ashley decided to return to facility life. She was hired by the corporate office to get facility 3100, which was faltering, profitable and harmonious again.

***Ida*.** Ida is a 55-year-old, white female who has worked at facility 3600 as the administrator for over 20 years. Facility 3600, which is for-profit and independently-owned, has a capacity of 160 independent and AL residents and is located off a small highway in a mid-sized Georgia town. The facility is in the immediate area of an abandoned pizza restaurant and the city's public works plant. Ida jokes about "nepotism" when she describes her position at 3600 – Ida's husband and his brother own the facility and two other properties across Georgia. Ida took some college courses and comes from a family of caregivers, which no doubt inspired her love of

working with older adults. She said, “My mother was a care giver, she was a nurse’s aide at a nursing home. It is something I have always heard about. I like that more than I like the business part - I like being with them [the residents]. That is it, it is just who I am.”

Factors Influencing Pathways to Assisted Living Administration

My grounded theory analysis found that administrators’ pathways to their position were influenced by individual-, community-, and facility-level factors. Examples of these factors include personal values, state regulations, and facility ownership status. Although every administrator was influenced by a convergence of all three types of factors, individual factors were, by and large, the most persuasive conduits into the administrator position. The remainder of this chapter will discuss each of these factors independently and will conclude with an explanation of the interactive nature of these multilevel factors.

Individual Level Factors

As noted, individual factors tend to have a greater influence on administrator pathways to AL than factors at the facility and community levels. Individual-level factors include personal values, social networks, education, work history, race, and gender.

***Personal values*.** Personal values, including altruistic motivations for working with older adults (and care-centered work in general), and religious beliefs proved to be the most influential individual-level factor. In fact, altruistic motives were seen in over a third (36%) of the administrators interviewed and in all size facilities. For example, Sharon at facility 3300, a medium facility, had long-standing career aspirations in LTC and said that working specifically with older adults “is my love, my passion.” The administrator at facility 4200, a large home, offered a unique perspective about working with the older adult population saying:

> I love elderly people. I think that in college I loved history and people are history. Did you know in this building I have 4,123 years of wisdom? And that's why I got into this business … once you get into this field it bites you, and you can't get out. There's nothing more fast-paced or dramatic.

Others believe that care work in general is equally as valuable. The administrator in facility 4100, a small mountain home said, "I love doing this kind of job, the rewards of it are better than the money." Multiple small facility administrators echoed this sentiment saying, "Trust me, I could be making so much more money. It ain't the money." Or, "It is my way of giving back. It is not a money issue. You have to have a lot of patience, a lot of love, and a lot of caring."

Administrators, like Teresa and Miss Jean, report a religious influence on their choice for becoming an administrator in AL, often describing their work as a "blessing" or "calling." Miss Jean, for example, said " … this is where God wants me to be … I'm not a business-minded person; I'm a religious person." Likewise, the administrator at facility 400, another small home, said, "God has put me in a position, well, God has instilled a lot of love and a lot of care for other people and I think that is why I am here. Really, this is my calling … " The administrator at facility 200, a medium home, saw her faith as a way to transition into a career in AL, saying: "I was at an age where I wanted to give something back to the community. I wanted to give back some of what God blessed me with. I wanted to do something more productive than sit at a desk."

***Social networks*.** The data show that social networks also play an influential role on both male and female administrator pathways to AL. Over one-third (36%) of the administrators in the sample were guided into their current position either by friends, family members, or colleagues,

with encouragement from family members being the most prevalent. Some administrators essentially "married into the business," like Ida, who also happened to come from a family of caregivers:

> It is a family business and I said it was nepotism; my husband gave me this job here. I like people - I am from a family of caregivers. My mother was a caregiver - she was a nurses' aid at a nursing home. It is something I have always heard about.

My data show that pathways may potentially be pre-determined in instances of family ownership, as one administrator, who owns facility 3500 alongside her brother and mother explained, "We are family owned and operated. It was just a natural progression for me to come up here." Some administrators had situations similar to Ida where they grew up in households with a parent (typically the mother) who also worked in LTC. The exposure to the elder-care environment at a young age can be seen as an influence into the field. Sharon recalled:

> My mother started with a company called Seaside Health Care Services out of Oregon, which is where I am from … I am the youngest of eight siblings and we all at one point in time worked at that nursing home. It is funny because throughout the years I would go to work with my mother and go to various activities. When I turned 14, I started volunteering at the nursing home where my mother worked.

Social networks also can act as a recruiting tool, as was the case with Bryan, whose sister-in-law convinced him to enter into the AL business partnership, despite the fact that Bryan did not have any direct experience in LTC. The same was true with Kirsten, who was recruited out of her banking job by her friend, who was the facility's owner.

***Education*.** It is unknown if an administrator's educational experiences helped to shape or promote a career in the AL field. However, the data show that the administrator's educational *background* was found to be an indicator of the *type* of facility where he or she ultimately works.

The data revealed that almost three-fourths (70%) of administrators in large facilities had a college or graduate degree, compared with little over half (53%) in medium sized facilities and one-fourth in small facilities. Five of the administrators in the sample had nursing degrees (LPN or RN). The administrator in facility 3200, a large urban facility, is an RN. She believes that having such a degree is "amazingly marvelous" in that it makes residents and their families feel more secure, especially considering the high resident acuity levels at her facility. Table 3.1 shows administrators' educational attainment by facility size. These statistics are directly influenced by facility- and community-level factors, which will be discussed in further detail below.

Table 3.1 Administrator Educational Attainment by Facility Size

	Small (N=18)	**Medium (N=13)**	**Large (N=14)**
> High School (%)	6	8	-
High School or GED (%)	12.5	23	7
Trade/Vocational (%)	12.5	-	7
Some College (%)	44	15	7
College + (%)	25	54	79

***Work history*.** The majority (65%) of administrators in the sample had work experience in either AL or LTC prior to becoming the administrator in their respective facilities. Forty-three percent of these administrators were promoted from within their facility; many worked either as caregivers or in another administrative position, such as activity director. Some administrators believe that having a work background as a caregiver allowed them to have a better rapport with care staff. The administrator in facility 2700, a small home in a mid-sized city, who started out as an aide, said: "It sort of separates me from the previous administrator who did not do direct care, and I think that is how they [care staff] received me better. They recognized me from the floor." Fred expressed a similar sentiment: "Having been a care manager, I try to see both sides and I

think the staff know I try to defend them when I can." Sharon agrees: "I think it is important that they all know I started as a CNA when I first started in long-term care and I have worked my way up the corporate ladder since that time."

The administrators in the sample without AL experience had a wide range of work backgrounds prior to becoming an administrator, including: fork-lift operator, factory worker, department store clerk, kindergarten teacher, professional therapist, accountant, and bail-bondsman, among others.

Similar to educational background, an administrator's work history in AL or LTC also tends to relate to facility size and be influenced by facility- and community-level factors. Just two of the 14 administrators in large facilities had no experience working with older adults prior to taking on the administrator role compared to 38% of the administrators in medium-sized facilities and 50% in small facilities. The influence of these factors will also be discussed in further detail later.

Gender and race. As reflected in Table 2.2, the large majority (87%) of administrators in this sample were Caucasian, with small facilities having the highest percentage of African American administrators (23 percent, compared to 12.5% for medium facilities, and 7% for large). Male administrators were in the minority (23% of the total sample) and were, for the most part, distributed equally among small, medium, and large facilities.

Societal gender norms, which historically place woman as primary caregivers in both the home and in LTC facilities, are clearly visible in the context of the AL administrator role, as displayed by the statistic above. Caregiving has long been considered a women's profession. The relatively low pay and equally low status associated with care work typically inspire men in the

field to take jobs in higher-paying, corporate facilities. However, this was not the case for the administrator in facility 400, and Bruce in facility 1900, who are both African American males who run low-income facilities.

In fact, race is also influential on an administrator's pathway because the AL industry as a whole tends to be primarily white – this is the case for both residents and administrators. African Americans have less opportunity to be administrators, and perhaps even less desire, except in low-income homes where some of the residents also are African American. This study is able to provide a closer look at how gender and race define an administrator's role within an ALF and will be examined in greater detail in the following chapter on administrator roles.

Community and Facility Level Factors

Although community- and facility-level factors were found to be less influential than individual-level factors in terms of *facilitating* an administrator's pathway to her position, my findings show that these factors act to *shape* the individual-level factors previously discussed. Community-level factors include the city/county size in which a facility is located, the economic conditions of the community, and the current AL regulations as dictated by state government. Current AL regulations in the state of Georgia are lenient in that administrators do not have to meet specific educational requirements, nor do they have to be licensed.

Facility-level factors include the facility's ownership characteristics (for-profit versus not-for-profit; independent versus corporately owned), size (small, medium, large), and facility policies – especially policies associated with hiring criteria.

Community and facility-level factors are influential in shaping an individual's social network. This is especially true in small communities where administrators likely know one another, their families, and work backgrounds by virtue of community size alone. This situation is exemplified by Bryan, Kirsten, and Ida, who each work in a facility that is located in a very small community, and each were "recruited" by either a family member or a friend into their position. Small communities are also more likely to have small, independent or family-owned facilities which, as the education statistics show, have a tendency to employ administrators who are less likely to have a college degree.

An administrator's education and work history also likely are shaped by community- and facility-level factors. Individuals residing in small, rural, or economically disadvantaged communities may not have the opportunity to pursue a degree in higher education. As previously mentioned, large facilities (which are typically corporately owned and operated) appear to prefer that administrators have both a college degree and previous work experience in AL or LTC, which impedes the job opportunities in large facilities for those without higher education or work experience.

Lastly, data indicate that an administrator's race, education, and age may combine with community- and facility-level factors to influence pathways to AL administration. Take Miss Jean, for example. Jean grew up in the 1940s as a disadvantaged African American in a southern community, which consequently limited both her education and job opportunities. Despite the fact that Miss Jean felt a calling for care work, it likely was one of only a few employment options. Jean's background is not unlike that of Bruce, also African American, who is the owner of a medium-sized, low-income home in a rural county. Miss Jean's background and opportunity

contrast with that of Amelia (the director of the large, urban, corporately-owned facility 1000), who is African American but considerably younger, at age 31, and college-educated.

Summary

Administrator's pathways are heavily influenced by three converging and overlapping factors, each important and instrumental in shaping how the administrator enters the AL field. Individual-level factors, including personal values, social networks, educational attainment, work history, and gender and race were shown to be the most influential in shaping one's pathway to AL administration. Community- and facility-level factors, such as community size and facility ownership, further influenced administrators' pathways.

Community-level factors, such as community size and economics, shape both an administrator's social network and education and work opportunities. Individuals residing in small, rural, or economically disadvantaged communities may be more influenced by their social networks by virtue of small community size, but individuals residing in such areas may not have the opportunity to pursue a degree in higher education, which subsequently overlaps with facility hiring policies – a facility level factor. Large facilities are more likely to hire individuals with a college degree and work history in AL or LTC. Race, an individual level factor, also proved to affect the aforementioned factors.

Using these pathways as a context, the next chapter will explore how administrators define their role within an AL facility and how the same individual-, community-, and facility-level factors influence his or her job.

CHAPTER IV

ADMINISTRATOR ROLE DEFINITIONS AND EXPERIENCES

As with pathways, my grounded theory analysis found that an administrator's role is strongly influenced by a convergence of individual-, community-, and facility-level factors. Using Kirsten, Anne, and Fred as examples of administrators from small, medium, and large ALFs, I will explore how these factors affect their roles and responsibilities.

It is important to first note a number of job responsibilities that my analysis found to be generally universal among all facilities (although executed in different ways), including: financial management (budgeting, accounting, payroll, benefits, and resident fees); human resource management (staff recruiting, hiring, supervising, disciplining, firing, scheduling, role assignments, dispute resolution, staff rewards and recognition, and conducting staff meetings); regulation compliance (Medicaid/CCSP reimbursement policies (if applicable), ORS/ombudsman requirements); staff training; and, family and resident services (family consultation and resident services, including care management and assessment). As will be discussed in detail later, ownership status and size determined the administrators' level of involvement in both the policy development and implementation of all the aforementioned responsibilities.

Performance of tasks typically handled by direct care workers, including resident personal care (assistance with ADLs), housekeeping or cooking, differentiated small facility administrators from their counterparts in medium and large facilities. In fact, three-fourths of small facility administrators said that they perform resident personal care responsibilities on a daily basis or on a regular as-needed basis, compared to 46% of administrators in medium

facilities and none in large facilities. Indeed, as will be seen, my analysis revealed that facility-level factors, including facility size and ownership (see Table 2.3) (combined with the various individual- and community-level factors) were the most influential in shaping these roles and responsibilities within an ALF.

Administrator Experiences

The following individuals illustrate several different ways that the administrator role is experienced in this sample of administrators. My data show that how administrators define and experience their roles is on a continuum ranging from those who "do it all," to those who "manage it all." Although variation in administrator types exists throughout the sample, the following selected individuals represent the most likely administrator experience for the corresponding facility size.

Small Facility – Kirsten

Kirsten's workday at facility 2600 begins around seven in the morning and ends about twelve hours later. In fact, her workload often can be relentless; she has come to expect the occasional 2:00 a.m. phone call, alerting her of a situation at either 2600 or one of the other two facilities she also manages. Furthermore, facility 2600's moderately simple organizational structure demands that Kirsten and the other staff take on a multitude of duties around the facility. Needless to say, Kirsten understands the implications of running a small, independently owned ALF:

> Small business, you just have to do everything. I mean, it includes personnel, it includes the bills, it includes repairs … it just includes everything, even filling in shifts when somebody does not show up. So resident care, you know, resident evaluation, it's busy, busy, busy … it just includes everything that has to be done to keep the business going.

Medium Facility – Anne

Anne has a dual obligation to facility 2000 because she is both administrator and owner. Her overarching responsibility entitles her to take on many different roles in the facility out of both necessity and want. Although facility 2000's medium size and greater resources allow Anne to employ a supervisor to share her workload, among other dedicated staff, Anne continues to act also as the day nurse in the facility to utilize her previous work experience as an RN. This also allows Anne to be out of her office and have a presence among her staff and residents, which she deems important:

> I work the floor, I am not like most directors - I own it too. I come in at 7:00 a.m. and set the medicines up and I make rounds and do the things on the floor with them [the staff]. I can see better what they do if I am on the floor with them.

Large Facility – Fred

Fred's main responsibility in facility 500 is to oversee the different departments within the facility to ensure they are properly implementing corporate policies and procedures. Despite widespread corporate oversight, Fred does what he can to help both residents and staff while simultaneously attempting to stay within his operating budget. Fred describes his responsibilities as follows:

> A little bit of everything. I am responsible for the overall day to day things of the community. Overseeing resident care, housekeeping, all the staffing concerns. Of course, I am involved in marketing and helping residents move in, all financial responsibilities.

Although Fred may classify his role as doing "a little bit of everything," the context is entirely different when compared to Kirsten and Anne's all-encompassing responsibilities. In other words, the large facility size with subsequently high staffing levels allows Fred to delegate tasks versus personally implementing them.

Factors Influencing Administrator Roles

My grounded theory analysis found that individual-level factors include gender, personal style, and work history. Community-level factors include location, considered in two different perspectives – urban versus rural environments and area of the state (north versus south). Lastly, facility-level factors include facility size, organizational structure, ownership, and available (or lack of) resources. The remainder of this section will explore the meaning of each of these factors and how they interact to shape what ALF administrators do and how they fulfill the underlying obligation to keep beds full and maintain a quality workforce – factors critical to staying in business and maintaining a profitable bottom line.

Facility Level Factors

Facility size and organizational structure. Facility size was found to have the greatest influence on administrators' roles and responsibilities in an ALF. Small facilities accommodate fewer residents and typically have lower fees, resulting in fewer resources and fewer administrative-level staff. The lack of both financial resources and additional managerial staff typically requires the administrator to take on multiple roles, like personal care, to ensure a profitable operation. In the majority of small homes, staff consisted of the administrator who is the director (also sometimes the owner) and the direct care staff. When asked about role responsibilities, the statement of "I do it all" was prevalent in the interviews among small ALF administrators. Many administrators of facilities with similarly simple organizational structures conveyed an opinion comparable to Kirsten's about what, exactly, their role entails. Miss Jean said, "Ah honey, I do it all…everything the employees do, I do. If I see somebody's bed need changing or bathing or needs assistance in any way, I'm there to help." Other administrators said,

"Everything – maintenance, housekeeping, cook – everything." Or, "Pretty much just making sure that the facility runs in its entirety."

Even though Bryan, in facility 900, has the opportunity to share some of his workload with his business-partner, Emily, his duties are as all-inclusive as those of most of the other small facility administrators. He does not, however, take on direct care worker tasks.

> I do the staffing, hiring, anything that is related to staffing. I do the scheduling; we are here 24-hours a day, seven days a week. I do the schedule a month at a time, who is going to work what shifts, that sort of thing. Anything related to marketing, showing our facility to prospects, I am involved with. Generally I am the one who meets with them and takes them through the facility and what we offer. If they seem interested, I am the one who interviews the potential resident either in their home, which is what I prefer, or here. Sometimes it is in a hospital if they are coming from there. Anything related to residents here I am involved in. If there is a need other than something the day-to-day staff handles like laundry or meals or personal needs. If there is something else, I will get involved with it. I have done everything from change light bulbs, to decorating ideas, to trips to physicians. Anything related to building and facility maintenance I am involved in. Making sure it is clean, there is no urine aroma in this building, and there are no stains on the carpet. Things are presentable and always should be, I get involved with that. We have procedures in place but there are things that happen from time to time that I will need to get involved in. Staff meetings I am involved in. Various things I am in. My business partner is much more involved in the kitchen, most aspects of the kitchen she handles. The menu planning, the ordering of the food, most management of the kitchen staff. She does more of that. She is also more involved than I am in the business and accounting.

My analysis found that medium-sized facilities have varying organizational structures. Some administrators have duties that mirror those of small facilities, while other administrators' roles involve more delegation than direct participation, as is seen in larger facilities. A higher resident census typically necessitates a more complex staffing structure, which distributes the managerial workload and frees the administrator from many responsibilities. For example, over 50% of the medium facility administrators delegated staff scheduling to the second in command which, in this sample, had a variety of labels, including: shift supervisor, lead caregiver, resident

care supervisor, director of resident care, personnel manager, assistant executive director, and health care coordinator. Furthermore, nearly 70% of medium facility administrators share employee hiring and firing duties with their second in command.

Sharon, in facility 3300, for example, oversees multiple department heads and even "shares" staff with another facility under the corporate ownership. She explained:

> Starting with the second in command, I have a health care coordinator, her name is Sarah. She is responsible for our wellness department as well as the resident care staff. I also have a dining service coordinator, and his name is Kent and he is responsible for the dining services department. I have an activity and volunteer coordinator, her name is Kristi, and she is responsible for the implementation of recreation and activities held here. I have a maintenance coordinator and he is over this community and the White Oaks community and his name is Wyatt. I also have an environmental services coordinator and she is responsible for the house keeping at both communities and her name is Courtney. Those are my department heads in this location.

Although some administrators in medium facilities, like Sharon, have the benefit of greater numbers of administrative staff, others continue to have responsibilities associated with the personal care of residents, mirroring the role expectations of small facility administrators. Teresa in facility 600, for example, defines her role as, "Executive Director, chief, cook, and bottle washer." Other medium-sized facility administrators said they did "the whole nine yards," or "a little bit of everything." These administrators were within the 46% who said that they participate in direct resident care on an as-needed basis. Bruce, for example who is owner of a facility in a rural area and housing all low-income residents, doubles as a caregiver on the night shift because he lives in the facility and the facility resource level is quite low. Likewise, as mentioned, Anne doubles as the day-nurse in her facility. Many of these role differences can also be attributed to personal style or past work experiences – individual factors, which will also be discussed in greater detail later.

The large facilities in the sample typically assume a corporate model with a complex organizational structure. In the interviews, the administrators of large, corporately-owned facilities displayed great similarity in how they view and define their role. This role similarity is likely in part because large corporations often have very specific training programs designed to teach administrators how to implement corporate policies and procedures. For example, the Quinault Corporation, which has ALFs located across the world, implemented its own "Quinault University," which offers in-depth training opportunities to all employees. Furthermore, large facilities typically utilize a corporate staffing structure where administrators' primary focus is providing oversight to departments versus providing hands-on care to residents.

The following are responses detailing their responsibilities from two administrators who both work for large, corporately-owned facilities. Ashley from facility 3100 said:

> To oversee the overall operations of the community. That includes managing the staff, managing the residents, managing the financial aspects of the community, customer service. Pretty much anything comes through me.

Amelia, the 31-year-old administrator from facility 1000, a Quinault-owned company, had a similar response:

> Basically the overall operation of the home. That would include taking care of budget issues and financial reporting, overseeing staff … and then of course compliance with state regulations as well as Quinault regulations. Overseeing resident care and each department that is here, resident care, maintenance, all of those issues and overseeing all of those on a day to day basis as well.

Ownership. The facilities in the sample displayed an array of ownership characteristics; some facilities are independently owned and operated by the administrator, as is the case with Bryan, Miss Jean, Bruce, and Anne, among others. Some of the independent facilities are owned and operated by a husband/wife partnership, with the wife typically assuming the administrator role. Teresa, in facility 600, has to make operating decisions in conjunction with the facility's

not-for-profit board of directors. Two facilities in the sample are privately owned, but operated by a corporate management company. Other facilities in the sample are corporately owned by small, independent companies, while others are owned by large, world-wide corporations, like the Quinault Company. In other words, significant variation in ownership patterns was seen amongst the facilities.

As previously mentioned, and as shown in Table 2.3, half of the small facilities in the study are independently owned and operated. The lack of corporate oversight results in a more flexible operating environment with the owner or administrator both creating and implementing facility policies and procedures. Bryan, the owner and administrator of facility 900, addressed the value of not being attached to a corporate office, suggesting that independent ownership even promotes a closer working relationship with his care staff:

> They [the staff] know if they have a problem they can come to me and Emily. The answer will never be, 'Gosh the corporate office won't allow that.' There will be a real answer. It will be, 'I would love to do that but I can't and here is why.' They will be looking eyeball to me. They will never get, 'That is not our policy.'

Husband/wife ownership also has repercussions on the administrator role. For instance, in facility 4400 and 4500, both small facilities under the same ownership, the husband and wife team create facility policies together and the husband has adopted many responsibilities around the facility, like maintenance, and he also helps with staff discipline and resolving staff disputes. Conversely, the administrator of 2500, a medium sized facility, is the primary decision-maker and her husband has very little involvement in how the facility is run despite their joint ownership. Ida's husband assists in policy making for facility 3600, a large facility, while simultaneously juggling the operation of the two other facilities under the ownership.

June, the administrator at facility 1700, a small, not-for-profit, Housing and Urban Development (HUD) supported facility with both independent and AL residents, exemplifies the interaction of size and ownership in defining the administrator role. June's tasks, like most small administrators, are all-encompassing. She said: "Well, we have a term … 'other duties as assigned.' I have a lot of those. I think my job description states that I have overall responsibility for the operation of the facility, everything." However, facility 1700's ownership status and its location within a large retirement campus allow June to insulate herself from direct care work. She admitted: "I am not making excuses but my priorities are with the administrative side of this facility."

Although 92% of the medium-sized facilities are corporately owned, they are mostly owned by independent companies. This type of ownership may allow for a more flexible operating environment than some of the very large AL conglomerates might tolerate, as seen in the large facility sample. However, some role rigidity was seen in medium facilities, emulating the experience of many large-facility administrators. Krista, the director of from facility 1200, a medium-sized facility that also houses a nursing facility on campus, discussed how corporate oversight impacts how she fulfills her role:

> The CEO tells me how I am supposed to run this place, and HR tells me how to go about it; then that is what I am going to put in place. I am not going to lose my nursing license for anybody, and I want to keep this [facility] like I am supposed to.

Other administrators echoed Krista's sentiment, saying that the corporate office creates policies dealing with issues ranging from benefits to uniforms; in such cases, the administrator's role is simply to implement policies developed from above. On the other hand, the administrator of

facility 2900, a medium, independently-owned facility, shares administrative duties, like budgeting, with the owner of the facility.

Despite overarching corporate standards that have to be met, some administrators of large facilities do feel a sense of autonomy in how they carry out their role. For example, the administrator of facility 1100, a white male, said: "We have total independence … as long as the budget is in line." Fred admitted to creating his own autonomy, in a sense: "We give annual raises. The budget says 3% but I am not known for giving 3% raises, more like 5% and 6%. It depends on the individual, but I am trying to get our budget a little higher. Don't let my financial manager hear this."

The administrator at facility 3200 discussed the implications of being managed by a third-party – her facility is privately owned but managed by a large corporation called Harbor Heights. The administrator reported that representatives from Harbor Heights visit only occasionally and, as such, this lack of oversight allows her to manage the facility as she sees fit.

> Harbor Heights does not [have control]. They may try but, so far, they haven't been really successful, to their disappointment … Harbor Heights has a uniform requirement of wearing a standard blue outfit. Sometimes I don't necessarily enforce that because sometimes people look a little better in other things.

Resources. A facility's resources – either monetary or human – can be directly associated with both ownership and various community-level factors. Large, corporately-owned facilities are generally more profitable than their smaller counterparts, which allows for some support in the implementation of the administrators' duties. For example, Amelia is pleased by the assistance she receives from the corporate office and a large regional team:

> … we have a great regional team. I have regional people I can call and say, 'Hey I got to go,' and my managers will call me if there is a problem. The regional team will come in with regional nurses, I have an area manager, we have regional dining, anything I need. If I say I have a big problem and I need you to schedule

> some time here, they will be here. The company is so big and we have a lot of resources and we definitely get a lot of support.

Conversely, the administrator at facility 100, a 32-year-old white female, has a vastly different opinion about her experience with corporate management at her large facility. Her facility is privately owned and run by a corporate management group:

> I don't think the owners care because they are not that involved in anything that we do. They have little involvement with any aspect of our building. I think we have always thought of ourselves as the step-children of Sequoia Hills because we are the only three communities nationwide that they manage and don't own. We don't get a lot of consideration for funding for things.

Resident fees are the primary source of revenue for facilities. As shown in Table 2.3, there is upwards of a $2,500 differential in monthly fees between small and large facilities. Small facilities sometimes are confronted with considerable challenges because of financial constraints. The data revealed that small facilities, like the board and care homes discussed in the literature, were more likely than medium or large homes to house low-income residents. Forty-three percent of the small facilities in the secondary sample participated in the CCSP or SOURCE program (both are restricted to facilities with 24 or fewer beds) or accepted individuals who receive SSI, compared with just one medium facility and no large facilities.

Low income facilities are more likely to house individuals with mental health problems, which subsequently create a more difficult workload for the staff and administrator alike. Unfortunately, such facilities also tended to have lower family involvement, which places many familial financial obligations, such as buying, supplies, incontinence pads, or clothes, back on the facility. Bruce, in facility 1900, a medium facility that does not participate in a Medicaid-waiver program but serves poor residents of the rural community where it is located, often purchased clothes or solicited donations from local charities so the residents who could not afford to buy

their own could look presentable when they left the facility. The administrator from facility 3000, a small, low-income facility said:

> We buy everything. My husband probably doesn't agree with this policy but I got so frustrated with trying to keep everybody's things separate and getting after the families [saying] 'they're out of shampoo, they're out of razors, they're out of this,' and so I just buy them all and don't charge them anything for it over the [monthly fee].

A facility's resources also influence the administrator's ability to create and implement reward and recognition programs for employees. Costly incentives like health benefits were rarely seen in small ALFs, yet were offered in every large facility in the sample. Administrators in higher income facilities reported efforts to improve staff morale and satisfaction with the use of gift cards and other forms of monetary recognition to acknowledge a job well done. Administrators in smaller, less profitable facilities were typically unable to provide such rewards.

In summary, all the aforementioned facility-level factors overlap in multiple ways. Facility size dictates the facility's organizational structure (simple to complex), which is influenced by ownership status. Ownership also affects a facility's resource levels, which are intrinsically linked to the location of the facility, as will be discussed in the following section.

Community Level Factors

Our data show that facility location is also influential in shaping an administrator's role when combined with facility-level factors. As shown in Table 2.3, there is a relationship between facility size and its location in the state (urban versus rural). Facilities located in small, rural communities are more likely to be small and, as just discussed, often have fewer resources than their large, corporate, urban counterparts. Small communities offer few options for low-skilled jobs, a situation which may make it difficult for administrators to find a qualified workforce.

Facility 400 can be considered an outlier, however, because it is a small, low-income facility located in the heart of Atlanta.

My analysis also found that area of the state (north versus south) influences racial and ethnic diversity of staff within the facility, which had implications for an administrator's role, particularly in terms of staff management and conflict resolution. Administrators in facilities located in the northern, mountainous regions of Georgia were less likely to have a racial mix among their direct care staff and resident population. However, racial differences amongst direct care staff were seen in ALFs in both the metro Atlanta (urban) and the southern region of Georgia. Staff in these areas are typically native-born black (African American) and/or individuals who emigrate from places like the Caribbean or African countries (foreign-born blacks) and administrators were more likely to report handling incidents of racism either among staff members or between residents and staff.

For example, the administrator from facility 3200, a large, corporately-owned facility, discussed some of the inter-staff difficulties she has encountered among African and African-American staff:

> The American blacks don't want the African blacks … the African blacks in the majority of the situations are more educated. We don't seem to have any conflicts with the whites - just the African and African Americans, which I thought was very interesting.

Administrators also discussed incidents of racism between white residents and minority staff in the interviews. Interestingly, most of the administrators said that staff typically understand the generational gap and dementia issues that usually precipitate offensive incidents. The administrator from facility 1300, a white male, discussed how he handles residents who make derogatory remarks toward his staff in his medium-sized facility:

> I go to the person [resident] and I explain to them that it is [year] 2005, it is not 1820, and I cannot put up with any racism, racial slurs, et cetera. If they do indeed have a problem with it, I'll be glad to help them find someplace else for them to live and I ask them to apologize to the person [staff] … but fortunately my staff know that as far as being culturally neutral that it doesn't make any difference whether they are white, green, black, grey, whatever color. I'm going to treat them the same. And so they respect that about me and tolerate it. It's like I tell them, 'Hey listen, this person's got dementia, you could have been a Mexican, you could have been anything other than what they are and they would have insulted you today, it doesn't make any difference.'

Ashley in facility 3100 noted the implications of foreign-born blacks' culture on interpersonal relations and how administrators experience their roles:

> One of the things I have come to learn managing people from Africa is they would never make eye contact and the way they would inter-relate was so different from managing someone from America. I learned to find out it is rude to look someone in the eye. There are certain things you need to learn about the culture to know how to manage them.

Race also plays an interesting role for Amelia in facility 1000 – she is a young African American administrator in a facility of mostly all white residents. She discussed this dynamic:

> I was the first African American [administrator] in Georgia for Olympic in the Atlanta area … I was the first one and now we have six. Here in this building, I was the first one as well. I really didn't get a lot of resistance from the residents, probably more so from vendors and competitors than family members. Of course, you will have a handful of family members who will express opinions, but actually, I am from the south - black people are the people taking care of people so they see this as a job we should have.

When considering the aforementioned factors, it becomes apparent that the race (an individual-level factor) of direct care staff, residents, and even the administrator can have implications on how an administrator experiences his or her role within an ALF.

Individual Level Factors

When combined with facility-level factors, gender, personal style, work experience, and race, as noted above, both together and independently proved to be the most influential individual-level factors in shaping how an administrator experiences and defines his or her role.

Gender. Gender provides for an interesting dynamic in the examination of administrator roles, especially in light of the fact that ALFs, and LTC in general, are staffed predominantly by women. Ten male administrators were interviewed in the primary study, and each offered a gender-specific perspective into their experience.

Generally speaking, the male administrators in the study fulfilled their roles according to the dynamics previously discussed. However, the male administrators, particularly those in small and medium-sized facilities, tended to take on more maintenance and grounds keeping roles rather than direct care work with residents. However, the administrator of 1300, a medium-sized facility, said that he will help with resident personal care if need be:

> I'm the motivator, I'm the initiator for our staff and I'm also the role model so in this case my staff know that I would never ask them to do something that I wouldn't do myself and have demonstrated on many occasions as far as providing direct care services to the residents, especially to men, and so that's all part of the executive director hat that I wear. Plus landscape consultant and trash picker upper. I have been known to help carry out the trash and help cook a meal, so, um, I wear a lot of different hats.

True to his word, one of the primary researchers on the project witnessed this administrator cutting the grass during one of her visits. Likewise, the administrator in facility 2100, a medium-sized facility, said:

> I don't like to be in my office if I don't have to. I am usually out with the residents or walking around staff talking with them and seeing how things are going…I try not to use my office if I don't have to. I am not the kind of person that likes to sit down very much … I go around pulling weeds.

Other administrators – even some females – talked about fulfilling tasks like changing light bulbs or painting. Assuming maintenance roles may also be influenced by facility size and resource levels. Large, corporate facilities typically employ a maintenance director. As such, no male administrators in the large facilities spoke of participating in maintenance roles. The roles male administrators choose to assume may also be associated with personal style, which will also be discussed.

Two male administrators broached the subject of working with women, who are the predominant employees in all size homes. Bryan in facility 900 said:

> This is a different environment for me because almost all of the people who work here are women. Even the women tell me they wish there were more men because they seem to have more problems getting along with other women. I think there are more issues; there are more things that I would not dream would ever cause a problem; there is certainly more crying that in any other job I have had. Not that that is a bad thing, I think they are getting someone's honest thoughts when that is going on. I think it has to be taken into consideration. There are some good things about it. Men have their own personality traits, their cockiness that gets in the way of what we are trying to accomplish in this business sometimes.

The administrator in facility 2700 discussed what he considers the difficulties in working with women:

> … Most of the staff are female and they build relationships and most of them become friends. If they don't become friends they are the opposite and believe me that can be problematic. I have seen some of the fights that I could never see as a man.

These male administrators bring up an interesting issue that seemed to be present in almost all the facilities: gossip. The all-female staff dynamic was found to be problematic also for female administrators because staff – particularly care staff – often form "cliques" and create an environment where rumors and gossip become seemingly inevitable. Ida in facility 3600 said:

> I have the standard memo I pull out on gossip and how it hurts people … we try to work on that. Oh yes, Lord have mercy. You have roller skates going downhill, that is the way gossip is. It moves very quickly and you just discourage it.

Personal preferences and style. An administrator may take on roles or manage the facility based on his or her personal style. For example, the administrator from facility 2100, a 29-year-old male, displays a management style that entails maintaining a constant presence throughout the facility:

> I don't like to be in my office if I don't have to. I am usually out with the residents or walking around staff talking with them and seeing how things are going. Meeting with families and meeting with the residents, see how things are going. If we have a new move in I go and meet with them and see how their move in is going. I try not to use my office if I don't have to. I am not the kind of person that likes to sit down very much.

Likewise, the administrator from facility 3200, a 56-year-old white female, discussed how her personal style influences her role and how she relates to staff.

> I am very, 'Here I am, this is what you get.' I don't have that self controlled professionalism. I thought I needed to be that, but it is not me and I am going to be me. Sometimes I wish I had that a little more but I don't. I think what they do see is I am very friendly and I do bring a lot of light and humor. On the serious side, when it comes to resident care, I don't allow any excuses or rationalizations. There are too many out there looking for jobs and I am going to get the right people. I think when I get the right people they are going to stay because I treat them well.

Individual values and preferences are also evident in the types of roles administrators choose to assume. As shown in chapter three, many administrators displayed altruistic or religious values that prompted them to enter the AL field. Miss Jean, for example, personally demonstrates these values by choosing to provide direct care to residents despite employing both an RN and DCWs. Conversely, the administrator in facility 800, a 53-year-old white female who was a loan officer in a bank prior to assuming the administrator position, is purposefully far-removed from the personal care aspect:

> Personal resident care, no. I will assist in the transfer of a resident. One thing I do not do, I don't do bathing or dressing, or incontinence. That is the only thing I will not do. I have cooked. I have painted. I have served meals. I have cleaned rooms. I could probably do it because I have the experience with my mom but I would have a problem looking at that person after seeing them naked. That is just me.

Ida's personal preference for working directly with the residents, combined with her care history, likely influences her to leave most of the business responsibilities of the facility to her husband, the owner:

> I am from a family of caregivers. My mother was a caregiver. She was a nurses' aide at a nursing home. It is something I have always heard about. I like that more than I like the business part. I like being with them. That was it, it is just who I am.

Work history. An administrator's work history also has a direct influence on how he or she fulfills their role. Anne is an excellent example of work history in the way that she incorporates her background as an RN into her daily routine by doubling as the day-nurse in her facility. Likewise, the administrator in facility 1100, which is an all Alzheimer's facility, is also an RN and he frequently utilized nursing terminology like, "charge nurse" and "director of nursing" when describing the various positions within the facility. Therefore, AL administrators with a nursing background may adhere to a medical model of care. The administrator in facility 2700, an African American male, often does direct care work because he used to be an aide in this small facility and he feels comfortable in that role. As discussed in chapter three, many administrators who had previous work experience in ALFs or LTC mentioned having a stronger camaraderie with staff, like the administrator in 2700 who said that the care staff recognize and appreciate him because of his time spent working as an aide.

Bryan's management style is shaped by lessons learned from previous work experiences:

> I have worked for a lot of different people. One of the best was when I was just out of high school and I worked for a state park as a life guard and the guy that

> was the park manager was our boss. We had situations where the people at the beach were unhappy because you wouldn't let them do this or that. The [boss] was always behind you. He would explain to them why it was. He may take me aside a little later and say, 'hey you could have done that differently, here's what you could have tried.' I thought, 'what a cool guy. He is behind me and he coaches me in private.' I try to do that with staff members here and be respectful of them as individuals and help them. I am 47 and most of them are younger than me. I try to help them learn what I have picked up. I have studied relationships for years. I think that helps.

Summary

This chapter has examined how a variety of individual-, community-, and facility-level factors influences how administrators experience and define their roles. Individual-level factors include gender, personality/values, and work history. Community-level factors include the ALF's location within the state (north versus south) and also its environment (rural versus urban). Facility-level factors include the facility's size and organizational structure, ownership, and available resources.

My analysis found that that how administrators define and experience their roles is on a continuum ranging from those who "do it all," to those who "manage it all." These role configurations are influenced by individual-level factors, such as the administrator's personal values and management style, gender, or previous work experiences.

Furthermore, facility size and ownership also had implications on an administrator's tasks within the facility; administrators in small ALFs were more likely to assume tasks associated with direct care work than administrators in medium or large facilities. These facility-level factors also can dictate the level of resources available to administrators, such as ancillary staff. Community level factors, particularly the ALF's location within the state, were found to influence an administrators' level of involvement in resolving staffing disputes involving race.

Overall, these multi-level influences determine both the type and number of tasks that comprise the administrator role as well as the way in which these duties are carried out.

CHAPTER V

DISCUSSION AND IMPLICATIONS

The majority of AL research has focused on the experiences of residents and the DCWs who facilitate their care. Thus, this thesis is unique because it aims to provide an increased understanding of the AL *administrator* position, which is pivotal in the creation and implementation of policies and procedures that affect AL residents' daily lives and care. My examination of the individual-, community-, and facility-level factors that influence administrators' pathways to their position and how they experience their role can help to better define the administrator position and what the administrator job entails. Furthermore, this information can help guide policy and practice regarding appropriate qualifications and training for those who occupy this critical AL role.

Summary of Findings

My findings reveal that multiple interactive and multi-level factors shape administrators' pathways to AL administration. Individual-level factors were found to be the most visible in determining an individual's pathway to AL administration, with those at the community- and facility-level having lesser impact. Individual factors included personal values, social networks, race, gender, work history and education. The data also revealed that work history and education affected pathways to the field as well as to type of facility. Moreover, administrators' race and gender were found to interact with community- and facility-level factors to influence pathways.

Similar to an individual's pathway to becoming an administrator, my analysis shows that how an administrator defines and experiences his or her role is influenced and shaped by an overlap of individual-, community-, and facility-level factors. Facility-level factors, including facility size, organizational structure, ownership, and resources, had the greatest influence on

determining the make-up of an AL administrator's role, while individual-level factors influenced administrators' unique personalization of their roles. Community-level factors further defined the administrator's overall job experience within an ALF.

My analysis also identified a number of job responsibilities that were found to be generally universal among all facility types, though executed in different ways according the facility's organizational structure. Depending on their particular job configurations, administrators can be placed along a continuum ranging from those who "do it all," to those who "manage it all." The "do it all" end of the continuum was representative of female administrators in small, independently-owned facilities, who typically incorporated resident personal care responsibilities as well as an array of other duties into their administrator role. The opposite end of the continuum was characteristic of heads of large, corporately-owned facilities whose roles primarily consisted of oversight of various lower-level managers.

Discussion

Pathways to Assisted Living Administration

The pathways to AL administration exhibited by individuals in this study have some similarities with the pathways of direct care workers (DCWs) to AL and LTC, as identified by Lepore and colleagues (Lepore, Ball, Perkins, & Kemp, forthcoming). Both administrators' and DCWs' pathways are shaped by comparable individual-level factors, including personal values, social networks, gender, work history, and educational attainment. Community- and facility-level factors also exert influence in similar ways.

Lepore and colleagues (Lepore et al., forthcoming) note the importance of the moral value of care work on DCWs' pathways. This, too, was evident in AL administrators' pathways with over half of the administrators reporting that either altruistic or religious values served as a

motivation into AL administration. Lepore and colleagues propose that moral values also can be "construed as justifications or rationalizations for individual choices, rather than motivations" (Lepore et al., p. forthcoming) into the field because of a lack of opportunity elsewhere. This situation was indeed the case for some administrators in the sample. Miss Jean, for example, despite considering her entrance into the field a "calling," as an African American in the South likely had few employment opportunities elsewhere because of her limited education and work history (as shaped by particular community-level factors).

The influence of social networks on AL administrators' pathways also mirrored those of DCWs. Lepore and colleagues (Lepore et al., forthcoming) note that DCWs' social networks acted to support an individual's moral motivations to enter the field or alert workers to available jobs. The same is true for AL administrators; over 36% of administrators in the sample were guided into their current position by friends, family, or colleagues, with encouragement from family being the most prevalent.

My findings strongly support the societal norm that the role of elder care (and direct care work in general) is largely reserved for women (Dilworth-Anderson et al., 2005; Lepore et al., forthcoming). In accordance with this standard, 70% of the administrators in the sample are women, proving that these gender norms are still evident today and continue to be a strong influence on women's employment trajectory into AL. My findings also indicate that gender influences how administrators carry out their roles.

Lepore and colleagues (forthcoming) also reported that some DCWs used their positions as "stepping stones" to higher positions. A minority of administrators in my sample began their LTC careers in direct care work and, thus, parallel these workers. The majority of administrators, though, were more highly educated than the sample of DCWs, and began their LTC careers in

administrative positions. In a similar fashion to the pathways of DCWs, the pathways of administrators, who are mostly white, reflect the interaction of race and gender. Since the majority of DCWs are black and female, the disadvantages of these lower-status workers are only compounded (Lepore et al., forthcoming).

My analysis found that education and work histories were indicative of the type of facility (small, medium, or large) in which an administrator works. Large, corporately-owned facilities were less likely to hire individuals without a college education or who did not have previous work experience in AL. Conversely, only a quarter of AL administrators in small facilities had a college degree or higher, emulating the characteristics of administrators in board-and-care-facilities, as outlined by Morgan, Eckert, and Lyon (1995).

These individual- and facility-level factors overlapped with various community-level factors, including community size, geographic location, and economic status, to shape facility and administrator outcomes. My analysis found that small communities were more likely to have small, independent, or family-owned facilities, which tend to employ administrators with more limited education. This hiring criterion is likely because individuals residing in smaller, rural, and economically disadvantaged communities may not have the opportunity to pursue a degree in higher education, subsequently limiting employment options. An administrator's race, class, and age are also contributing factors in this respect. Conversely, the data also show that large, corporately-owned facilities are generally located in urban areas and have profit margins that can attract administrators with more experience and higher education levels.

Large, corporately-owned chain facilities have experienced considerable growth over the past decade, a situation that has repercussions for small, independently-owned facilities (Golant & Hyde, 2008). Although the state of Georgia currently does not have education, certification, or

licensure requirements for AL administrators, the influx of corporate facilities into the market with higher administrator proficiency expectations runs the risk of disenfranchising many small ALF administrators. Moreover, it is likely that corporate ALFs will continue to maintain substantial competitive advantages over small facilities to such an extent that small ALFs will no longer have the resources with which to operate. Other studies show that a variety of forces are contributing to the decline of small ALFs (Ball et al., 2005; Carder, Morgan, & Eckert, 2008; Perkins et al., 2004).

Administrator Role Definitions and Experiences

My analysis found that individual-, community-, and facility-level factors, both independently and collectively, help to shape and define an administrator's role within an ALF. Facility-level factors, including facility size, organizational structure, ownership, and resources, were found to be powerful determinants of not only what an administrator does, but how their roles are fulfilled. Individual-level factors help to shape how an administrator personally experiences his or her role.

The data revealed a number of job responsibilities that were found to be generally universal among facilities of all size categories, though executed in different ways. Many of these duties mirrored those described by Allen (1999) including, regulation compliance, financial management, and human resource management. However, my analysis, unlike Allen's, looked at role expectations beyond the corporate model and, as such, is able to provide an understanding of the role variability across facility size (small, medium, and large).

A facility's organizational structure, which is variable by facility size, was found to be central in determining administrators' roles and level of involvement in the development of facility policies and procedures. This finding directly parallels that of Ball and colleagues (Ball,

Lepore et al., forthcoming) in their examination of DCWs' responsibilities by facility size. The authors found that a facility's size and organizational complexity affects the number and type of tasks DCWs perform, which is precisely the case with administrators' roles and responsibilities. Thus, both DCWs and administrators have a wider array of tasks in smaller homes.

My analysis found that administrators' performance of tasks typically handled by direct care workers, including resident personal care (assistance with ADLs), housekeeping or cooking was, above all, the role that differentiated small facility administrators from their counterparts in medium and large facilities. Other AL studies have found that administrators, who often are owners, of small facilities with a simple organizational structure commonly said that their responsibilities included "everything" (Ball et al., 2005; Morgan et al., 2004). Thus the administrators in my study mirror the "mom-and-pop" model of operation discussed in the literature (Ball et al., 2005; Morgan et al., 2004; Morgan et al., 1995).

My analysis also revealed the influence of facility ownership on the AL administrator role. Ownership was found to determine the level of flexibility in the facility's operating environment and the availability of resources (both monetary and human) provided to administrators. The availability of resources also dictated an administrator's ability to develop and implement and reward and recognition systems, which was found to be important to both the retention and satisfaction of direct care staff (Ball, Hollingsworth, & Kemp, forthcoming).

The small, low-income facilities found in this sample, like those discussed by Ball and colleagues (2005) in their examination of LTC options for African American elders, are beneficial and important to their local communities, despite their lack of revenue. One facility in the sample was not-for-profit, which created a unique operating environment for the administrator who reports to a board versus a corporation. Although my analysis found that this

ownership dynamic was indeed different from other facilities in the sample, the limited data did not allow me to fully understand whether or not and how this characteristic affected the administrator's role.

The small facilities in the sample were primarily independently owned and operated. As such, administrators in these facilities experienced a relatively flexible operating environment which most of the administrators seemed to value, despite having fewer resources than their corporately-owned counterparts. Multiple small and medium facilities were under husband/wife or family ownership, which influenced how the administrators in such facilities view their role. This ownership dynamic was also influenced by societal gender norms because the wife typically assumed the administrator role while the husband's involvement in the facility was variable.

Administrators in corporately-owned facilities of all sizes generally understood that their role was simply to implement policies that were developed by the corporate office. These administrators provided mixed responses about how they fulfilled corporate expectations; some felt that they had no flexibility and independence, while others felt like they had total freedom as long as they adhered to their budgetary requirements. One administrator in the sample found that the abundance of resources provided by the corporation helped fulfill her job obligations. This finding is consistent with Sikorska-Simmons & Wright (2007) who note that large chain facilities can be more accommodating in the provision of services because of higher revenues.

The "bottom line" was found to be critically important in all facility sizes. Administrators were under constant pressure to keep beds filled because resident fees are the primary source of revenue for all facility types. Forty-three percent of the small facilities in the secondary sample are low-income and participate in public assistance programs, which create particular financial challenges (Perkins et al., 2004). These facilities resemble the board-and-care homes from the

literature and (as both Ball and colleagues (2005) and Morgan and colleagues (1995) note), which often house a more vulnerable adult population, including those with mental health problems, creating distinctive administrative issues, such as dealing with mentally ill residents (Leroi et al., 2006).

Various community-level factors also were found to be influential in shaping an administrator's role when combined with the aforementioned facility-level factors. My analysis shows that a community's size and location within the state have repercussions for the administrator role. As previously discussed, facilities located in small, rural communities are more likely to be small and have fewer resources than their large, corporate, urban counterparts. Furthermore, these communities typically offer few options for low-skilled jobs, making it difficult for administrators to find a *qualified* workforce. On the other hand, it may be easier to find staff if it is one of the only available options in town, confirming the findings of other AL studies (Morgan et al., 1995; Perkins et al., 2004).

A facility's location within the state or Georgia (either north or south) was found to influence the diversity in a facility, which has implications on the administrator's role – particularly in terms staff management and conflict resolution. Other studies using the same sample of staff and facilities as mine have shown the effect of racism on the facility environment. Perkins, Sweatman, and Hollingsworth (forthcoming) reported incidences of racism among DCWs and even between administrators and DCWs. Other studies revealed racism between DCWs and residents and their family members (Baird, Adelman, Sweatman, Perkins, & Ball, forthcoming; Kemp, Ball, Hollingsworth, & Lepore, forthcoming; Kemp, Ball, Perkins, Hollingsworth, & Lepore, 2009). With the increasing diversity of the long-term care workforce

(Redfoot & Houser, 2005), dealing with racial and cultural conflicts likely will continue to confront administrators in AL, where resident populations continue to be primarily white.

My analysis found that individual-level factors, including gender, personal style and attitudes, work history, and race (as noted above) were also influential in shaping the administrator role, when combined with community- and facility-level factors. Personal style influenced administrators' management styles and also helped to determine what types of roles administrators choose to assume. My findings about gender in the context of the administrator role explore an interesting dynamic in the AL field. As mentioned earlier, social norms have long dictated that women retain care roles (Lepore et al., forthcoming).

Our data included ten male administrators who offered gender-specific perspectives into the AL administrator profession. My analysis found that male administrators in small ALFs typically fulfilled their roles according to societal gender norms – they choose to assume maintenance and business-oriented roles versus personal care roles. (This was not applicable to male administrators in large, corporately-owned ALFs because they typically employ a maintenance director.) The male administrators also discussed the difficulties of being the sole male in a female dominated workplace, citing the need to handle frequent inter-staff conflicts between females. Perkins and colleagues found, however, that dealing with "female" issues also was a challenge for female administrators (Perkins, Sweatman, & Hollingsworth, forthcoming).

Personal style, education, and work history were also found to influence how an administrator experiences his or her role. Those who cited altruistic or religious values were more inclined to take on resident personal care roles, as were administrators who had a work history providing direct care. Administrators with an RN or LPN were also more likely to provide direct care and incorporate their nursing background into their administrator role. These

administrators may also utilize a medical model of care within the facility, which has the potential to restrict resident autonomy (Lidz et al., 1992). However, in light of the changing demographics of the older population, having an RN as an administrator may prove to be a valuable commodity for a facility. Personal style and work history can have a strong influence on the "provider's way," as discussed by Ball and colleagues (2005), or influence how the administrators maneuver through the process of negotiating risk and affect the social environment of the home, which have implications for resident care (Perkins et al., 2004).

Implications for Policy and Practice

The findings from this study have shed considerable light on the AL administrator role, which will help in the formulation of AL policies and encourage better practices. First and foremost, the AL industry must reduce its alarmingly high administrator turnover rates. Although the turnover rates of DCWs have garnered much attention, research has shown that *management* turnover not only has a "destabilizing influence within the facility" (Castle, 2005, p. 187), but it can also alter employees' commitment to the workplace and erode the quality of care provided to residents. The longer tenure an administrator has within a facility, the better he or she can connect with staff and promote employee commitment (Anderson et al., 2004). This research will help to provide a more coherent understanding of the administrator role, which may be a necessary start in reducing turnover rates. The benefits of providing a concise "job description" of the administrator position are twofold: first, if DCWs, residents, families, and even officials from the corporate office more clearly understand the expectations associated with the administrator role, the facility can run more efficiently and effectively, limiting opportunities for administrator "burnout." Furthermore, a better understanding of the administrator role may also

help to decrease the turnover rate if candidates for administrator positions had a firm grasp of the job expectations and common experiences associated with the role *before* assuming the position.

Second, older adults in our country are living longer, but not necessarily in better health (DHHS, 2008). The AL industry is projected to experience considerable growth, yet it will also be forced to provide higher levels of care to older, sicker residents (Golant, 2008). As Mollica (2007) notes, AL administrators are often insufficiently trained to handle the growing social and medical needs of AL residents. Although some administrators in the sample had training beyond state required hours, such as certification as an ALF administrator or as a retirement housing professional, it is unknown whether or not such training will sufficiently address the changing needs of AL's consumers.

My analysis also found that because of increasing racial and cultural diversity in AL, administrators may require more intensive training on cultural competence in order to handle personnel issues with sensitivity in light of the changing demographics of direct care staff. Further research on AL administrators' training backgrounds is needed to expose any inconsistencies in training and experience that will be necessary in caring for the upcoming generation of older adults.

Additionally, administrators need to have a firm grasp on business administration. As has been outlined in my analysis, an ALF is a complex business in which success ultimately depends on the bottom line. Although Miss Jean may say that she operates her facility as a "ministry, not a business," her job, as well as those of all other administrators, necessarily entails the running of a business, whether Miss Jean admits it or not. The business aspects of an ALF must be a primary focus for administrators in the future, and a successful administrator will be well-served with adequate training about running a business.

Finally, a more concise understanding of the AL administrator role will promote a greater sense of credibility to the AL field, especially on the forefront of its projected growth. As the baby boom generation begins to transition into ALFs and, consequently, the notion of an ALF moves more into the mainstream, the administrator position may be under close scrutiny. Administrators should therefore be mindful of the information presented in this analysis.

Limitations and Suggestions for Future Research

I acknowledge some limitations to this study. First, the primary study was not intended to look solely at AL administrators; the questions asked of administrators in the primary study were focused on DCWs and, thus, did not delve into the administrator's experience in or feelings about his or her role. Moreover, I was not able to provide a more in-depth examination into particular administrator roles, such as how much autonomy one might have in budgeting. Second, I do not have data explaining if, when, and why an administrator may have left his or her position. Third, the data is limited to Georgia, but the facilities examined in the study are comparable to those found nationwide. Fourth, the data do not relate administrator findings to any resident, administrator, or facility outcomes.

Future studies should examine how role configurations, personal characteristics, training, education, and experience influence outcomes for administrators, residents, and facilities. Also, it may be beneficial to examine a much larger sample of administrators across states to see if characteristics of small, medium, and large found in this study hold true. Lastly, it would be interesting to gauge AL administrator management styles and their effects on both DCW and resident satisfaction in the facility.

REFERENCES

Aaronson, W. E., Zinn, J. S., & Rosko, M. D. (1994). Do for-profit and not-for-profit nursing homes behave differently? *The Gerontologist, 34*(6), 775-786.

ALFA: Overview of assisted living. (2009). Retrieved January 27, 2009, from http://www.alfa.org/i4a/pages/Index.cfm?pageID=4361

Allen, J. E. (1999). *Assisted living administration*. New York: Springer Publishing Company, Inc.

Anderson, R. A., Corazzini, K. N., & McDaniel, R. R. (2004). Complexity science and the dynamics of climate and communication: Reducing nursing home turnover. *The Gerontologist, 44*(3), 378-388.

Baird, J., Adelman, R. M., Sweatman, M., Perkins, M., & Ball, M. (forthcoming). Job satisfaction and racism in the service sector: A study of work in assisted living. In *Frontline workers in assisted living*. Baltimore: The Johns Hopkins University Press.

Ball, M. M., Hollingsworth, C., & Kemp, C. L. (forthcoming). Rewarding workers. In *Frontline workers in assisted living*. Baltimore: The Johns Hopkins University Press.

Ball, M. M., Lepore, M. J., & Hollingsworth, C. (forthcoming). "We do it all:" Universal workers in assisted living. In *Frontline workers in assisted living*. Baltimore: The Johns Hopkins University Press.

Ball, M. M., & Perkins, M. M. (forthcoming). Research overview. In *Frontline workers in assisted living*. Baltimore: The Johns Hopkins University Press.

Ball, M. M., Perkins, M. M., Whittington, F. J., Hollingsworth, C., King, S. V., & Combs, B. L. (2005). *Communities of care: Assisted living for African American elders*. Baltimore: The Johns Hopkins University Press.

Ball, M. M., Whittington, F. J., Perkins, M. M., Patterson, V. L., Hollingsworth, C., King, S. V., et al. (2000). Quality of life in assisted living facilities: Viewpoints of residents. *Journal of Applied Gerontology, 19*, 304-325.

Banaszak-Holl, J., & Hines, M. A. (1996). Factors associated with nursing home staff turnover. *The Gerontologist, 36*(4), 512-517.

Bishop, C. E., Weinberg, D. B., Leutz, W., Dossa, A., Pfefferle, S. G., & Zincavage, R. (2008). Nursing assistants' job commitment: Effect of nursing home organizational factors and impact on resident well-being. *The Gerontologist, 48*(Special Issue 1), 36-45.

Cahan, V., & Lancashire, J. (2008). Press Notes - Older Americans 2008: Key indicators of well-being. Retrieved February 13, 2009, from http://www.agingstats.gov/agingstatsdotnet/main_site/default.aspx

Castle, N. G. (2005). Turnover begets turnover. *The Gerontologist, 45*(2), 186-195.

Castle, N. G., & Shugarman, L. R. (2005). The effects of top management professional development on administrator turnover. *Journal of Applied Gerontology, 24*, 404-418.

Dilworth-Anderson, P., Brummett, B. H., Goodwin, P., Williams, S. W., Williams, R. B., & Siegler, I. C. (2005). Effect of race on cultural justifications for caregiving. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 60*, S257-S262.

Eaton, S. C. (2000). Beyond 'unloving care': Linking human resource management and patient care quality in nursing homes. *International Journal of Human Resource Management, 11*(3), 591-616.

Estes, C. L. (2001). *Social policy and aging: A critical perspective*. Thousand Oaks, CA: Sage Publications.

Feldman, P. (1993). Work life improvements for the home aide workforce. *The Gerontologist, 33*(1), 47-54.

Georgia Long-Term Care Ombudsman Program - 2007 Annual Report. (2007). Retrieved March 5, 2009, from http://www.georgiaombudsman.org/docs/AnnualReport.pdf

Golant, S. M. (2008). The future of assisted living residences. In S. M. Golant & J. Hyde (Eds.), *The assisted living residence: A vision for the future*. Baltimore: The Johns Hopkins University Press.

Golant, S. M., & Hyde, J. (Eds.). (2008). *The assisted living residence: A vision for the future*. Baltimore: The Johns Hopkins University Press.

Hawes, C., Phillips, C. D., Holan, S., Sherman, M., & Hutchinson, L. L. (2005). Assisted living in rural america: Results from a national study. *The Journal of Rural Health, 21*(2), 131-139.

Hawes, C., Phillips, C. D., & Rose, M. (2000). High service or high privacy assisted living facilities, their residents and staff: Results from a national survey. Retrieved January 30, 2009, from http://aspe.hhs.gov/daltcp/reports/hshp.htm#chap1B

Hawes, C., Phillips, C. D., Rose, M., Holan, S., & Sherman, M. (2003). A national survey of assisted living facilities. *The Gerontologist, 43*(6), 875-882.

Hawes, C., Rose, M., & Phillips, C. D. (1999). A national study of assisted living for the frail elderly. Executive summary: Results of a national survey of facilities. Prepared for the Office of Disability, Aging, and Long-Term Care Policy, Department of Health and Human Services. Myers Research Institute, TX.

Kash, B. A., Castle, N. G., Naufal, G. S., & Hawes, C. (2006). Effect of staff turnover on staffing: A closer look at registered nurses, licensed vocational nurses, and certified nursing assistants. *The Gerontologist, 46*(5), 609-619.

Kemp, C. L., Ball, M. M., Hollingsworth, C., & Lepore, M. J. (forthcoming). Connections with Residents: “It’s All about The Residents for Me.” In *Frontline workers in assisted living*. Baltimore: The Johns Hopkins University Press.

Kemp, C. L., Ball, M. M., Perkins, M. M., Hollingsworth, C., & Lepore, M. J. (2009). "I get along with most of them": Direct care workers' relationships with residents' families in assisted living. *The Gerontologist*(49), 224-235.

Konetzka, R. T., Stearns, S. C., Konrad, T. R., Magaziner, J., & Zimmerman, S. (2005). Personal care aide turnover in residential care settings: An assessment of ownership, economic, and environmental factors. *The Journal of Applied Gerontology, 24*(2), 87-107.

Lepore, M. (2008). *Care workers' motivations for employment in long-term care, assisted living, and particular facilities: Reconciling inconsistent values* Georgia State University, Atlanta, GA.

Lepore, M., Ball, M. M., Perkins, M. M., & Kemp, C. L. (forthcoming). Pathways to caregiving. In *Frontline workers in assisted living*. Baltimore: The Johns Hopkins University Press.

Leroi, I., Samus, Q. M., Rosenblatt, A., Onyike, C. U., Brandt, J., Baker, A. S., et al. (2006). A comparison of small and large assisted living facilities for the diagnosis and care of dementia: The Maryland assisted living study. *International Journal of Geriatric Psychiatry, 22*, 224-232.

Lidz, C., Fischer, K., & Arnold, R. (1992). *The erosion of autonomy in long-term care*. New York: Oxford University Press.

Maas, M. L., & Buckwalter, K. (2006). Providing quality care in assisted living facilities: Recommendations for enhanced staffing and staff training. *Journal of Gerontological Nursing, November*, 14-22.

Mollica, R. (2007). Residential care and assisted living compendium: 2007. Retrieved February 2, 2009, from http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.htm#box1-1

Morgan, L. A., Eckert, J. K., Gruber-Baldini, A. L., & Zimmerman, S. (2004). Policy and research issues for small assisted living facilities. *Journal of Aging & Social Policy, 16*(4), 1-16.

Morgan, L. A., Eckert, J. K., & Lyon, S. M. (1995). *Small board-and-care homes: Residential care in transition*. Baltimore, MD: Johns Hopkins University Press.

Perkins, M. M., Ball, M. M., Whittington, F. J., & Combs, B. L. (2004). Managing the care needs of low-income board-and-care home residents: A process of negotiating risks. *Qualitative Health Research, 14*(4), 478-495.

Polzer, K. (2008). NCAL: Assisted Living State Regulatory Review. Retrieved January 15, 2009, from http://www.ncal.org/about/2008_reg_review.pdf

Schein, E. H. (1996). Culture: The missing concept in organization studies. *Administrative Science Quarterly, 41*, 229-240.

Secretary of State: Rules and regulations for personal care homes. (2008). Retrieved December 15, 2008, from http://rules.sos.state.ga.us/docs/290/5/35/14.pdf

Sikorska-Simmons, E. (2005). Predictors of organizational commitment among staff in assisted living. *The Gerontologist, 45*(2), 196-205.

Sikorska-Simmons, E. (2006). Linking resident satisfaction to staff perceptions of the work environment in assisted living: A multilevel analysis. *The Gerontologist, 46*(5), 590-598.

Sikorska-Simmons, E., & Wright, J. D. (2007). Determinants of resident autonomy in assisted living facilities: A review of the literature. *Care Management Journals, 8*(4), 187 - 193.

Singh, D. A., & Schwab, R. A. (2000). Predicting turnover and retention in nursing home administrators: Management and policy implications. *The Gerontologist, 40*(3), 310-319.

Stone, R., & Yamada, Y. (1998). Ethics and the frontline long-term care worker: A challenge for the 21st century. *Generations, 22*(3), 45-51.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

U.S. Department of Health and Human Services: A statistical profile of older Americans. (2008). Retrieved February 13, 2009, from http://www.aoa.gov/press/prodsmats/fact/fact.aspx

Utz, R. L. (2003). Assisted living: The philosophical challenges of everyday practice. *The Journal of Applied Gerontology, 22*(3), 379-404.

Weech-Maldonado, R., Shea, D., & Elmendorf, K. (2007). Long-term care providers and their perceptions of the external environment: Rural versus urban differences. *Journal of Applied Gerontology, 26*(1), 78-94.

Wilson, K. B. (2007). Historical evolution of assisted living in the United States, 1979 to the present. *The Gerontologist, 47*(Special Issue III), 8-22.

Zimmerman, S., Gruber-Baldini, A. L., Sloane, P. D., Eckert, J. K., Hebel, J. R., Morgan, L. A., et al. (2003). Assisted living and nursing homes: Apples and oranges? *The Gerontologist, 43*(Special Issue II), 107-117.

Zimmerman, S., Sloane, P. D., & Eckert, J. K. (Eds.). (2001). *Assisted living: Needs, policies, and practices in residential care for the elderly*. Baltimore, MD: The Johns Hopkins University Press.

Zimmerman, S., Sloane, P. D., Eckert, J. K., Gruber-Baldini, A. L., Morgan, L. A., Hebel, J. R., et al. (2005). How good is assisted living? Findings and implications from an outcomes study. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 60*(4), S195-S204.