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Communication in Assisted Living*

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Abstract

This study of communication in an Assisted Living Facility (ALF) focuses on staff's interpretive frameworks and situational tactics for managing elderly residents. It is based on interviews with staff and residents in an ALF together with ethnographic fieldwork. As in other quasi-total institutions, staff members engage in control as well as care, monitoring residents for compliance with rules and directives. Residents, aware of the threat of being moved to a nursing home, also monitor their own behavior and cognition in comparison to other residents. Other communication issues include the infantilization of the elderly by staff, and the race, class, and ethnic prejudices of residents.

This paper is concerned with communication between residents and staff in an Assisted Living Facility (ALF) we will call Arden. Our purpose is to explore how communication affects issues relating to residents' maintaining cognitive and physical functioning so that they are able to remain in residence. This facility is part of a Continuous Care Retirement Community (CCRC) that also includes a nursing home to which residents are moved, either temporarily or permanently, if they can no longer manage in assisted living. Arden consists of independent living, assisted living, and nursing home units. This study included the 39 residents of Arden ALF as well as eleven day and evening shift staff who provide care at Arden. The ages of residents interviewed for this study ranges from 70 to 88, and as in most such facilities women far outnumber men (28 out of the 39).

Arden serves a fairly wealthy and non-minority clientele in a suburb of a large Midwestern city. The cost of residence at Arden ranges from \$3,326 to \$5,971 per month, depending upon size of apartment and services offered. Meals are served in a restaurant-like dining room with table linens and menu options. The décor is colonial, with high ceilings and carpeted floors. Staffing during the day consists of a Director of Nursing (DON), a nurse (RN or LPN), two Certified Nursing Assistants (CNAs) and a Certified Medication Aide (CMA). The class and ethnic status of the administrative staff match those of the residents but the "bed and body work" staff are mostly minority--some foreign born--women, and a few men.

Our focus is on communication between staff and residents that affects whether residents transfer to the nursing home or continue to live in the ALF. First we discuss the *context of communication*, and the *interpretive frameworks* that staff members use to assess residents'

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communications, competence--and communicative competence. Then we address the specific, day to day communications between residents and staff that serve to monitor resident behavior for compliance and cooperation. Finally, we discuss staff and residents' different—and sometimes similar—critiques of Arden as a workplace and as a home.

Our findings reflect three key issues for staff and residents in this ALF. Communication is problematic, and is similar to traditional nursing home communication, including infantilization and lack of opportunities for interaction. Issues of race and class are also reflected. However, residents are primarily concerned with the cognitive and physical decline that necessitates their transfer to a nursing home. Both staff and residents engage in comparative monitoring of resident participation and performance that reflect compliance with ALF requirements or signal the need for nursing home placement.

THE AGING POPULATION AND ASSISTED LIVING

By 2050, 87 million Americans will reach 65 or more years of age and 21 million will be 85 years of age or older (Federal Interagency Forum on Aging-Related Statistics 2004). Aging adults require assistance in activities of daily living (ADLs) for an estimated 25% of their life span (Manton and Stallard 1991). With aging baby boomers and a projected decrease in the number of available family caregivers (United States Bureau of the Census 1992; United States Bureau of the Census 1993), conservative estimates are that 2 million elders will require supportive care (traditionally provided in nursing homes) by 2030 (Decker, Dollard et al. 2001).

Traditional nursing home residents are physically frail and require assistance, thus are relatively powerless and relinquish decisions such as when to eat, bathe, and sleep (Abrams, Beers et al. 1995). Many develop learned helplessness (Rodin and Langer 1980). Nursing home staff are trained and function under traditional institutional models, which often stress care over control (Hummert and Ryan 1996). For staff, physically demanding, task-oriented assignments, a lack of adequate staff, and frequent turnover rates are exacerbated by personal stress and differing cultural backgrounds from care recipients (Camp, Burant et al. 1996).

In nursing homes, loss of autonomy in making decisions contributes to isolation, depression, and further cognitive and physical decline (Aud and Rantz 2005). Staff interaction with residents is often limited, controlling (Lanceley 1985), and task-oriented (Grainger 1995; Lubinski 1995; Williams, Ilten et al. 2005), restricting residents' involvement in decision making and reinforcing dependency (Baltes and Wahl 1996; Williams, Kemper et al. 2003). Dissatisfaction with traditional nursing home care is reflected in surveys, indicating that 30% of older adults would prefer death to permanent nursing home placement (Matimore, Wenger et al. 1997). Residents' fear and dislike of nursing homes has led to a search for alternatives.

Assisted living is one of these emerging alternatives, providing options for elders who require some assistance with ADLs, but not complex nursing care. ALFs currently serve one million older adults and are the most rapidly growing segment of the elder care market (Aud and Rantz 2005; Mollica and Johnson-Lemarche 2005). The philosophy of ALFs is to enable residents to maintain optimal independence, by promoting autonomy, dignity, choice, and aging in place (NCAL 2001). These goals mirror values expressed by older adults: autonomy, dignity, privacy, individuality, enjoyment, functional competence, and spiritual well-being (Kane 2001).

The success of ALFs in achieving these goals and overcoming the problems encountered in traditional nursing home care remains undetermined. Although social cohesion, health, participation in activities, family contact, and an environment free of conflict were found to predict high quality of life for residents (Mitchell and Kemp 2000), little research has examined

whether assisted living is meeting older adults' needs, or to explain why approximately 24% ALF residents leave due to dissatisfaction (Phillips, Hawes et al. 2000).

Qualitative research is ideally suited to the exploration of the daily lives of staff and residents at ALFs. There have been several classic qualitative studies done over the past few decades in nursing homes and other traditional forms of elder care (Gubrium 1975; Diamond 1992). Recently, attention has also been paid by qualitative researchers to ALFs (see for example, Carder, 2002; Dobbs, 2004; Morgan, Eckert, Piggee and Frankowski, 2006). Debra Dobbs (2004), who did an ethnographic study of an ALF in the Midwest in the late 1990s, notes that qualitative research on such facilities is important because it identifies social and cultural, as well as individual and medical, sources of elderly residents' behavior. This is what we attempt to do in this paper.

METHODS

This paper is part of a set of papers focused on the experience of Assisted Living in four different facilities from the point of view of both residents and staff. Informed consent was obtained from both staff and residents under the Human Subjects Protection guidelines of the University Medical Center. Focus group or individual interviews were conducted with staff and women residents of Arden, with a goal of identifying issues related to communication, and maintaining ALF residency.

Ethnographic field notes also were compiled in visits to the facility to supplement the interviews conducted with staff and residents. The first focus group had eight nursing staff participants: Certified Nursing Assistants (CNAs) and Certified Medication Aides (CMAs) plus a Licensed Practical Nurse (LPN) and Registered Nurse (RN). Since it proved difficult to assemble staff members together at one time, this focus group was supplemented by an interview with two CNAs, and another with one CNA. These individual interviews provided the opportunity for member checking to assure reliability. Staff participants were provided a \$20 honorarium for their participation in the study. Five women residents volunteered to be individually interviewed and did not receive an honorarium. Five open-ended questions were used to elicit resident and staff perceptions of the ALF experience; focusing on communication in the ALF, transitions in and out of the ALF, the homelike atmosphere of the ALF, and strategies to improve or maintain ALF residency. The interviewer is identified as KW in interview quotes

The interview and focus group data were tape recorded and transcribed verbatim. We identify residents by pseudonyms, using both a first and surname. We identify staff members only by their roles, such as RN or CNA. Our decision to name residents was based on the fact that the residents live their entire life rounds in ALFs, whereas ALF staff live only—or at least mainly--their roles in the facility. This decision established an individual identity for resident subjects. The maintenance of self is a major issue for ALF residents as they incorporate past history into current institutional contexts (Golant 2003; Morgan, Eckert et al. 2006; Moss and Moss 2007).

The interviews were generally welcomed by both staff and residents, but particularly by residents. The interviews gave residents the opportunity to engage in social interaction with someone other than fellow residents, family or staff, and to see themselves as "helping" someone else. Doris Wilkerson said of the interview, "I'm glad you helped fill in my morning." When KW apologized that she had overstayed the interview's promised time by thirty minutes, Ellen Hardy said, "I'm here to help you." The desire to contribute, expressed by these elder women, parallels the need to maintain a work identity for older men in care facilities reported by other researchers (Moss and Moss 2007)

Analysis of the qualitative data was done by the inductive method: generating concepts from the data rather than deducing hypotheses from theory. The “constant comparison” method was used; in this case the comparisons were between staff and residents and among residents (Warren and Karner 2005). As Gubrium (2001) says of older adults’ narratives:

While they attend to local spheres of meaning in constructing their stories, taking them into account in forming their thoughts ... they also use elements of their own biographies to specify meanings shared with others (p. 27)

Although we have given room to both kinds of voice in this paper—the staff members and the residents of Arden—the overarching interpretive framework—and the context of communication—is the staff’s. The fundamental purpose of this research is to understand the living conditions and experiences of Assisted Living residents at Arden and elsewhere in the context of staff communication. This increased knowledge may then be used to improve care in ALFs. In the words of the PI, “We want to find out how to make this place more like a home.” The reader will be able to judge whether or not the words of one resident, in reply, have the ring of truth: “I don’t think that is possible.”

THE CONTEXT OF COMMUNICATION

All communications take place within a context—a context that has *economic* implications, *structural* frameworks, and a local *culture*. With regard to economics, nursing home care may be reimbursed by Medicare or Medicaid, while assisted living is most frequently supported by private pay funds, with limited Medicaid support. Nursing home care is likely to be more expensive than assisted living care because rates are based on amounts and types of care given, and more, generally, is given in nursing home than assisted living. A typical nursing home resident exhausts Medicare (acute rehabilitative) support, and their private finances, and then qualifies for Medicaid payment for long term care. Not all assisted living facilities accept Medicaid payment—indeed, Arden does not—so that only personal finances may be available to support assisted living residency.

Other *economic* aspects of Arden—indeed all such institutions—include the *ratio of staff to residents*, and the access staff have to *technologies* that make their job easier, such as the mechanical lifts used to ease the burden of bed and body work. The staff at Arden complain of inadequate numbers of nurses and assistants on their eight-hour (sometimes doubled to sixteen hour) shifts to give proper care to residents. They also note that technological supports differ from nursing home settings. As an RN noted, the absence of lifts is one factor in the set of factors contributing to movement of some residents from assisted living to nursing home:

Not able to get up and down out of bed by themselves and it takes a two person or two people or a lift to get them up and down. And there’s no lifts over here.

Although Arden has some residents who are in wheelchairs, there are only a few rooms that are fully handicapped accessible; residents who are still ambulatory with supportive aids (walkers or canes) are the mainstay of Arden and other ALFs.

As Goffman (1961) and others have noted, homes such as Arden have many or all of the characteristics of total institutions such as prisons or boarding schools: a dyadic hierarchy of staff and inmates, control of the life round of sleeping, waking, and eating, and a total or partial ban on leaving. Staff characterize the *structural framework* of Arden as “(like a) school.”—specifically, a boarding school. Arden is divided into three sectors: the (relatively invisible) administrative staff, the bed and body work staff, and the residents, whose life rounds the staff control and monitor. As in a school, residents form cliques for socializing and mealtimes. Staff observe the gender segregation of this coed “school”

LPN: Some [residents] visit and go walking with each other and sit out here and talk to each other...

CMA: But the men, no. They visit at the table...

LPN: The board of directors sit right there [laughter]. And after that, they go to their room and that's it.

As the staff identified, the local culture of Arden is like a boarding school--a co-ed one with a large majority of women. As such, Arden's local culture mirrors that of the larger society, with different patterns of communication attributed to women and men: the sociability of the women, and the dominance of the male "board of directors." The women are seen by both staff and other residents as more likely to engage in activities and gossip, while the self-segregating men talk of sports and politics, and then retreat to solitary activity. Limiting social ties in the ALF may be used by men to distance themselves from the institution and deny similarities to other residents or may reflect societal expectations that masculine interactions are instrumental (Moss and Moss 2007). Because male residents are "excused" from those ALF activities that reflect feminine roles, it is possible that staff may monitor women's behavior more closely.

As in a boarding school, residents are expected not only to partake of meals and have regular bedtimes, but also to engage in various scheduled activities and outings. School children who do not comply are defined and treated as stubborn and resistant. Although male residents may be excused, women residents who do not participate may also be seen in this manner; however, their resistance is likely to be interpreted as having *medical meanings* related to aging and/or Alzheimer's. In ALFs such as Arden, participation or resistance communicate compliance and competence, or noncompliance and incompetence, and thus readiness—or not—for movement into the nursing home.

These medical meanings of participation are read within the context of two interlinked elements of the *local culture* of Arden: the internal status system, and residents' fear of moving from assisted living into the nursing home. As in all closed settings, Arden has its own status system, linked to but not identical with the "external" statuses of class and gender. The status "currency" of elder institutions revolves around visitors, guests and outings—how many visitors and guests, whether family takes the resident out, and so on. In one exchange:

CMA: Oh Sunday was just wonderful!...

LPN: And it was great and we had 10 guests!

RN: Everybody was happy!

This currency establishes status among the peer group of residents; for staff and residents, it is also an indicator of the "goodness" or "badness" of residents' family networks. In the words of Alice James "I feel sorry for these people who don't have anybody."

Residents know that the most likely movement out of assisted living is by death or into the nursing home—few of them will return to independent living. The interviewer asked Alice James about getting out of assisted living:

KW: You must have seen some residents that have had to move out of assisted living?

AJ: Oh yeah, some have died [laughter].... Yeah. Then they go to Health Care [the nursing home] if they can't make it here.

In a study of spirituality in ALFs, it was determined that residents recognize that they will not return home, even though they may continue to own a house in the community. Residents don't view the ALF as "home" but as "a place to ponder their 'real' destination," that provokes anxiety over their future (Black 2006). Although the nursing home is a better option than death,

it is not much better, in the eyes of residents. Remaining in the ALF may establish distance to the eventual destination.

What is so problematic about “going to Health Care [nursing home]”? It is, of course, one movement closer to death. But there are more mundane issues also. As the RN interviewed notes, going to the nursing home is “a stigma thing.... That’s the words that are used”. A resident who is moved to the nursing home is deemed not competent enough to cope in assisted living; in the words of the RN, “they’re going to lose a lot more independence when they go over there.” It is well established that older adults who enter nursing homes surrender choice and personal preferences in most aspects of everyday life, since these institutions operate under a medical model of care. In contrast, ALFs are based on a philosophy of maintaining autonomy and agency in achieving a social, less institutional model of care. This may account for the increasing popularity of ALFs as an alternative to nursing home care although the success of ALFs in achieving these goals remains undetermined (Golant 1999; Carder 2002; Morgan, Eckert et al. 2006).

The environment of the nursing home, compared to Assisted Living, is also poorer. In assisted living, residents have their own apartments, but they may have roommates in the nursing home. Brenda Johnson, who was back on assisted living from a temporary stay in the nursing home focused on the noise and (ironically) the lack of assistance:

That’s terrible up there! That’s terrible!....they don’t have enough help. And constantly that buzzer is going off. Constantly. All day long. And when you did buzz for help or push the button, they were forever in coming.

As this resident summarizes the dilemma of compliance: “this is assisted living. And they can’t assist too much,” adding

We talk about [other residents] going to health care...no one wants to go there...it’s a nightmare compared to what’s here.

This “fear factor” element of the local culture provides, as we shall see below, a background of motivation for the residents to comply with staff members’ instructions and demands.

INTERPRETIVE FRAMEWORKS

Staff interpret residents’ compliance against the background of possible movement to the nursing home; they frame their interpretations of individual residents’ communications within several frameworks, the most general of which are *personality*, and *decline*. “Personality” is cultural shorthand for what we see as the unique characteristics of the people we interact with, that either draws us to or repels us from them. Decline—by illness, aging, or Alzheimer’s—is in some ways the erasure of personality, the removal of the self from fully competent interaction.

Within these personality and decline frameworks, and in the school structure and local culture of Arden, staff members use a number of situational frameworks for dealing with day-to-day communications with residents. Individual frameworks include *race*, *class*, and *cohort*. In addition, there are two *collective* frameworks that identify group rather than individual factors to explain some of the residents’ communications: peer pressure and family.

“Personality” and Decline

Personality as an interpretive framework refers to the way someone is all through their adult lives. Personalities, in our culture, are characterized as positive or negative, affecting perceptions of and communications with others. The RN said that she and others “connect with [particular residents] very well...I think it was their personality.” A CNA invoked the

understanding of personality as a way to try to connect with both residents and other staff members. She described one resident as

a sweetheart. Everyone has their special things about them that make them unique and special and fun to be around. If you can find the niche...If you don't, you'll clash all the way.

Other residents are seen as having bad personalities. A CNA described a resident as "...very, very rude...I think that's her personality" This staff member said that "some residents...are just naturally rude," distinguishing "natural" rudeness based on personality from that based either on decline or on other factors such as race, class, or cohort.

Either way—bad personalities or not finding the good in personalities—the outcome is communication problems and conflicts—"you will clash all the way." So one CNA focuses on

Finding the niche for each one. You find what they like...then you go with the flow. ...to keep from having a conflict, you have to find something in common with them. If you don't have something in common with them, you make sure you figure out a way to have something in common with them.

The trouble is, the aging process itself has a way of gradually erasing personalities—the dilemma of decline.

Whereas personality is lifelong, decline is its inverse: the waning of life and self. "Decline" is used by staff members to explain some of the negative communications made by aged and aging individuals. Although there may be temporary improvements or returns to the baseline (see below), the basic "fact" of aging is "decline"—loss of memory, loss of functioning, loss of autonomy. As one CNA puts it:

You physically decline...It's just time. You can't stop aging....So all of it just goes back to declining. There's nothing you can do about it

Decline is, of course, particularly consequential for staff—and other residents and family—when it is associated with the onset or development of Alzheimer's disease or other dementias.

Dementia poses special problems at Arden and in other institutions for the elderly. Dementia, over time, loosens the association between actions, communications, and consequences for those afflicted. The victims of this disease are no longer able to try to respond to directives, manipulations, or threats—compliance moves gradually away from their grasp. Dementia is seen by staff and residents as an illness superimposed upon the normal process of aging and decline, and one that comes with its special problems. For staff members, problems with dementia residents revolve around not only the lack of compliance but the lack of reason that underlies the possibility of compliance.

For fellow residents, dementia patients embody what Goffman (1961) calls the "contaminative" feature of co-residence in total institutions. As Margaret Smith puts it: "there's so many of them that are really ill and that is not very nice sometimes". In addition to fear and dislike of contamination—which is commonplace among mental patients and prison inmates—elderly residents are also affected by the mirroring effect of Alzheimer's disease and other dementias. Their future is before them. One staff member comments on the reaction of other residents to the impaired:

they want them out of here. Because they don't want to look at their future....This is what they are seeing and they are offended by it.

Especially for cognitively intact residents who are still aware of their situation, the consequence of decline is emotional distress—anger, unhappiness, loneliness. From staff members'

perspectives, many of the elderly are, in the words of an RN and a CNA: “just plain angry at the world” or “very unhappy” Residents generally concur. Alice James says, “I wish my memory wouldn’t go...that’s the hardest part of getting older.” Later in the interview she adds:

I can’t say I feel happy, but I can’t say I feel sad either. So I don’t know what to say there. I’ve felt lonely....No, I don’t enjoy my life at all.

KW: Really?

AJ: Yes.

One consequence of distress over decline, as the CNAs and CMAs in particular see it, is rudeness to them:

We cannot make them laugh. So, when we get to their rooms ‘Get me this...Do this. Don’t do that’....yeah their lives are very unhappy sometimes.

By invoking residents’ unhappiness, staff members are able to distance themselves from what they see as residents’ rudeness to them, whether the source of this rudeness is aging itself, or problematic of race, class or cohort.

Race, Class, and Cohort

Some staff members see residents’ “rudeness” to dark-skinned or foreign-accented staff as racism. Others excuse residents’ racist attitudes and behavior on the grounds that this was “typical” for the cohort within which they were raised. Still others note that the gulf of social class between (working poor) staff and (upper middle to) middle class residents account for the residents’ disinterest in or disdain for staff. An LPN said that most of the female residents:

Didn’t work. But [they were] still financially better than we were. And they think they pay a lot of money to live here, they have a right to treat you the way they want to.

Some staff members expressed appreciation for residents’ educational and class background. One CNA said:

They are very educated, the residents. If you interact with them, chat with them. Whenever there is a chance, they are very educated.

Another CNA describes a couple of the male residents:

One’s talking about politicians of the old day and the other one, they listen to the news all day long....because of their backgrounds. We have one guy that...was good in economics. So he always went out there and did stuff, money.

Arden staff discussed the problems of racist remarks, especially to foreign nationals with accents, made by staff to and about residents. In the focus group a CMA commented about a resident:

This one ...kept on telling me, ‘What are you doing in this country?...you know you are abusing our money. We don’t want you here. Go back to your country’....We learn somehow to live with them. And then, you get disappointed...And then you leave. But tomorrow you have to be here, you have to help her.

Expressed racism may be interpreted as a cohort effect of being brought up in the 1920s-1950s when “things were different.” An LPN said that “I think in the old generation you still have some prejudice there.” A CMA described how a resident did not want black staff members attending to her. The following exchange ensued:

LPN: That’s because of the time era she was born in back in the 30s and 40s.

CMA: But she’s a young lady, she’s about 40.

LPN: Depends on her parents....They was born into the upper class....So we as working people, we aren't worth their time.

We can see from this exchange that class, as well as cohort frameworks are used by staff members to "explain away" racist and other rude communications on the part of residents.

Together with personality and decline frameworks, cohort and class interpretations excuse the "racist" communicator as not responsible for their words or beliefs; this interpretive device is amplified when the resident is diagnosed with dementia or Alzheimer's and thus "can't help it" medically either. This entire interpretive set enables staff to "take it," "just sit there and say nothing," and "just do their job" without returning rude or racist remarks. As one CMA said:

You have to learn to live with it....you just keep quiet and pretend that you didn't hear what they say. Because if you pick it up you are going to start a fight and you don't want that. You just pretend.

From the residents' perspective, problems with foreign nationals' communications are not racist, but practical. Elderly people who are already hearing-impaired may have additional problems understanding foreign-accented speakers; as Brenda Johansen said of the staff at Arden

We do have so many accents. And it is more difficult to understand accents when you have some hearing loss already.

Furthermore, hearing loss among residents leads to raised voices on the part of staff, which can lead to accusations, by residents and other staff, of staff—including those without accents--shouting at them. As one CNA commented

If their hearing aids ain't working right, if they talk louder, you talk louder. And if someone overhears you, they think you're yelling at them. Some residents are also afraid of mistakes being made with medications because of English

language issues. Ellen Hardy said of a female and a male staff member:

She...doesn't speak the language very well...this one man...never gets an order straight when he takes it....So they've got this man who can't take an order for food doing the medications.

Other studies of facilities for the elderly indicate that medicine misunderstandings may indeed occur, among native English speaking as well as foreign born staff. As a 67 year old disabled man and temporary nursing home resident, Barry Corbet was intimately familiar with the medicines he was supposed to take, and the catheters he was supposed to use. This was not the case with other residents. He notes that:

There are repeated staff errors with my medication, even though I myself administer all my medications but one. It's easy for me to spot the errors, but what about all the residents who have no idea what they are taking? (2007: 84).

Peer Groups and Families: Collective Interpretations of Communication

Although much of the communication between staff and residents is interpreted through the lens of individual personality or decline, there are some situations in which it is mediated by peers or by family members. These collective contexts of communication generally make staff's tasks more difficult. Peer groups strengthen residents' resistance to compliance, while family may try to block staff's decisions concerning residents' remaining in the ALF.

Peer group pressure is invoked by staff to explain the behavior of individual residents who otherwise might act differently. In the "school" that is Arden, staff members interact with

residents collectively during mealtimes as they serve food, and at various other times of the day. An LPN describes getting ready for a museum trip:

And then all it takes is one resident to discourage the whole group. One day I had about 5 or 6 people getting ready to go. And then one resident starts saying, 'Well, we've been there before. All we're gonna see is the same thing.' And it dwindled down to one.

This LPN also describes mealtime rudeness as a consequence of peer pressure:

I've known some residents never said a harsh thing. And you sit back at their table where they're at that stage in their life, they are easily dragged into something by other residents. And it's because they want to belong.

Staff have at times to communicate not only with residents but also with residents' family members. Staff members report racist behavior from residents' families as well as from the residents themselves. A black staff member says of family that

I've sat at the desk and I've had family members come up to the desk, and....I can even have my name tag on and they will not ask me a question or they will give their paper to someone else besides me simply because I am black....And I just shake my head and say eventually they're gonna give it to me.

Family may have an indirect impact on communications between staff and residents because of shared knowledge that the elders do not want to go into the nursing home. In particular, family members put pressure on senior staff members not to discharge them from the ALF despite issues such as incontinence or dementia. An RN says that "A lot of times families.... say they won't" move the elder to the nursing home; if there is "no choice...our administrator sends out a letter to the family. And that's the biggie."

Some residents know, and use, the fear that administrative staff have of lawsuits in some of their dealings with middle class, educated family members: For residents, relatives are not only the "currency" of the status system, they may also be resources to draw upon in their efforts to get in to or out of various residential settings. Brenda Johnson described how her daughter had insisted to administrative staff that she be returned from nursing home to assisted living care:

She said this is the top one...And that's when I went to healthcare. And...word came through that they wouldn't accept me....She called the head honcho here....And they thought they would have to deal with it. And they, I think they saw being sued, I think they saw dollar marks.

With their own agendas, family members may interfere with staff's attempts to monitor residents and to deny reasons such as cognitive decline that might indicate a need for transfer to a nursing home. An RN recounted how the daughter of a resident told an Arden administrator that "I don't want that word used around my mother....and if you continue to use that word around my mother, I will pull her out." That word was "forgetful." Backed by family, residents are less concerned with staff monitoring and their own compliance:

CMA: They can be so nice to you and the minute you turn around and you can still hear them talking, they'll just stab you. I mean, they will cut you.

LPN: And other residents too.

MONITORING AND COMPLIANCE

The monitoring of residents for compliance and competence is, along with bed and body work, one of the primary day-to-day preoccupations of staff—within the context, as we saw above,

of such factors as staff/resident ratios and available technologies. Monitoring takes place against the background interpretive frameworks of personality and decline, race, class and cohort, and peer and family influences.

Staff attempt to enforce compliance with rules and directives. In Arden, as in all “schools,” the care function is inevitably complemented by the control function—which is why they are sometimes known as “care and control” institutions. One small example at Arden—one of many—is the staff’s attempt to break up mealtime cliques. As Margaret Smith said “They don’t want you sitting in one place all the time.” But, as in any school, there are small violations to match the small rules: “But right now we are.”

As social scientists have found in all types of total or quasi-total institution, the process of *typification* underlies staff-resident interactions. In order to work speedily and get the job done, staff members sort residents into general types—“the elderly are so hard to work with;” and specific types—“Emma is a whiner.” In turn, residents also typify staff members—although their typifications have little power within the institutional framework.

Residents are not only monitored by staff, they also engage in *self-monitoring*, and in *other-monitoring*. Self-monitoring occurs in the context of knowing the staff’s expectations for resident behavior and attitude, and residents’ motivation to not be sent on a permanent basis to the nursing home. Other-monitoring by residents of other residents is comparative: observation and evaluation of other residents to see how one is doing, either worse or better. Residents willingly communicate that they may be doing worse than other residents in terms of emotional factors such as depression or loneliness, but they generally insist that others are doing worse than they when it comes to compliance with the institution’s bed and body requisites.

Staff Monitoring of Residents

Baseline and *improvement* are important conceptual tools used by staff in their day-to-day monitoring of assisted living residents for continued suitability or unsuitability for semi-independence. Residents are permitted into assisted living with patterns of behavior that communicate semi-independence—they need help with respect to others, such as toileting or bathing. These patterns are the resident’s baseline, from which s/he cannot stray too far without movement into the nursing home. An RN says

A lot of times residents will leave assisted living because they have had a fall....And they don’t come back to their baseline. And that’s basically how most of our residents have landed on the health care [nursing home] side.

Staff also theorize that for some new intakes, the baseline is exceeded for a period of time, and there is improvement. The cause of this improvement is said to be the “assistance” in assisted living, which gives new residents a chance to engage in activities other than the basics of cooking and cleaning. As the RN said:

When they get here and...we’re doing some assistance for them... They sometimes step up. We have a resident...that has actually improved on assisted living.

But since decline is inevitable and improvement a honeymoon phase, monitoring and attempts to enforce compliance are continual.

Staff monitoring of residents revolves around day-to-day judgments of how much—not too much, not too little—assistance is required by a given resident. Residents should, in general, be able to get themselves to the dining room on time at mealtimes, and get themselves up in the morning and down in the evening without a fuss. They must shower, and accept assistance with showering if they need it. Above all, they must be seen to be engaged in activities. In

answer to a question concerning how to keep residents “sharp” enough for assisted living, a CMA said:

Just activities. And some of them it doesn't matter what activities. You can't do nothing.

When noncompliance with rules is observed by staff members, they attempt to elicit the desired actions—showering, toileting—or getting up—by directives, “trickery,” or threats.

When residents say or do things that staff members think they should not, staff may issue corrective directives. An LPN describes such an event:

It was lunch and one of the residents yelled out ‘Belinda wet the chair!’ And...I said...’The whole dining room wouldn't have known if you hadn't yelled it out...she probably is embarrassed.’ I said that wasn't a good thing...And that's something you have to correct right then and there because she'll forget it.

Alternatively, staff members may resort to what they call trickery to bring residents into line. One CNA describes how she gets balky residents to take a shower:

Well I talk about some other things. I bring up another subject.... And then I'll say, ‘Well, come in here. Let's go in here and see what's going on.’ [laughter]...

LPN: That's trickery!

CNA: I do, I do!

LPN: That's trickery is what that is! [laughter].

Some residents recognize staff trickery. Ellen Hardy, whose husband—also in assisted living before he died-- had Alzheimer's said that staff:

Found that my husband was easier to handle if he [staff member] would say—well, they all do—‘Wanna go home?’ He would say, ‘Okay, honey, we'll go home. But first I have to do such and such.’....they lied to this person....he didn't want a shower. ...And they said ‘Well you need to because your son is coming’....and [to me] they're like, ‘The son's not coming, you know, but she won't remember,,,,,And I was like, ‘Oh I don't know,’ and that's a hard thing.

The threat of having to go to the nursing home part of the facility is overtly used to exact compliance from residents. Staff members describe the process:

CNA: The way you can sometimes get them to do some more things for themselves tell them that they may have to go to the nursing... That's how we get some of them motivated.

These threats are seen as successful because of the stigma, loss of independence, and greater cost of the nursing home:

RN: It's a stigma thing too. They just don't want to go to a nursing home. That's the words that are used....

LPN: They're going to lose...a lot more independence over there....

RN: They also have a level of care which is money and the higher the level the more money....That sometimes triggers some of them to ‘Oh no, I guess I can do that myself.’

In summary, these three types of communication—directives, trickery and threats—are seen by staff as part of a learning curve that communicates to residents how they must behave to stay in assisted living. The RN comments that: If you beat your head against the wall enough

times...it finally sinks in that this is what I have to do to stay over here...lessons to learn.” Nevertheless, the reprieve is only temporary; in the end, as the LPN says ruefully, “it is just a matter of time...all of it just goes back to declining.”

Residents’ Self-and Other-Monitoring

Residents are well aware that they are being monitored by staff, and thus they need to self-monitor for compliance with staff expectations. Gubrium and colleagues (2003) note that stroke survivors engage in frequent benchmarking of their functional abilities as central to their identities during rehabilitation. We found that assisted living residents (and staff) similarly engaged in constant benchmarking, focused on functional losses instead of improvement. In assisted living, benchmarking comparisons to other residents were also common.

Functional assessment does not end when stroke survivors leave medical or rehabilitation settings: it is an ongoing part of their orientation to and understanding of their disabilities. They continuously take account of their abilities to function in the world (p.203).

In response to the interviewer’s question about what needs to be done for a resident to remain in Assisted Living, Brenda Johnson says “I try to take part in whatever activity they have....I try to walk every day.” Like the other residents, Doris Wilkerson expresses the irony of assisted living, where assistance is promised, but if it is rendered the resident may be judged in need of a nursing home. So the residents do more for themselves than they probably should: “they [staff] encourage me here because they don’t realize how difficult it can be for me....the stress of trying to do beyond my sight.”

Non-demented residents are also extremely aware of the staff’s expectations for compliance. Alice James, who has been living at Arden for three years described how she, in the questioner’s words, is able to “keep yourself able to stay here longer”:

I know to...eat well and do my exercises....You gotta get with it. not sit around and feel sorry for yourself....I do what they ask me to do. I’ve never had to go over there [nursing home] yet.

Compliance takes some effort—the travails of aging are made worse by the effort that has to be put out to remain less assisted in assisted living-- but it is reinforced by threats. According to Alice James “I have had some hard times. Like, I have fallen sometimes, and they say ‘You gotta get up and get moving here or you can’t stay here.’”

Residents monitor the communications and behaviors of other residents in order to compare and assess their level of competence and compliance in the context of the known demands of “remaining in assisted living.” Although she described herself as “terribly depressed,” 87 year old Doris Wilkerson is proud to have a job at Arden filing paperwork. She says that if she did not do the job “I’m in [another resident’s] category where I can’t do it. I can if I will tax myself a little bit and that’s good for me.” This resident plays bridge with the residents in independent rather than assisted living, comparing herself favorably to the others in ALF:

I don’t...play bridge...’on this side[ALF]’...I will play bridge with the independent people because they’re, as I put it, playing with a full deck....I’m more comfortable that way....There’s more competition and it’s much more fun.

She continued “I am probably not perfect, but I can be thankful when I see other people here,” and later in the interview added “I have fallen a couple of times here and I didn’t get hurt. I feel sorry for those whose hips give way.”

Staff also note and comment upon the comparisons that occur among residents. In her discussion of other residents’ response to Alzheimer’s residents, one can said that residents

“feel more powerful because they think ‘Oh I understand this, I’m not that bad...’ Oh I’m smarter’....they’re not thinking ‘Oh I’m gonna be there.’” Furthermore, residents—according to staff members—resent the impaired when they are “loud and rude” because they pay so much for assisted living care. One CNA says that “they are offended ...’How dare they? I paid this much money.”

Residents monitor staff communication and behavior toward themselves and other residents. In institutions where the ill, helpless or dependent are cared for, *infantilization* of residents by staff is a common communicative typification (Williams, Kemper et al. 2003; Williams 2006). Alice James says that staff members “look down on us:”

It’s like they think we’re children...at least they give the attitude. So I think they should recognize people here are elderly but they aren’t stupid and they aren’t three years old

A former nursing home resident describes infantilization in detail:

The diminutives! The endearments! The idiotic *we*’s. Hello dear, how are we today? What’s your name dear? Shall we go to the dining room Eve? Hi hon....Don’t we look nice today!....Chirpy singsong voices. Who thinks we want to be talked to this way? (Corbett 2007)

Staff are also criticized if the *adultize* the elderly by not recognizing their frailties and limitations. Alice James says that staff

treat you like you’re thirty years old....And I think they should be told, you know, that’s not the right way to treat [elderly] people.

Not all reported communications between staff and residents consisted of typification, monitoring, directives or threats. Some staff, and some residents, reported relating to, and liking one another—as one of the residents commented, “some of them are very nice.”

“Some of them are very nice”

Resident niceness—like resident nastiness—was sometimes glossed by staff as “personality,” as we saw above. But there were other sources of positive communication. Both residents and staff referred to *biographical knowing* as an important aspect of appreciating the other; staff also referred to *joking relationships* with residents as important to positive interaction. Residents liked to be, as much as they could, in *helping* relationships with staff members and fellow residents in order to generate positive feelings.

Alice James links enjoyment of the other to knowledge of the other: “you get to know the ones you really enjoy. You do enjoy them.” Brenda Johansen said of a male staff member: “I feel like I have a relationship with him. I mean, I know he’s going to school and all that. And what he wants to be and all that.” Staff members rarely mentioned biographical knowing as an important aspect of their communication with residents; at the same time, residents saw staff as too busy to talk to them or get to know them. Alice James said that staff “never have time to talk to you” Ellen Hardy concurred, saying that staff

don’t come in and visit with me. I don’t expect them to...this lady came and picked up. But she’s the cleaning lady. A very nice gal.

Without conversation, there cannot be the kind of personal knowing that leads to appreciation—or in the case of “bad personality” nonappreciation—of the other.

Joking relationships were mentioned by both staff and residents as one factor in generating positive feelings for the other. A staff member described his relationship with a table of residents at mealtimes as one in which “we joke all the time with them....they’re very nice.”

A resident says of a staff member “He makes us laugh. And I think that’s very good for us.” Laughter was also part of some interview exchanges. While complaining to the interviewer about staff’s infantilization of residents, Alice James said:

I think that’s one of the biggest objection of the women I talk to. ‘I don’t want to be talked to like I’m three years old...Even though you act like it sometimes!

Being cared for by others, residents found it important to try and help or care for others. In discussing the staff’s problem with overwork and long shifts, Doris Wilkerson said that

I watch TV. I give them information....because they don’t know half of the time.... they don’t have time to do the news and stuff.

Residents told stories that involved them helping other residents, stories that also served a comparative purpose, underlining the teller’s greater capacities. Ellen Hardy said that:

Today, at lunch, everybody else had their food. All of us had eaten our food before [other resident] ever got hers. And I finally couldn’t take it any more and asked where was her food.

Later in the interview, this resident described “a sweet lady, but she’s totally deaf. And I am trying in my own way to learn to sign.”

CRITIQUES OF THE ALF

Staff and residents both engaged in critiques of the way Arden is run. These critiques and were based in part upon the kinds of interpretive frameworks noted above; for example, foreign staff would prefer that residents refrained from racist remarks, while residents’ preference was for hiring native English speakers. Ideas about how things worked and how to change them were also, of course, linked to the staff’s and residents’ position in the structure of the “school.” For the staff, Arden is a workplace; for the residents, it is their “home”—the place where they will either end their lives or move from into a nursing home.

Staff and residents had two critiques in common: that staff should not perform both dining room and bed and body work, and that staff were overworked. Residents also found fault with the activities and outings that were offered to them, although some residents admitted that they did not engage in those that were offered, and would rather watch TV, read, work on computers—or sleep away their days. Finally, residents feared danger in the context of overworked, “untrained,” sometimes foreign-accented workers.

“The Universal Helper”: Food Service and Bed-and-Body Work

Neither staff nor residents were satisfied with mealtime arrangements—staff members as the “universal helper,” doing both mealtime and bed and body work (Zimmerman, Sloane et al. 2005). Staff and some residents objected to the servant-like role of staff serving food but not sitting down and sharing meals. Ellen Hardy, a former nurse, recalled that

Nurses never had to do that. I can’t believe it. But they’re called ‘international helper’ now.

KW: Or, yeah, ‘universal’....universal workers, that’s a big thing now.

EH: I know, and it’s wrong....I think it’s bad, it’s very bad. Because I don’t feel like the gals that take care of you here should be asked to do that kind of stuff.

Staff members concurred. One CNA thought that “the way it is set up in the dining room I don’t think it is right, especially for us.” She proposed a more egalitarian serving structure that she framed as both more homelike” and better for residents’ functioning:

When they see us, they want to rely on us to help them more than they need....I would like to have like at home, you serve....Dishes, pass out the dishes, and they can take whatever they want by themselves. I think most of them, they are able to do it.

Residents complained about staff members' "lack of training," either in practical matters, human communication, or both. Several residents were worried about hygiene at mealtimes. Doris Wilkerson said that:

They need to be trained. They're not trained at all...these gals that work with you go down and do stuff in the kitchen and they serve you... I think that's a very poor combination.

Ellen Hardy concurred: "They have their finger in the ice cream....they'll walk by and pick up a nut when they're serving food, stick it in their mouth. You know, that's not right." Some staff members also complained about the hygienic contradiction of combining food service and bed and body work. A CNA said:

We're giving showers. We're changing diapers. We're stripping sheets. We're making beds. And we're handling their plates....everybody's hands are contaminated.

In addition to the servant role of staff and the hygiene issue, there were several other complaints about various aspects of mealtimes from both staff and residents. Doris Wilkerson, indicated that most of the verbal contact between staff and residents occurs at mealtimes; her complaint is about what she perceives as the staff's lack of training in communication skills:

I don't think they are trained to be as understanding as they should be...I don't think the staff is properly trained to deal with geriatrics, geriatric people as well as they could be....our main contact with them is at meals...the staff can be very short. Not as understanding.

It is clear that whatever the ideology behind the "universal helper," the concept is not working for the staff and residents of Arden. The servant-like role is problematic for staff, while hygiene issues bother both staff and residents. The shortness and staff's lack of communication at mealtimes may also be related to staff's perceived overwork and, possibly, turnover.

"Overwork" and Turnover

Staff and residents referred to the excessive amount of work staff are responsible for and referred to inadequate staffing as the reason. However, many staff members also chose to work two eight hour shifts. Both staff and residents identified staff overwork as an excuse for staff not taking time to talk or visit with them. An LPN said:

We have 40-something people over here for two people that are working the floor... It's not fair to the residents....they don't get the care. Everyone wants a certain amount of attention. We need someone to come in and say, 'Hey how are you doing?'

One resident, in discussing staff's lack of response to her emergency button calls, speculated that because they have so many demands on their time "perhaps [staff] dismiss my calls. Put them off a little until they do what seems more pressing." Another resident says of staff that "They're not bad people. They're just so tired, they're dragging their self around." One staff member complained not only of the two people in charge of 39 residents, but also that "there's a nurse here that's going over to [the nursing home part of the facility], that's not fair to the residents."

Staff turnover is a problem in many elder and other institutions; most staff and residents thought that turnover was not as much of a problem at Arden as other places. Doris Wilkerson, however, complained that:

The staff changes too fast... You get acquainted and you like them and they go somewhere else.

“My residents have the right to sleep”

There are a number of opportunities at Arden for activities and outings—bingo, reading and writing, crosswords and bridge, crafts, whirlpool, exercises, trips to the local museums and shops. Residents generally acknowledged this range of options, although some of them wanted different ones, a few said that there were not enough activities, and others did not want to participate in the activities offered. One resident thought that cooking classes should be offered, and exercise using a large ball. Others “knew” that they should engage in activities in order to underline to staff their continuing eligibility for assisted living, but they didn’t necessarily want to comply. When the interviewer asked about exercises, Alice James said that:

Well, yeah, I do some...I don’t do very many anymore. I do what they ask me to do.

Several women—and apparently all the men-- kept to themselves most of the time--several of them on their computers—Ellen Hardy saying that “I don’t really relate to the people here...I sorta stick by myself. I have my computer and TV.” —and “I sleep a lot.” As we know from the work of Jaber Gubrium (1975), sleep is, to staff, a meaningful communicator of elder institutional residents’ state of being. In Arden in the 2000s, as in the “Murray Manor” of the 1970s

Where one sleeps to pass time makes a difference in how the sleeping is evaluated by others. Sleeping in bed most of the day is judged negatively, but spending nearly as much time sleeping in the Manor’s lobby or lounges is considered just a matter of dozing off. The former is believed to be a deliberate plan to *just* sleep, whereas the latter is treated as one of those things that ‘happens’ when it gets warm and quiet. Dozing off is defined as an event that ‘happens,’ even though for some patients and residents it happens fairly systematically (p. 179-180).

Sleeping too much, or in the wrong place at the wrong time, has been an issue in facilities for the elderly at least since the fifteenth century. In his training manual for geriatric staff, Zerbi (1489) warns that “Moderate rest is recommended for old people,” but not “rest that is inordinate” (p. 118). In the light of more than five hundred years of practice, suggesting that staff do not use sleeping patterns as an indicator of resident compliance would probably be futile.

The issue of monitoring sleep is one aspect of what Goffman (1961) refers to as the “looping” problem in total institutions: everything the resident does is a potential source of monitoring and assessment, and thus of self-fulfilling prophecies of deviance or decline. We wish there were a recommendation we could make that would stop the looping effect. But there isn’t; as Corbet (2007: 91) notes of the nursing home

restraint is a constant condition for all of us here. It’s not force majeure, not even staff obstinacy; it’s conditioning, habit, insistent reminding that this is how we do things. We know how things go smoothly. Smoothness is greatly admired here. But when smooth operation is the paramount goal, subjugation follows. It’s built into the institutional model.

Implicitly recognizing the looping feature of total institutions, the RN insisted to another staff member that “my residents have the right to sleep. Did you not read their rights?”

CONCLUSION: HOME/A HOME

The following exchange took place in the interview with Margaret Smith:

KW: If we could figure out how to make it more like home here....

MS: I don't believe that would be possible.

KW: some things are kinda like at home. You have some of your own things here.

MS: This is all my stuff. But that's only a little bit of it.

When someone moves from home s/he may move from her local community as well as from the home's space. Time spent at home is left behind and lives on only as memories, and the "little bit" of things that can be brought into assisted living. Mealtimes are now structured by someone else's choices; food and drink options are increasingly restricted. Pets will probably have to be left behind. A husband or wife may be with the resident in ALF at first, but then dies and leaves the other alone.

A home is not home, but it should be a place where needs are met and dignity is maintained. For more than five hundred years, the environment and staffing of facilities for the aging has been of concern to gerontologists and geriatricians. Today as in the fifteenth century:

The person in charge of the aged must be a man [sic] whose chief function is their restoration. Let him be liberally educated...Let him be frugal....The gerontocomos must be experienced in both the affairs of a family and those of a physician....Not only must the gerontocomos give orders, but also carry them out so that his assistants will imitate him as he does so....Let him be very zealous in regard to cleanliness and elegance of surroundings....Let him employ assistants who are zealous and keep them very frugal. He should remove the lazy and stupid. Among the assistants there may be men or women. Off duty or on duty they are ordered to behave politely. Let the gerontocomos impress upon them that they should be easily available for restoring the old people. Their duties are first of all not to disturb the functions of health care since not all the assistants are equal to all services involved....nor should the old people have a just complaint due to the improper number of assistants....Let the workers strive to carry out the orders of the gerontocomos properly and not think they know more than he does (Zerbi 1489: 87-89).

Arden is a clean and elegant facility, with a well educated person in charge, and a definite sense (as is the case in all institutions) of cost effectiveness. There are a variety of assistants with training in medical, bed and body, and other work, who strive to be polite. But in the end, the "affairs of a family and those of a physician" are very different.

Discussion

An ALF is an institution and cannot be a home. But as a homelike facility, ALFs should be at least as well maintained and staffed as those described in fifteenth century Italy—Arden, indeed, is. Some of the elements of home and of the individual's autonomy and agency can be retained in ALFS, particularly if staff support resident everyday life decisions and control. As Debra Dobbs says of ALFs:

A better understanding can result in more empathetic staff and positively affect the type of care they provide: Social scientists doing ethnographic work in long term care settings could benefit the field by....educating staff on how to seek social explanations for residents' behaviors (2004:70).

Indeed, aging and Alzheimer's disease - together with personality - provide some of the individual, life cycle, and clinical explanation for the behavior of residents in ALFs. But there are social explanations as well. It is through communication in everyday situations that life is lived by residents, and work done by staff, in ALFs. Staff's tasks are made more or less difficult by the structure and economics of the workplace. General and local cultural norms of gender,

race, ethnicity, nationality, and competence shape the ways in which staff and residents communicate.

Our focus on communication between residents and staff reflects the structure of life experiences in assisted living and the primary concerns of residents and staff. Institutional aspects of ALF life were revealed as well as social issues. Concern over maintaining ALF residency dominated communication within this ALF. Residents expressed fear of decline and nursing home placement while staff report monitoring and motivating residents to comply with ALF requirements.

At the level of the local culture, typifications of personality and decline shape staff's response to residents. Using these typifications, staff monitor residents for compliance and competence, while residents also monitor themselves and each other. Critiques of the workplace are offered by both staff and residents, sometimes in agreement with one another and sometimes not. It is this complex structure of communication and its context that forms the foundation of everyday life—its satisfactions and dissatisfactions—for staff and residents in this institutional workplace and a home.

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