The Facade of Stability in Assisted Living

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Objectives. The study sought to identify the varied types of change arising from internal and external influences in assisted living (AL) settings, expanding upon the literature's limited focus on resident decline and staff turnover and clarifying the importance of changes to life and work there.

Method. This analysis employed qualitative interviews and observations from 4 studies involving 17 ALs to identify elements of change largely absent from the literature. Case material identified by the research team members relating to persons, groups, and settings exemplifying typical changes, as well as variations across settings, are presented.

Results. Multiple domains of AL change were identified, to include those in: (a) the external economic or competitive environments; (b) ownership, management, or key personnel; and (c) physical health or cognition of the aggregate resident population. In many cases, the changes influenced residents' satisfaction and perceived fit with the AL environment.

Discussion. Change of many types is a regular feature of AL; many changes alter routines or daily life; raise concerns of staff, residents, or families; or modify perceptions of residential normalcy. Environmental gerontology should more often extend the environment to include the social and interpersonal characteristics of collective living sites for elders.

Key Words: Assisted living—Environmental gerontology—Long-term care—Quality of life.

ORGANIZATIONS providing senior housing with personal care, as well as the residential care settings themselves, may convey an appearance of stability to persons unfamiliar with them. This appearance arises in several ways. Each senior housing setting occupies a building or buildings in an established location, carries a known name, undertakes ongoing institutional practices, retains familiarity and reputation in the community, and exists in a framework of governmental regulations. For a senior housing sector like assisted living (AL), many providers share common goals, physical features, organizational structures (e.g., presence of nurses or certified nursing assistants), and daily routines of meals, personal assistance, and activities (Mollica, Houser, & Ujvari, 2010). Consistency of public image is further encouraged by uniformities present in state regulations (Mollica & Johnson-Lamarche, 2004; Polzer, 2012). The general public's impression may be that individual AL settings are relatively established entities, evidencing noteworthy stability. What outsiders discern is only a limited view, which may change dramatically once a friend or relative requires AL care.

Our ethnographic research in 17 diverse AL settings (2004 to the present) has found evidence that what may appear to be quite stable is, in fact, a facade. First, our research indicates that stability—in many senses—is not the norm for ALs (Perkins, Ball, Whittington, & Hollingsworth, 2012). Changes occur at multiple levels of person (residents, family members, staff, or managers), collectivities (groups or types of residents, staff, or managers), organizations (owners or corporations) and external

environments (economies or competitors) (Morgan et al., 2011). Second, among these multiple levels and dimensions of change/instability, only a few have been examined substantially in research to date. The literature has focused most on resident-level outcomes and changes, with select studies addressing staff quality, turnover and select organizational-level characteristics, and changes (Ball et al., 2004; Perkins et al., 2012; Sikorska-Simmons, 2005). Here, we utilize qualitative data to describe the three broad, observed levels of change (external, organizational, and group), which carry the potential to meaningfully reshape the daily experiences and evaluations of both AL residents and staff members. The changes in AL communities contradict their outward appearance or façade of stability and may profoundly affect the quality of life for residents. Our research extends recent attention to facility-level change (see Kemp, Ball, Hollingsworth, & Perkins, 2012; Perkins et al., 2012).

PRIOR RESEARCH ON AL VARIATION AND CHANGE

Prior research describes variations in the AL sector both across states, which define and regulate AL, and over time. States may limit their definitions of AL to newer, purpose-built settings or fold selected existing settings of varied sizes or configurations into their definitions of AL. Consequently, the size, variety, and costs in care settings labeled as AL vary a great deal (Mollica et al., 2010; Morgan, Eckert, & Lyon, 1995; Zimmerman, Sloane, & Eckert, 2001). Consumer decisions regarding selection of

an AL, and subsequent attachment to and satisfaction in AL, vary across these dimensions of AL differentiation across states (Ball et al., 2005; Cutchin, Owen, & Chang, 2003; Frank, 2002).

AL, initially developed as a “social model” of care involving limited medical services and staff, has from its beginnings included two distinct approaches: transfer and aging in place (Ball et al., 2004; Bernard, Zimmerman, & Eckert, 2001; Chapin & Dobbs-Kepper, 2001; Heumann, 1993). Some states’ legislation endorsed aging in place as a goal (Mollica & Jenkins, 2001), creating a tension between the social model of care and increasing care needs associated with aging in place; this tension continues to play out in AL settings today. While nominally offering aging in place and encouraging expectations for residential stability, many ALs have struggled to balance these goals. Studies show that the goal of aging in place competes with AL policies that have encouraged transfer of residents with challenging behaviors or complex health needs (Ball et al., 2004, 2005; Bernard et al., 2001; Eckert, Carder, Morgan, Frankowski, & Roth, 2009; Heumann, 1993).

Although early AL residents’ functioning often matched the social model of care, over time, aging in place and delayed entry into AL resulted in residents who arrive with greater care and supervision needs (Caffrey et al., 2010; Hawes, Rose, & Phillips, 1999; Morgan, Gruber-Baldini, & Magaziner, 2001). Research has also shown that changing facility structure and culture (e.g., adopting an aging-in-place approach) may contribute to diminished fit for some residents (Ball et al., 2004, 2005; Perkins, Adelman, Furlow, Sweatman, & Baird, 2010; Perkins et al., 2012; Phillips, Munoz, Sherman, Spector, & Hawes, 2003).

Another dimension of AL change reflects staff turnover. Findings are mixed, with some studies indicating organizational performance (i.e., leadership, wages, treatment of staff) influencing retention or loss of staff (Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004; Sikorska-Simmons, 2005; Stone, 2001; Stone, 2010; Stone & Dawson, 2008; Wood & Stephens, 2003; Young et al., 2008). Other work shows AL facility traits as less important than the larger economy for staff intent to leave or job dissatisfaction (Perkins et al., 2010). The “turnover” approach further suggests that direct care staff members are fungible—more or less equivalent units of service provision—rather than persons of varied skill, motivation, history, and attachment to residents (Ball, Perkins, Hollingsworth, & Kemp, 2010).

The literature on resident change focuses on diminishing function resulting in departure, as well as the multiple dynamics of social relationships within this residential context. The functional change research highlights progression of resident health conditions, which may serve to diminish fit with an AL environment and may influence relations with others residing there. The progression of physical or cognitive decline, resulting in growing care needs, is responsible for most departures from AL (Assisted Living Federation

of America [ALFA], 2009; Phillips, Hawes, Spry, & Rose, 2000). Reported length of stay in AL averaged between 20 and 29 months, with shorter stays (10.9 months) among those with dementia (ALFA, 2009; Chapin & Dobbs-Kepper, 2001; Koptez et al., 2000; Lyketsos et al., 2007; Phillips et al., 2000). Evidence shows that stays in AL are growing in duration (Caffrey et al., 2012; Hawes et al., 1999) due to increased aging in place. Although average stays are relatively short, a subset of residents have stays of many years, permitting substantial time for them to observe notable changes within their ALs (Ball et al., 2005; Mollica et al., 2010; Morgan et al., 2001; Phillips et al., 2000).

Research also points to the importance of social connections within ALs; studies demonstrate both the value of peer connections and their fragility. Social relations of residents in AL are shaped by a range of person-level factors (e.g., physical health/cognition, class, religion, race, and ethnicity) (Ball et al., 2005; Eckert, Zimmerman, & Morgan, 2001; Kemp et al., 2012; Morgan et al., 2011; Park, 2009; Perkins et al., 2012), as well as facility-level factors (e.g., policies, programming, and physical layout) (Kemp et al., 2012). An examination of ALs in Georgia has shown the importance of socially similar others to both AL selection and subsequent resident comfort in that AL (Ball, Perkins, Hollingsworth, Whittington, & King, 2009). Good social relations are linked to positive resident outcomes (Ball et al., 2005; Eckert et al., 2001; Kemp et al., 2012). Many of these studies, by focusing on pair relationships, however, attend less to the collective dynamics of the resident group in terms of its potential influence on fit and well-being.

CONCEPTUAL PERSPECTIVES

We frame our discussion within environmental gerontology, specifically person/environment (P/E) fit and residential normalcy (Golant, 2011; Kendig, 2003; Lawton & Nahemow, 1973). Although ALs may appear initially similar to outsiders, consumers seeking residence quickly learn that settings vary in cost, amenities, services, physical layout, size, location, and ownership status (e.g., independent or chain) and affiliation (e.g., religious, fraternal organization, etc.) among other factors (Eckert et al., 2009; Zimmerman, Sloane, Eckert, Buie, et al., 2001). Moves into AL, often precipitated by health changes (Ball et al., 2005; Eckert et al., 2009; Frank, 2002), follow from a recognition that the current residence is no longer suitable. Selecting among affordable, well-located sites with openings, similar others, and suitable services often occurs under severe time constraints (Ball et al., 2009; Frank, 2002). Choice requires weighing how well the future resident’s needs and preferences match the options offered by each AL setting—the extent to which it provides, in Golant’s term, residential normalcy (2011). The prior home environment, now a problematic fit to its occupant, is replaced by the selected AL,

where the goal is to improve P/E fit through physical and service adaptations to reduce environmental press (Wahl & Weisman, 2003).

The literature on P/E fit and environmental gerontology has focused on changes in the aging person as eroding fit (Lawton & Nahemow, 1973; Wahl, Iwarsson, & Oswald, 2012). Other work has recognized the deleterious influence of poorly maintained housing and neighborhood changes on P/E fit (Iwarsson, 2005; Kendig, 2003; Wahl, Oswald, & Zimrich, 1999), including poor accessibility or lighting and fall hazards (Gitlin, 2003; Golant, 2003; Wahl & Weisman, 2003). Less attention has focused on the community and interpersonal dimensions of residence or costs arising from loss of a sense of “home” engendered by relocation into a care setting. Features associated with relocation include altered daily schedules, diminished privacy, and exposure to unfamiliar others (Rubinstein, 1989; Wahl & Weisman, 2003).

Also important to consider, however, are the *continuing* changes in P/E fit *during* an individual’s tenure in AL, arising from the resident or the environment (Golant, 2011). Annie, whose mother [Nellie] was a resident of Valley Glen, described how she came there as her dementia progressed, after having rejected a nursing home. Annie said, “My mother would die if I sent her there, and I couldn’t do it.” Once Nellie became eligible for Medicaid waiver funding, they visited Valley Glen. “I went to Valley Glen and immediately – I was there about five minutes, and I said ‘This is it.’” Its small size and personal attention to each resident helped Annie, now determining fit on behalf of her mother, select it (Morgan, Eckert, Piggee & Frankowski, 2006).

While changes in residents and staff are expected, other dimensions of change in the AL environment are less recognized or anticipated. Nonetheless, changes

in the AL environment appear regularly and may serve either to enhance or diminish AL quality and support of resident well-being (Golant, 2003; E. Kahana, Lovegreen, B. Kahana, & M. Kahana, 2003; Thomése & van Groenou, 2006). As primarily a private-pay, for-profit sector (Mollica et al., 2010), the rhetoric of consumer choice for AL contends that any dissatisfied resident (or family) has the option of relocating. However, research suggests serious challenges that impede the undertaking of another stressful move to a new, but equally changeable, AL environment (Carder & Hernandez, 2004; Eckert et al., 2009; Frank, 2002). Residents and families sometimes struggle with AL-based changes, which reshape daily life and their evaluations of AL (Kahana et al., 2003). This paper identifies and provides examples of important multilevel changes we have observed during qualitative research in 17 AL settings since 2004.

METHOD

This paper is based on the results of four multiyear, NIA-funded research studies, listed in the acknowledgements. The studies used qualitative research methods to examine transitions, social stigma, quality, and autonomy in AL. The ALs in the study are all located in Maryland, a state with a broad definition of AL, including small, larger legacy and newer, purpose-built ALs (See Table 1). Sites ranged from very small to large; six were non-profit, and five held affiliations with religious, fraternal, or other organizations. Methods of the studies variously utilized: participant observation; semistructured ethnographic interviewing with multiple participant groups (residents, family and AL managers or direct care staff); informal interviews and conversations; document reviews; and development of case studies.

Table 1. Description of AL Settings Included in the Sample

Pseudonym	Studies	Resident capacity	Chain	For-profit	Locale	Affiliated ^a
Arcadia Springs	1	45	No	Yes	Suburban	No
Boxwood Gardens	1	104	Yes	Yes	Suburban	No
Chesapeake	3	100	Yes	Yes	Suburban	No
Covenant Home	1	100	No	No	Urban	Yes
Fatima House	2	60	No	No	Urban	Yes
Franciscan House	1	8	No	Yes	Suburban	No
Aragon	1	155	Yes	Yes	Rural	No
Greenbrier	1	92	Yes	Yes	Suburban	No
Huntington Inn	3	36	No	Yes	Rural	No
Laurel Ridge	1	112	Yes	Yes	Suburban	No
Middlebury Manor	1	42	No	Yes	Urban	No
Stonemont	1	228	No	No	Suburban	Yes
St. Brigid	1	18	No	No	Suburban	Yes
Valley Glen	1	6	No	Yes	Suburban	No
Walden	1	16	No	No	Suburban	No
Wetherby Place	1	48	Yes	No	Suburban	Yes
Winter Hills	1	75	No	Yes	Suburban	No

Note. AL = assisted living.

^aAffiliations with organizations that may be religious, fraternal, etc.

Methods are further detailed in prior published work (Eckert et al., 2009; Morgan et al., 2011; Roth et al., 2012).

Time spent in sites varied across studies, with multi-month periods (typically 6–8 months or more) of observation and interviewing. Both the duration of our research and relationships with staff and residents enabled the research team to learn, through follow-up visits or phone calls, about later changes in many settings. Over the four projects, data collection produced 876 field notes from participant observation and informal conversations and 897 interview transcripts from formal interviews (211 interviews involving direct care and administrative staff, 222 with family members, and 464 with residents).

Each study had a distinct focus; none specifically addressed AL change as an emphasis. Narrative relating to AL changes arose in interviews, as part of responses to other questions or while discussing life or work in AL concurrent to changes. Given that three ALs participated in multiple studies, the cumulative time available for observation of change was expanded for these sites. AL selection was purposive in all four studies, to reflect key dimensions of variation in AL, including non- or for-profit status, size, urban, suburban or rural location and newer purpose-built versus older settings. All studies were approved by the IRB at the University of Maryland, Baltimore County and all names of ALs and persons are replaced with pseudonyms.

Each project was organized so that it included two types of researchers: field ethnographers and data analysts. The four studies involved a total of 11 persons as field ethnographers, several of whom were involved in multiple studies; an additional 12 persons participated as data analysts, whose work, along with the ethnographers, involved reviewing data, developing and refining the coding schemas, and analyzing narratives. The data analysts typically did not spend much time in the field but read extensively in field notes and interviews as part of the coding and analysis processes. Research teams for all four projects employed biweekly meetings for discussion of data collection issues and to develop thematic coding relative to each study’s aims. Ad hoc meetings were also held for discussions of data analysis or publication development. The topic for this paper emerged initially during such team meetings, where regular note was taken of changes of varied types occurring

in our sites as we collected and coded data. The great majority of narratives from these projects were team coded (rotating teams of two members independently coding narrative materials and reconciling differences; ethnographers did not code materials they generated). Remaining disagreements were returned to the team for further discussion. When coding agreement was established, coded data were stored in a text base and analyzed using Atlas.ti, a well-known qualitative software package (Muhr, 2013).

Three forms of data analysis were employed. First, ethnographers wrote detailed accounts of significant episodes of change that they had observed in the AL settings in which they worked most intensely, including commonalities and differences across settings familiar to them. These initial accounts were discussed in small groups and later a larger meeting; this work provided the foundation for additional steps to expand and refine the domains of change observed. Second, additional data on instances of change were collected from the full-text bases via systematic code searches using select codes (e.g., “transition,” “home operations/management,” “socio-cultural environment,” and “regulation/policy”). These codes, common across most studies, allowed identification of organizational-level changes, as well as those involving persons or groups, whether residents, family members, or AL staff. We then examined these narrative segments from code searches for additional relevant content and parallel or disconfirming evidence across participant groups or sites. From these steps, we developed initial categories of change and subsequently refined them into core domains of change reported here. Third, the authors met in groups to discuss and review details relating to the changes they had observed and to confirm the ideas from the earlier analytic steps, based on their close experience in these settings. While talk about some types of change appeared more often in some participant groups than others (e.g., ownership change more often mentioned by staff than residents), in other ALs, all participant groups might discuss the same change.

RESULTS

Findings of our research on change are presented below in three sections: externally driven, organizational-level, and group-based change (see Table 2 for themes).

Table 2. Summary of Major Themes of AL Change and Subthemes

Level	Major theme	Subtheme
External environment	Competition among ALs	
	Downturn in the economy	
Organizational	Ownership change	
	Leadership or key personnel change	
Group	Changes in resident population	Residents’ physical functioning
		Residents’ cognitive functioning

Note. AL = assisted living.

External Environment Changes: Competitive and Economic Pressure

All types of organizations encounter stresses or supports arising from the external environments within which they operate (Scott, 2008). Examples for AL include changes in the regulatory environment and in the larger and local economies, including emergence of geographically proximate competitors (Perkins et al., 2012). Although Maryland regulatory change was modest during the time of these studies, and thus not widely discussed in our data, much of this research occurred during a period of dramatic change in other external influences. First, the AL sector was affected by the major economic downturn of the late 2000's. Potential clients for AL services saw their financial resources reduced; many needing proceeds from selling a home to finance AL care were unable to find buyers (Healy, 2008). Second, the vestiges of the earlier AL building-boom meant that new competitors continued to open their doors. This added competition in the already-limited market for new residents. Both for-profit and non-profit providers were affected, but responses to these challenges varied. We saw many changes to the ALs we were studying as their resident censuses dropped, sometimes precipitously.

Middlebury Manor, a mid-sized, family owned setting under study during the downturn reported greater competitive pressure from the opening of a large, new AL nearby. As their census numbers began to drop in 2007, the administrator reduced staff and services to residents, covering only essential needs, as management defined them. When the activity coordinator's hours were halved, this well-liked staff member quit. In response, one resident said, "Well, that affected everybody that's here." He added that right after her departure, "[T]hey were supposed to have a birthday party.....for everybody that has a birthday in that month. And [she] wasn't here to dish out the ice cream and cake, so they didn't have any.....I asked how about wine and cheese day—I guess because there's nobody around to pour the wine.....We're left out." To attract a more specialized clientele, Middlebury Manor began a new marketing campaign to attract residents with dementia. To enable this change, administrators relocated some current residents from long-occupied (and preferred) rooms to other rooms or floors to create a separate dementia care unit.

Similar fiscal and census pressures affected the Chesapeake, part of a for-profit chain. Early in our research there, the Chesapeake consistently operated at full capacity. Residents and families appreciated its meticulously maintained building, its convenient location, and community reputation. With a waiting list, management employed a transfer approach; they proactively required residents with advancing physical or behavioral challenges to relocate. Later, reacting to diminished applications, the Chesapeake shifted toward aging in place. Administrators encouraged current residents to remain as long as possible and became more reluctant to pressure difficult residents to move out.

Other ALs we studied also changed practices by becoming more flexible on fees or accepting late payments in light of this heightened competition.

A third exemplar of external pressure involved the religiously affiliated Covenant Home. When the census began to decline, management adjusted admission criteria by accepting clients who were not members of their denomination. This greatly affected the social environment for residents, who had viewed this AL as a good fit expressly because they could live among others who shared their beliefs. John Bishop, a resident, noted,

"Of course when I came in.....it was quite different. At that time we had [around 90] residents and all were [members of this denomination] except one.....now we have all denominations. And I have no problem with that. But when you get all church people you have a – certain standards, you know, common standards."

In addition, an established "safety net" program at Covenant Home for long-stay residents who ran out of money was discontinued. When this change began, Eileen Fisher expressed her concern about another resident being forced to move due to lack of money.

"[I]t was a shock to her.....the fact that she had to move, drag herself someplace else and she probably wasn't feeling all that great....Well, of course there's that opinion that the home should take at least two or three people free or not free but to help people out, yeah.... I think they should have maybe down on my floor, three or four rooms down there that are for the poor souls but no such, no such ..."

Fatima Home, a non-profit, religiously affiliated AL, was in the process of adopting culture change as we completed fieldwork there for one of the studies. This planned change in their model of care was not linked to a low census but was instead intended to keep Fatima competitive and attractive to clientele in the future. Culture change involved alterations to the physical environment and transformation of staff roles from specialists to universal duties. This meant cutting both the housekeeping and activities staffs entirely. The Executive Director, Paula, described culture change positively as "person-centered care, to support autonomy and choice" rather than a cost-saving step. Paula also predicted that this change would be a "work in progress," upsetting residents, staff members, and families for a time. According to field notes of a conversation with her prior to the family meeting to introduce these changes, Paula was preparing for negative reactions.

[Paula] expects "fireworks" as some families and staff members are against it, and they have been "lobbying" other families and staff to fight the change. She will have "plenty of food" and "plenty of chocolate" to calm people down at the meeting.

Paula was not surprised by the overwhelmingly negative reactions; comments such as "We don't want our loved ones to be the guinea pigs," or "Change is not *always* so good" characterized reactions of many in attendance. The

dismissal of so many favorite staff members was of particular concern because of close, established relationships with them. One daughter, reacting to the elimination of activities staff, said, "How can you take away Erica and all of the activities?.. My Mom needs Erica." Her final comment at the meeting was, "This is *way* too much change." While the organization's leadership felt that culture change was the right choice, some of the direct care staff also expressed their views that this innovation was chosen primarily to make their AL more attractive in the increasingly competitive market. From all of these examples, we concluded that key parameters of operation and models of care may be subject to change in response to changing external market forces.

Organizational Changes: Ownership, Management, and Key Personnel

Ownership change.—Ownership changes, some linked to a major ownership consolidation in the for-profit AL sector, were surprisingly common among the for-profit ALs we studied. In this group, 5 of 11 had changes of ownership during or shortly before or after our data collection. Other ALs also reported earlier changes of ownership, some of which had significant impact. Non-profit ALs we studied, including those with religious or other affiliations, remained mostly unaffected, although one was purchased by a for-profit provider after our research there concluded. The impact of new ownership varied widely; in several cases, dramatic changes followed, whereas in one AL, new ownership was nearly invisible to those residing or working there. These contrasts are demonstrated in two for-profit settings: Arcadia Springs and Winter Hills.

When we began our research there, Arcadia Springs was a typical mid-sized, for-profit AL, housing a mixture of residents. Its owner, a real estate developer, was uninvolved with day-to-day operations. The director was given authority over all operational issues, including admissions, staffing, and daily care for their residents, including persons on Medicaid. After our research there ended, a team member visiting the site learned from two staff members that Arcadia Springs had been sold. The sale, according to their reports, had "changed everything" about the AL. "You wouldn't be able to interview anyone [residents] here now," one said, emphasizing dramatic changes in the resident profile. Arcadia Springs had changed its name and focus to cater to persons with dementia. This change meant that the social dimension of daily life, observed among residents during our research there, had become very limited, due to the cognitive impairment of the current residents. Signs of trouble, reported by the two staff members, included having three activities directors in succession over a 4-month period and an increasingly stressful work environment.

In contrast, Winter Hills, a repurposed mansion with a modest "institutional looking" addition, had been operating for 7 years when our research there began. It was part of a national chain, however relatively little notice was taken of this fact by residents or staff in their interviews. Executive Director Victoria introduced us to about eight direct care staff on the day shift during a tour. When she asked them to raise hands indicating how long they had worked there, all present proudly raised their hands for at least 5 years—many for all seven. Rachel, a family member, said, "[S]ome of the staff have been there for a long, long time; that I find unique and actually comforting." This unusual degree of stability of daytime staff meant that the kitchen knew that Mr. Braun wanted fried eggs for breakfast or that activities staff knew he had been a "loner" all his life and only wanted to come down for musical entertainment.

As we concluded our fieldwork, Winter Hills' parent company merged with another provider. The Director of Nursing expected some changes, but remained optimistic.

"I think definitely there will be some impact....I have a new boss in corporate, so it's going to take a little getting used to...they're going to try to pull the best from [their company] and the best from [ours] I'm sure there'll be some changes that people don't like, but that's going to be normal."

While ownership change brings the potential for other changes, at Winter Hills the staff and residents neither expected nor seemed worried that the change in ownership would affect day-to-day routines in this unusually stable environment. Each ownership change for an AL becomes part of a string of such changes over time, which may have a cumulative effect and magnify the importance of ownership transitions, particularly for long-tenure residents or staff.

Changes in Management or Key Personnel

A distinct element of change involves turnover of valued managers or key personnel, which sometimes alters daily life and care. The most notable sequence of leadership change we observed was at Huntington Inn, an older site participating in three studies. This semirural AL, housed in an older, institutional-style building, was purchased by its initial administrator, Mr. Hill, and co-owners in 1988. For nearly two decades, Mr. Hill's leadership shaped Huntington Inn; he was a formidable advocate and leader, well-liked and respected by residents, families, and staff. Operating the AL with largely silent co-owners, he worked with residents and family members to help them meet their changing needs, such as assisting them to qualify for Medicaid Waiver funds. Consequently, staff members, families, and residents were dedicated to him; he, in turn, was protective of them. Mr. Hill's passion and actions to sustain his social model of care provided notable stability.

Mr. Hill's unexpected death set off a chain of leadership transitions and eventually new ownership, each step resulting

in some degree of disruption. Mr. Hill's widow hired Jenny, an experienced nursing home administrator, whose management style and philosophy differed dramatically from Huntington Inn's social model of care. According to reports from two administrative staff members and residents, Jenny transformed Huntington Inn's low-key, social model of care into a quasi-nursing home environment. Jenny enforced her new rules (e.g., prohibiting residents who liked to help out by clearing tables after meals, as one does at home, from continuing this activity; requiring that all residents be in their rooms by a set time each night) that she enforced with an "iron fist." These changes were quickly followed by departures of both long-term staff and dissatisfied residents, who missed Mr. Hill's approach. Mrs. Hill decided to remove Jenny after only a few months; the precipitating event was Jenny's refusal to permit a long-time, terminally ill resident to remain "at home" at Huntington Inn to receive hospice services. After her firing, the resident's death was managed within the AL, as she and her family preferred. Mrs. Hill next rehired Tammy, a young woman who had worked with Mr. Hill since her teens, coming up through the ranks to be his assistant. Tammy restored the prior social model of care and began to rebuild the staff and the resident census.

Still operating under the original ownership, Tammy managed Huntington Inn for about 3 years, until a long-silent co-owner decided to take charge. Tammy was replaced by a series of administrators who failed to meet the owners' expectations. Finally one co-owner's wife, Glenda, despite her inexperience, took leadership. She began replacing the direct care staff with her choices of new recruits, added many new rules, and hired an untrained family member to direct activities. Glenda's vision of how Huntington Inn should be run included her belief that AL residents are "like children" and should be treated accordingly. Glenda's changes were not successful either. After less than a year, Huntington Inn was sold to new owners, which led to yet another transition of management and approach to care. The contrast between the stability of Huntington Inn during Mr. Hill's tenure and the subsequent years is striking. The series of changes in leadership resulted in complete turnover of the direct care and activities staffs, leaving only the long-serving cooks from Mr. Hill's tenure as director. These transitions generated feelings of uncertainty and negativity among the few remaining residents who lived through them.

Another exemplar of leadership change occurred at the Chesapeake, where its often-absent and corporate-minded director was replaced by Marita, a very "un-stuffy" and hands-on leader. Many residents and family members remarked about this positive change. Marita became involved in the residents' lives, listened to their concerns, and was visible daily, rather than staying in the office or spending time off site. Having begun her career in direct care and working her way up to her managerial position, Marita never asked staff to do tasks that she had not done

in her past or would not still do, if needed. One daughter's comment described this positive change. "Before her it was a man who was not involved with patients like this gal is.... [From him] I would get a letter for a raise in the room fees, and that was it." Clearly the residents, staff, and family members noticed a marked improvement simply through a change in the approach of leadership. Quality of life and work in this AL was positively affected through this single change.

Changes in the Resident Population

As some residents move into and out of an AL and others age in place, change in the overall resident population occurs. Our research found that an altered social life for residents often followed. Over time, the cumulative effect of resident turnover and aging in place may lessen the odds of finding agreeable meal partners or friends. Such change may occur quickly, as when an AL decides to re-market itself (e.g., for dementia care) or makes changes to its admission or retention standards, as described above to address a drop in the census. While the smallest, family-run settings (Valley Glen and Franciscan House) and most of the non-profit ALs had already enabled some degree of aging in place before the recession, most of the remaining for-profit settings moved from a "transfer" approach toward aging in place. Consequent shifts in the resident mix, according to informants, profoundly altered the daily lives of residents, as well as increasing the demands placed on the direct care staff.

Physical Health Change

As described above, recent economic challenges to both ALs and their clients have contributed to changing the aggregate health status of the resident population toward higher care needs (Caffrey et al., 2010; Hawes et al., 1999). Family members, staff and other residents across the ALs we studied frequently noted the more substantial health limitations of those entering ALs in recent years. Research team members also observed this change directly at the three sites involved with multiple studies (See Table 1). For example, the Director of Nursing at Covenant Home noted that residents were applying both older and sicker. Instead of moving in at ages near 65, she said ages now ranged as high as "95, 96, 98 years old," raising Covenant Home's averaged move-in age to 88. This change, paired with the longer retention of residents, had expanded demands placed on direct care staff at a time when there were also fiscal pressures to downsize that staff.

Resident-to-resident helping was observed to varying degrees in all ALs we studied; over time, we observed limits to this help, as more residents refrained from helping others and staff members discouraged certain forms of help (e.g., pushing wheelchairs or helping others to stand) due to safety concerns. Julia Conklin at Fatima liked helping

others, including helping them with toileting. She had been encouraged by staff in her voluntary assistance to others, and continued helping, despite her own health changes. At the Chesapeake, a group of friends supported one member by monitoring her activities, assisting with her meals, and ensuring she navigated correctly to activities and her room; their actions delayed her relocation to dementia care for a year. At the Greenbrier, two women, one with physical limitations and another with cognitive limits, worked as a team to do laundry. One moved the clothing to and from their rooms and the other managed operation of the washers and dryers. However, increased physical limitations among residents lessened the extent of such mutual helping, further increasing reliance on staff, families, or, for a few with funds, personally hired care aides.

Beyond implications for staffing and resident safety, AL providers faced additional issues when housing more physically impaired residents. Public spaces and dining areas often had not been designed to accommodate large numbers of wheelchairs or walkers. At the Chesapeake, it was a daily challenge to get everyone into and out of the dining room without collisions, conflicts, or delays. Field notes also recorded the Chesapeake's redesign of their snack bar, lowering coffee pots and snacks to a level accessible to the increasing number of people using wheelchairs or motorized scooters. Not all ALs were able to make environmental changes to better suit the changing physical abilities of their residents.

Finally, greater physical impairment of residents influenced decisions of potential customers as to whether they belonged in there. Those younger or healthier than an AL's current resident population described avoiding settings where wheelchairs were prominent or activities reflected a "lowest common denominator" of physical ability. One example came from Annie, describing her mother's [Nellie] reaction during a visit to an AL they were considering. "She would look at them [current residents] and think, 'God, no. I'm not like that.'" Clearly Nellie distinguished her capacities from those of residents she observed there, perceiving a poor fit (Morgan et al., 2006). This concern about potential customers seeing more impaired residents in public spaces was also thought to be behind the Greenbrier's removal of chairs with arms from their lobby. This change decreased the likelihood of visitors witnessing residents dozing in the lobby or revealing their mobility limitations, which required chair arms to rise.

Changing Cognition of the Resident Population

Some of the ALs we studied were addressing the growing need for oversight and engagement for residents entering AL or aging in place with cognitive impairment. Many ALs serve residents with cognitive impairment, either in an integrated environment (i.e., sharing floors or units with persons with primarily physical challenges) or in a specialized

unit. The issues for impaired cognition were most clear to us in the integrated settings, where the presence of residents with progressing dementia affected the lives of others in important ways, including exposure to persons who vocalize loudly, demonstrate persistent walking, or engage in disruptive movements.

In the integrated settings, activities were adapted not just for physical limits but also moved toward the "lowest common denominator" of cognition. For example, Fred Brasky at Wetherby Place described his peers' challenges relative to one of his favorite pastimes. He described one female friend,

"[E]xcellent bridge player, has forgotten a lot of it. Mixes up her cards..... all of them love to play bridge, but they've forgotten how to play it. So, it's very difficult to get bridge players together."

Bingo was the only game played at Covenant Home, where many residents remained capable of much more challenging activities. Additional activities could not be mounted there to match varied residents' needs, or in most other ALs, since budgets and personnel for activities were very limited. Other residents complained in their interviews of loneliness, since most of their peers were not able to carry on a "normal" conversation due to confusion or memory impairment.

Residents also had to deal with troubling behaviors. At the suggestion of staff, Mr. Polinvalle posted a large "STOP" sign on his door at Arcadia Springs to discourage a resident's repeated entry into his room; Ms. Carson called the police after staff at Boxwood Gardens failed to take seriously night-time visits from a male resident with dementia, who repeated crawled into her bed with her (Morgan et al., 2011). In contrast, ALs with dedicated dementia care units could transition residents demonstrating disruptive or discomfiting behaviors there as available space, family agreement and finances permitted.

Residents with long AL stays may both experience their peers declining physically or cognitively and observe poorer health or cognition of those arriving; both may contribute to alterations of daily life and perception of quality. The key point is that changes in the *aggregate* status of the residents at any AL, not just changes to individual residents, affect interpersonal and social life for others who share that collective living environment (Morgan et al., 2011; Park, Zimmerman, Kinslow, Shin, & Roff, 2012). This conclusion suggests that examination of P/E fit extend beyond focus on single persons in relation to the physical environment to take into account the functional level of the collectivity in light of available resources to provide support. An expansion of resources could theoretically move AL care beyond addressing needs of those with the poorest cognition to include residents with a range of capacities, enhancing P/E fit. However, constraints related to cost, staff training and skills, and funding and regulatory structures do not enable most ALs to succeed in this area, often resulting

in fewer alternatives and lower degree of fit, particularly for higher functioning residents.

DISCUSSION

Although prior research has provided useful findings regarding change in residents and staff, less research to date has examined other aspects of change in ALs at the levels of the external environment, the organization, or of internal groups. Based on our research, we found that changes were linked to forces both external to the setting and dynamics relating to the internal organization and collective lifestyle of ALs (i.e., factors operating at levels other than the individual). The persistence of change during our research in varied settings, in light of some degree of expected AL stability, is a notable addition to our growing understanding of living and working within AL communities.

Our study has several limitations. First, all of the AL sites are from one state, with a definition of AL not shared across all states. Second, our data, drawn from four studies, spanned 9 years. This provides some distinct advantages but also involves differing time contexts for external environmental changes, such as the economic downturn of 2008. In addition, some ALs participated in more than one study, giving us deeper insight into change over time in that subset of sample; our representation of change remains temporally limited in other ALs. Finally, our sample of ALs, while chosen to be diverse, may not adequately represent all dimensions of importance to the study of change.

Our findings confirm preferences for stability and aging in place among residents and families, as demonstrated in prior research (Ball et al., 2009; Eckert et al., 2009; Frank, 2002). Following the serious life and health challenges that lead to relocation into AL, consumer aspirations for stability and consistency remain high. Moving into AL may serve as a mechanism to establish a new P/E fit. When resources permit, this goal is sought by consumers through careful choice of an AL where a supportive physical environment and staff assistance enable aging in place to succeed, even if the original goal of living out one's life in the original home has been thwarted (Ball et al., 2004; Morgan et al., 2011). Consumer unfamiliarity with the multiple dimensions of change possible within the AL setting over time, however, may threaten the goal of living out one's days in a familiar, stable, and intentionally fitted AL environment. Our findings on ALs' responses to influential external (economic) and ownership changes support Perkins and colleagues' (2012) work in focusing research attention on multilevel influences operating to change P/E fit in these settings over time.

In contrast to nursing homes, ALs have been viewed as offering a more normative way of life, with greater privacy, autonomy, and a social model of care; many ALs aspire to achieve Golant's notion of residential normalcy for their residents (2011). Despite early use of a transfer approach to managing resident decline, economic and consumer pressures to

enable aging in place have reshaped ALs to serve a much higher acuity resident population than initially expected by providers. Prior studies of larger, more representative surveys of AL residents (Caffrey et al., 2010; Hawes et al., 1999) show the broad-based decline in health and cognition and parallel expansion of demands on staff. However, attention to such health changes has mostly overlooked its impact on the interpersonal context of residents' daily lives.

In addition, changes driven by new owners or managers and altered competitive pressures challenge contemporary ALs to provide services beyond the original intention for this sector under the social model of care that dominated its origins (Ball et al., 2005; Wilson, 1990; Zimmerman et al., 2001). Without altering the physical environment and staff size and training, ALs are challenged to satisfy their consumers, both residents and family members, and to meet regulatory expectations while maintaining both safety and quality of care; this challenge persists as a tension in the AL sector (Ball et al., 2004; Chapin & Dobbs-Kepper, 2001; Zimmerman et al., 2003). This analysis, with a sample of diverse AL settings over a 9-year period, confirmed and expanded upon the changes reported in prior research (Ball et al., 2005; Perkins et al., 2012). Ongoing change tests the capacity of AL settings to both fully support desires to both age-in-place to its natural conclusion with end-of-life care in AL and to meet needs and wishes of diverse resident populations as they shift over time (Ball et al., 2004).

IMPLICATIONS

From this analysis of qualitative data from multiple studies, the notable presence of internally and externally driven changes clearly debunks any idea of stability as normative for AL. Managers, staff, and consumers (both residents and their close others) learn about the extent of possible changes only after spending time in one or more of these settings, sometimes discovering their aspirations of stability thwarted. Participants' notice of changes and their consequences in our conversations and interviews with them sometimes suggested surprise at the frequency and extent of changes that may occur in a relatively short period of time.

Conceptually, the literature on P/E fit has often focused on the changes to the resident as diminishing fit, focusing less on aspects of residential care environments, such as AL, in shaping initial fit or its change over time. This research has identified multiple levels of the environment that influence P/E fit, all of which are subject to change over time. Movement at these levels over time may reshape AL philosophy, services, social environment, and even physical spaces in important ways, influencing residents and employees alike. The limited prior research focus on external, organizational, or collective levels of change in AL may be particularly important to those residents who experience long stays.

Both practitioners and researchers have reason for interest in attending to the multiple levels of AL change, which affect both fit and quality for their residents. The nature and dynamics of the group of social others in AL, inclusive of staff and other residents, is a notable element of the environment influencing daily experience and environmental press. Understanding the regularity and importance of changes of all types may lead to more proactive attention to shifts that reshape care needs. For researchers, these findings emphasize the need to more regularly focus on the social and interpersonal contexts of the collective living environment to more fully understand P/E fit in AL. Our findings support results of others (Ball et al., 2010; Thomése & van-Groenou, 2006) regarding the importance of including the social dimension of environment to more fully understand the dynamics of settings such as AL.

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