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The Quality of Life in Assisted Living Facilities in Grand Rapids

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Author's Note

My profound interest in the elderly population and the dynamic of assisted living facilities originates in my work as a personal care aide in an assisted living facility for three years. As an aide, I assist residents with their activities of daily living, such as dressing, toileting, bathing, feeding, and transferring. I also give the residents their daily medications, assist with wound care, as well as take their vitals. I can care for the residents and their medical needs, but I also care for them as people. When you are a nurse aide, braiding the resident's hair and listening to their stories is just as much care as giving them their medication and taking their blood pressure. I would work 12-hour days, and I assisted residents in getting ready for the morning and saw them off to bed. We spent whole days and summers together, and we grew to know each other very well. During the time that I have worked at an assisted living facility, I have had some of the most impactful moments of my life and I know the residents that I care for feel the same way. A lot of the residents that I cared for are at the most vulnerable stages in their lives, and little things like knowing when they want to get up, when they are hungry, or the emotion they are feeling just by a simple look, I can care for them better, which not only helps them have a better day but I believe a better quality of life. I have visually seen and felt the differences that care in an assisted living environment can make in the lives of older adults, which is why I chose this project—to hear the rich stories of older adults and to understand directly from them what makes a quality life as they age.

One thing that I did note is that there is not too much information related to this topic available, with the exception of a few studies. Most of the relevant information about quality of life dealt with residents in nursing facilities rather than assisted living facilities. In addition, many of these studies that did take root in assisted living facilities were relatively dated. Because

of our ever-changing society, and the addition of new technology, norms, and ways of thinking, I believe that information regarding the quality of life in assisted living should be regularly talked about and studied. What I believe is novel about this research is the fact that it is based in Grand Rapids. Every area, including Grand Rapids, has a different environment, values, and ways of living that I think can also affect the way that we care for older adults. Because of this, I think that this project could have important impacts on our community and loved ones in the region of Grand Rapids.

Abstract

This research study looked at the quality of life of residents in assisted living facilities in Grand Rapids. The purpose of this study is to consider the life satisfaction of residents of assisted living facilities in Grand Rapids and explore the determinants that can make their time spent at assisted living facilities as enjoyable as possible. This study highlighted the voices of the residents in assisted living facilities by doing a qualitative study using an interview-styled approach that asked the residents about a variety of topics, such as routines, feelings, values, personal facts, health status, care provided, relationships, and views on the facility. This data was analyzed by reviewing the transcripts recorded during the interviews, looking for similarities and differences within the data, and organizing the data into categories. Thirteen domains of quality of life were found from the information gathered in this study including the physical environment of ALF, sense of community, communication within and outside the facility, visitation by the outside community, attitude and perception, staff, sense of independence, activities, food, faith, security, memory, and routine. This study emphasizes the key components of quality life in assisted living facilities and establishes areas where improvements can be made.

Introduction

From country to country and family to family, the way that the elderly population is cared for differs incredibly. For example, in many Asian countries, the importance of family and their elders is greatly valued and because of this view, the family is the primary source of support as their loved ones grow older (Poulin et al., 2012). In contrast, society in the United States values more independence and growth, and while some families care for their elders as they grow old, other families search for different manners of caring for their loved ones. While family caregiving still is the most common source of assistance for older adults in the U.S. (Kasper et al. 2019), family dynamic varies and so do the needs of older adults and when family support is not feasible, other opportunities must be sought.

There has been a steady increase in non-nursing home care such as assisted living facilities in the United States (Kasper et al. 2019). As a society, more emphasis has been put on these types of residential-based care because of the changes that we are seeing in the demographic of our population. Even compared to just a couple of decades ago, there are more technologies and solutions in health care today than there ever were before. Due to these advancements in medicine, there has been an increase in longevity in the human population. In 2000, the U.S. population included 35 million people 65 years and older and by 2030 it is predicted that this number will rise to 71 million individuals 65 years or older or 20% of the estimated population (Poulin et al., 2012). As more people are growing older, we are faced with challenges of how to care for this aging population, and one solution has been assisted living facilities (Kasper et al., 2019). Assisted living facilities are defined as group residential homes that are not licensed as nursing homes and provide care in activities of daily living and other realms of assistance (Zimmerman & Sloane, 2007). The growing population of the older

generation combined with the increase in assisted living facilities raises concerns for quality assurance in assisted living facilities, and the primary people who should have a say in quality should be the people who receive the care or the residents of assisted living facilities (Ball et al., 2000).

Background: Assisted Living Facilities

The way we care for the elderly population has gone through several changes throughout the years. The idea of assisted living facilities and nursing homes as well as other types of institutionalized care settings for older adults have their roots in almshouses (Olson & Knapp, 2020). Almshouses were created by the Dutch and were public institutions for homeless and aged persons who did not have the means to live by themselves or did not have a family; they were often connected to churches or charities and run by people who were referred to as "wardens" (Olson & Knapp, 2020). Until the government played more of a role after the Great Depression, this is how the state of elder care in the United States remained for hundreds of years (Olson & Knapp, 2020). Since then, several different acts have been passed that have allowed the growth of institutional care for the elderly and called for greater national standards of the quality of institutions, including the passing of Social Security in 1935, the 1959 Housing Act and the 1965 Older Americans Act that established the Administration on Aging and the addition of Medicare and Medicaid to Social Security, and the Affordable Care Act passed in 2010 (Olson & Knapp, 2020).

Since the passage of the Social Security Act, more resources have been devoted to the care of seniors and the services available to them (Olson & Knapp, 2020). It is expected that by 2050, there will be double the population of adults who are 65 and older, which is the fastest-growing of all other age groups (Olson & Knapp, 2020). Because of the frailty of this population

and their susceptibility to chronic disease, this increase in population puts new pressures on the field of senior care as we rely heavily on institutional-based care (Olson & Knapp, 2020). There are many different fields of present-day providers of care for the elderly that differ in their care philosophies and services, some being long-term acute care hospitals, skilled nursing facilities, continuing care retirement homes, group or family care homes, hospice, home health, memory care, independent senior housing, assisted living facilities, and many more (Olson & Knapp, 2020).

As aforementioned, all of these facilities provide care to elderly adults but differ in how they provide care and the philosophies that they take on, including assisted living facilities (Olson & Knapp, 2020). Zimmerman and Sloane in "Definition and Classification of Assisted Living" define Assisted Living as "…a term that has come to be applied to a wide array of residential settings for older adults. In the broadest sense, AL includes all group residential programs not licensed as nursing homes that provide personal care in activities of daily living and can respond to unscheduled needs for assistance" (2007). In their research, Zimmerman and Sloane focused on the benefits and limitations of drawing definitions on assisted living facilities because while defining the population and philosophy of assisted living facilities can be beneficial for consumers, practitioners, and policymakers, there also is a worry that this type of typology can induce regulation and a "McDonaldization" process that discourages diversity in the care setting (2007). Another definition in Chapter 1 of the book "The Health Services Executive: Tools for Leading Long-Term Care and Senior Living Organizations," by Knapp and Olson state the definition that an assisted living facility is "…housing for elderly or disabled people and provides some level of nursing care, housekeeping, social activities, and prepared meals as needed and based on individual preferences" (2020). Looking specifically at the United

States, there are over 28,000 assisted living facilities (ALFs) that house more than one million people (Olson & Knapp, 2020). The average age in ALFs is 83 and more women are living in ALFs compared to men in around a 3 to 1 ratio. The average size of ALFs is 43 rooms but can range from 3 to 200 rooms, and the average number of residents in a facility is 40 but that can range from one resident to 175.

Background: Quality of Life

While the term "quality of life" has been used greatly in literature, defining what quality of life is has been challenging for many people (Karimi & Brazier, 2016). Some definitions of quality-of-life focus on quality of life as one's conscious judgment of the satisfaction of their life in the context of the culture in which they live and with the personal standards and goals that they have (Karimi & Brazier, 2016). However, some people have taken other approaches and have argued that quality of life definitions should be based on more objective factors such as well-being described by objective descriptors of physical, material, social, and emotional well-being and personal development and purposeful activity (Karimi & Brazier, 2016). Even more difficult to define is the concept of health-related quality of life which has at least four different definitions, some including how a person functions in life and their perceived well-being in the domains of health, how perceived well-being is related to state of health, or values given to different health states (Karimi & Brazier, 2016). As concluded by Karimi and Brazier in the article "Health, Health-Related Quality of Life, and Quality of Life: What is the Difference?", the concepts of quality of life and health-related quality of life overlap (Karimi & Brazier, 2016).

The confusion around these terms goes back to the confusion of what health is and how it relates to life satisfaction and quality of life. The World Health Organization defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of

disease and infirmity" (Karimi & Brazier, 2016). If we consider the population of assisted living residents in relation to this definition, we realize just how many layers of information that need to be considered in the studies of the quality of life of these residents. Many residents are older and have physical and mental capabilities and because of their advanced age, they have likely lost family members and friends. Just considering these factors alone, it can be determined based on the definition of health from the WHO that the elderly do not have complete health. However, not having complete health does not necessarily mean that these residents are unhappy or not satisfied with their lives, so we can draw that quality of life is determined by more than health and by a multitude of factors. Residents of assisted living facilities are in a unique situation: they live in a community of people they often have not known throughout their lives; they have many resources available within a small area creating a sort of microcosm of their old lives; they have schedules that often differ to their old ways; and they do not work, and therefore have to search for other means of energy exertion. Because of these extra considerations of residents of assisted living compared to say a 40-year-old person with a job and family, special studies must be done on these residents to determine how their distinct situation as AFL residents affects their quality of life.

Although they are not plentiful, there have been some research studies on quality of life specifically in assisted living populations. In one study titled "Quality of Life in Assisted Living Facilities: Viewpoints of Residents," performed by Georgia State University in 2000, they interviewed 55 residents in 17 assisted living facilities in three counties in Georgia (Ball et al.). Most of the residents that they interviewed were elderly and the facilities that they sampled ranged from 2 to 75 residents (Ball et al., 2000). The data collection included in-person, structured interviews with the providers and residents, observation of the environment of the

facilities, and review of the records of the participating residents (Ball et al., 2000). Questions consisted of a mix of forced and open-ended questions that addressed a wide range of topics, such as “daily routines, personal characteristics, attitudes and values, health status/functional ability, care provided, family and relationships, policies and procedures, and staffing” (Ball et al., 2000). The qualitative data obtained was analyzed by the grounded theory approach where data is analyzed for emergent categories in a process called opened coding and then linked to other categories by axial coding which denoted cause and conditions, context, intervention conditions, actions, and interaction strategies, and consequences (Ball et al., 2000). This study was able to identify 14 significant domains of quality of life of the residents that included psychological well-being, independence and autonomy, social relationships and interactions, meaningful activities, care from the facility, comfort, cognitive functioning/memory, sleep, food, connectedness to the community outside facility, physical functioning, religion/spirituality, physical environment, and safety and security (Ball et al., 2000). This study concluded by saying that their research has shown assisted living facilities have a duty to understand their residents’ own definition of the concept of quality of life so that they can do whatever they can to improve their quality of life, and it is also the role of the residents and their families to choose a facility that best fits their needs and preferences that leads to this satisfaction (Ball et al., 2000).

In another study called “Correlates of Caregiver-Rated Quality of Life in Assisted Living: The Maryland Assisted Living Study,” the researchers studied the quality of life in randomly selected cognitively normal and impaired assisted living residents and assessed the contributions of the caregivers in the domains of cognition, functional dependence, physical health, depression, nonmood neuropsychiatric symptoms, and activity participation (Samus et. al). The study sample was comprised of 198 ALF residents from 22 facilities that included 10 16-bed or more facilities

and 12 15-bed or fewer facilities (Samus et. al). The quality of life of these residents was measured by using the Alzheimer's Disease-Related Quality of Life Questionnaire (Samus et. al). Despite having cognitive impairment, it was found that residents in ALFs had a relatively high quality of life (Samus et. al). However, non-mood psychiatric symptoms explained 37% of the variance in the data (Samus et. al). This study concluded that psychiatric symptoms are prevalent in assisted living and contribute to lower ratings of quality of life; therefore, detection and treatment of psychiatric symptoms are important to improve the quality of life of the residents (Samus et. al).

In a multidimensional study, researchers Mitchell and Kemp studied the quality of life in assisted living facilities (2000). These researchers studied four domains of quality of life of assisted living residents, which included characteristics of health status, social involvement, facility characteristics, and social climate (Mitchell & Kemp, 2000). The participants consisted of 201 residents from 55 AFLs in California, and these residents had functional impairments (Mitchell & Kemp, 2000). Quality of life was measured using scales for depression, life satisfaction, and facility satisfaction (Mitchell & Kemp, 2000). Regression analyses of the results of these scales found that cohesion has the strongest correlation to quality of life, but other quality of life predictors included fewer health conditions, participation in social activities, family contact, and low conflict environment (Mitchell & Kemp, 2000). Overall, the researchers in this study concluded that quality of life in assisted living facilities can be enhanced by making a "cohesive social environment, and encouraging social participation and family involvement" (Mitchell & Kemp, 2000).

Methods

Purpose of Study

The purpose of this study is to consider the life satisfaction of residents of assisted living facilities in Grand Rapids and explore the determinants that can make their time spent at assisted living facilities as enjoyable as possible. The idea of the study was to find out what makes a quality of life directly from the residents of assisted living who know the life in assisted living best, as little information specifically about the quality of life in assisted living exists.

Study Procedures

The research performed in this study was qualitative and involved performing individual interviews with residents of assisted living facilities in Kent and Ottawa County in Michigan. The interview consisted of an array of open-ended questions about their life before assisted living and their life in assisted living, the differences between each, as well as their values in life as a whole. These questions were designed to begin to understand what makes a quality of life in assisted living. The questions used to analyze this information have been included in Appendix A at the end of this paper.

Sample

The population for this study included residents in assisted living facilities that housed primarily elderly residents in either Kent or Ottawa County in Michigan. These facilities were found using a Google search and compiled into a list of over 100 ALFs from all over Kent and Ottawa counties. A random number generator was then used to determine which assisted living to contact about possible participation in this research study. The assisted living facilities were initially contacted by phone using the script visible in Appendix B. Once confirmation of interest in this study was established, the employee recommended a resident with enough cognitive health to be able to answer the basic interview questions for the study.

There were five residents interviewed for this research study, belonging to four different assisted living facilities in Kent and Ottawa counties. The participants' ages varied from 86 years old to 92 years old. Three out of the five residents that were interviewed identified as male, whereas the remaining two identified as female.

Data Collection Method

All interviews took place in the assisted living facilities that each participant lived in. Each resident was asked where they would be most comfortable conducting the interview, and based on their desires three of the interviews were conducted in the residents' rooms and two were conducted in a common area of each ALF. Prior to beginning the interview, the researcher presented the informed consent research form to each resident and read each bullet point to the resident. The resident was asked if they had any questions and if they agreed to participate in the study. In all cases, each resident approached agreed to participate in the study and agreed to be audio-recorded. The audio was recorded on an application on the researcher’s phone, and then promptly deleted after transcription. The participant was then handed a copy of the informed consent form. All interviews were conducted in the morning, and they lasted from 29 to 55 minutes. After data was collected and the interview was over, the participants were allowed to ask further questions and were pointed to the contact information of the researcher on the informed consent form provided in case of future questions. A copy of the consent form provided is available in Appendix C.

Data Analysis

The researcher began the process of analyzing the data by transcribing word-for-word audio recordings of each interview, however, any identifying information, such as name,

addresses, and other personal information was omitted. The transcribed data was read multiple times, and the data was coded by looking for emerging patterns in the responses of each participant. After taking notes and simplifying some of these emerging patterns, these patterns were then organized into categories and subcategories. Although some of this process of the categorical organization was straightforward since the interview questions were already organized into categories, since the questions were open-ended, there were variable responses and further analysis that needed to be done. After this occurred, special attention was paid to the attitudes regarding each category that was identified, as some participants had positive responses to certain questions, while others had more negative ideas regarding the questions asked. After all this was completed, certain quotes were identified and pulled from the data that were exemplary of the determinants of quality of life that were analyzed from the data in a manner of equal representation for all participants interviewed.

Results

Based on this researcher's experiences in conducting this study, these are the results of the research. Grounded on the interviews of the residents, thirteen domains of quality of life were identified: the physical environment of ALF, sense of community, communication within and outside the facility, visitation by the outside community, attitude and perception, staff, sense of independence, activities, food, faith, security, memory, and routine. Many of these categories are interrelated, and just a handful dominated the conversation of the interviews. Because of that, the five most significant determinants of quality of life will be discussed, which are a sense of community, activities, food, attitude and perception, and staff.

Sense of Community

In the interviews, the residents expressed that the people that make up their community are the friends and family that visit them, as well as the friendships that they have formed within the facility. All residents interviewed expressed that their relationship with family and visitation and communication with them was important. In a question that stated, "What do you appreciate or value most in life?" each resident stated that family and/or family and friends were what they valued most in life. Four out of the five residents interviewed also get visitation by their children on a multi-weekly basis, whereas the other resident maintains contact with their families through the telephone. For example, Resident 2 stated, "I have two daughters here and they visit me once a week, and then on holidays I tell them to do their own thing. I have plenty of company here…". This quote goes to show the consciousness residents have of other people's relationships, as well as a reliance that has grown on the ALF for company and community. Two of the five residents that were interviewed had partners in the ALF home and expressed fondness for being able to continue living with them in the home. Asked what they value most in life, Resident 3 stated "I'd say that I can still live here with my wife. I think that would be the best thing." Resident 5 also expressed about his wife that "…we have been very, very blessed to be together at our age."

In addition to family visitation and contact in the home, some residents also experience community through maintaining relationships with friends and family outside of the assisted living facility. Two of the residents interviewed expressed enjoyment at getting to leave the facility every so often to visit friends. Resident 1 expressed, "One friend that I golfed with for 25 years picks me up for church every Sunday morning." Resident 5 communicated that their relationship with friends outside of the facility is still "very close" and "We get together every Tuesday morning, my friend picks us up, and we go and have breakfast together." However, it is important to note, that at the advanced age of these residents, they are losing more and more

people who were close to them, and some residents expressed discontent over losing relatives and/or not seeing friends and family since moving into the home. Resident 3 said “Friends are down. I lost about four of them in the last year. Good friends. Because they are all about my age now.”

Lastly, another form of community that is built for the residents is with the other residents in the ALF itself. Four out of the five residents interviewed expressed extremely close relationships with the other residents in the facility and even stated that it was like a family. Resident 4 stated “Well I would consider [name], strange enough, my best friend. We visit fairly often, and he is like a brother totally. But as far as everybody, I think that we are all good friends. Those of us who participate [in activities] seem to do everything together. There are about five or six of us and whatever is going on we are there you can count on it. We just know each other quite well.” From all the responses of the residents and from this quote in particular, it can be gathered that many of the relationships and community between the residents are fostered during activities hosted by the ALF, as well as the three meals that are eaten together. Resident 2 also expressed the family-like relationship between residents when she said “It is just like one big family, everybody has their own quirks and we have to laugh around it.”

Activities

All residents interviewed expressed some enjoyment that they get through the activities that they participate in in their ALF. Some of the common activities that residents participated in were exercise, trivia, playing cards, playing board games, bingo, watching movies, putting together puzzles, attending religious events, such as communion or bible study, and more. Each resident expressed certain interests in different activities, for example, Resident 3 stated that he looks forward to going to a men’s club where he can converse with the other males in the

facility, as well as a "…happy hour that he looks forward to…". All facilities offered an exercise class in the morning that four out of the five residents interviewed participated in almost every morning. Some residents stated that exercise is one of their favorite parts of the day, and Resident 4 expressed how she experiences pain and "exercise does help."

Many of the facilities, as mentioned by the residents, put on special activities as well, such as holiday parties. One resident stated, "Once in a while we have activities where there are organized games of various cornball, knock over the pins, get the ring over the bottle, circus, carnival kind of games that they set up, and those all are the games I enjoy." Another resident stated how they had a Halloween party where the lobby was all decorated and they had a party where they had bean toss games and bowling. In addition to more organized activities, two of the four facilities included in the interviews offered a bus that takes the residents to the store, in addition to outings for pleasure. When Resident 5 was asked their favorite thing to do in the facility, they responded by saying "I like when they take us out for a bus ride." These quotes were pulled from the data to show that more special activities that do not occur daily, such as bus rides and holiday parties, are highly valued by the residents.

Residents also mentioned that activities, along with their organized mealtimes, allow them to have a schedule in the home. Many residents expressed that they enjoyed being busy during the day. Resident 4 expressed that "there is so much to do" that she often does not spend very much time in her room, and Resident 2 when asked what her favorite thing to do here, responded by saying "I like the whole routine." In addition, as aforementioned in the previous section, it was found that activities are some of the primary ways that residents experience a sense of community in the home. Some residents enjoy getting more involved in the community and the activities by helping to run them. For example, Resident 3 mentioned "I enjoy being

involved in doing things like working on running the movies" and another resident took it upon themselves to plant flowers in the community flowerpots. All these quotes show how activities are able to promote a community within the facilities.

Food

One topic that dominated the conversation of the interviews was food, and reasonably so, as the residents usually participate in three meals a day in the dining room of each ALF. Meals are the one place where all of the residents can gather and see each other, participate in conversation with other residents, and receive the meals provided to them. Although there were many differing opinions on the food in the facility, every person interviewed had at least one negative thing to say about the food. Resident 3 stated that the worst part of living at the ALF was the food in the following quote: "The worst thing is the food. No question about that. The food is bad. You know you see people eating it and they are not really happy, but they eat it because that is all they [have]." Resident 1 stated "My wife was a wonderful cook. So how is it here compared to that? Not so good." This resident then goes on to state that the food that he does like, such as ice cream, they are very limited in giving. Resident 5 had a milder and more understanding attitude toward the food served at the ALF where she stays as she realizes that they have to cook for many people; however, she does wish to participate in the cooking of the food. She said, "I'd love to get my fingers in the kitchen over here and just share a few little tips here and there that I have discovered through many years of cooking."

One thing that was available at almost every ALF was an alternative menu for residents if the main course did not appeal to them that offered alternative neutral options such as hamburgers, hotdogs, chicken tenders, etc. Regarding their meals, many residents expressed how the ALF was able to adapt to tastes and needs, such as health conditions that required special

diets. For example, resident 1 goes to the store to buy food and he says, “They cook specially for me.” Two other residents shared that they had health conditions that required them to stay away from certain foods, and while in some cases the ALF showed adaptation, in other cases, it made eating certain meals difficult. For example, one resident stated that she is diabetic and that “Supper time is a lot harder because it is a lot of carbs and often no vegetables, so that is different for me.”

Attitude and perception

From the information gathered, the residents’ notions and experiences of the quality of life seem to go far beyond the four walls of the assisted living facility and the services that they had to offer. Many of the residents expressed the importance of having a good attitude and faith in the home. For example, when asked to describe his mood most days, resident 1 responded by saying “I have a theory on a lot of things. Life is a lot what you make it, and my theory is why not be happy.” In contrast, resident 3 had a more negative attitude toward his situation and life in general. In one statement, he said, “Enjoyment is a way of life and I do not have much of a life anymore” and when asked to describe his mood he stated “Just about flat. I am not completely happy, but I decided this is where I am going to be, and I have to come to terms with it.” For four out of the five residents, faith plays a very significant role in their lives and these four residents were able to express their faith in the ALF home by doing things such as attending services in the chapel included in the facility, listening to religious singers that come to the ALF, attending bible studies, taking communion, participating in prayers before meals, and reading their bible on their own time. The important role that faith plays in the lives of the residents is exemplified in a quote by Resident 5: “I cannot live at home anymore and I know that, so this is my home and so

I am happy. Every morning I wake up and say, 'Dear Lord this is another day that you have made with us together, and I am going to rejoice and be glad in it'".

Staff

As some of the primary people that the residents interact with during the day, each person interviewed expressed differing opinions regarding their relationship with staff. From the information gathered, one important way that the staff interacts with the residents is to provide conversation and a listening ear throughout the day. Whether it is delivering medication, providing meals, or facilitating activities there are many opportunities for staff interaction with residents. Resident 4 describes her relationship with the staff as "excellent" and when asked how you would describe "good care" in the interview, she stated "I think the number one thing would be able to listen. You need to be able to listen to our needs whatever they are. I have a couple of caregivers who are willing to, when they have time, sit down, and talk for five minutes, which is great." Similarly, Resident 5 stated when asked about his relationship with the staff "They are wonderful. We have a wonderful staff. They know our names. You walk down the hall, and they say 'Hi [name] and hi [name]'". One of the reasons that conversation is important as expressed by a resident is to maintain memory. When asked to describe her memory, resident 2 stated "Somedays it is good and somedays it is not. It depends on how much talking I do. It seems like the more I talk, the better I remember."

Another role of the staff gathered from the interviews is promoting independence. All of the residents interviewed said that they were fairly independent in their ALF, and that independence was important to them. For example, resident 1 stated "I feel like I am pretty independent in the home, and I can do what I want" and Resident 4 stated, "I do what I want and nobody cares, I mean if I wanted to raise the roof in my room I guess maybe then they would

start objecting." When asked to describe "good care," Resident 5 simply put it as "help when you need it and not when you don't." This quote illustrates the role of caregivers and staff in promoting independence but still providing quality care when it is asked for.

In yet another role of the staff in the lives of the residents in the ALF is providing them with care. Regarding this aspect with staff, there was a plethora of mixed positive and negative opinions. Resident 3 had complaints about the staff regarding the care of his wife in the ALF. When asked to describe his relationship with the staff, he said, "Well actually it is not that bad but sometimes you just wish they would get here soon for her problems. I cannot complain a whole lot about the staff, but I am not going to give them an A+." He then went on to say that the caregivers sometimes do not make it quick enough to get her ready in the morning to make it to breakfast and that the only time that he uses his call light is to draw attention to the needs of his wife. However, Resident 2 described how the staff has always "been on time," but she states that the worst part of living at the ALF is that "…employees come and go and adjusting to each one to get the communication between them and me."

Another positive attribute that contributed to the staff and AFL, in general, was providing extra help when needed. One resident expressed that when he moved in, his wife needed extra help, and compared to other ALFs that he lived at, the staff at his current ALF provided care such as "helped her take a shower and get dressed." Similarly, Resident 2 stated, "I take care of myself so far but when I have been sick, they have always…been good to whatever needed to be done." Many residents interviewed moved into ALF for a specific reason, whether it be controlling diseases such as diabetes and Parkinson's, rehabilitating broken bones, or fighting loneliness, and many residents expressed satisfaction in the way that they have recovered through their ALF. For example, one resident who suffers from Parkinson's stated "The

Parkinson's is the reason that I am in here. It was so bad when I came in, I could not walk." However, after being able to control his medication through the facility, he made a recovery.

Discussion

In this study, 13 domains of quality of life were identified from the data, including the physical environment of ALF, sense of community, communication within and outside the facility, visitation by the outside community, attitude and perception, staff, sense of independence, activities, food, faith, security, memory, and routine. However, five determinants of quality of life came up in almost every interview with each resident, and those were a sense of community, activities, food, attitude and perception, and staff. It was found that having a sense of community, participating in activities, having a positive attitude and outlook on life, and having good relationships with staff contributed positively to the residents' time spent in their ALF. However, the food served in the assisted living facilities contributed negatively to their experience in ALFs.

The results found in this study are very comparable to the results of the study in the article "Quality of Life in Assisted Life in Assisted Living Facilities: Viewpoint of Residents" By Mary Ball et al, which was expected since many of the domains of quality of life found in this study were used as the basis for questions in the interviews performed during this research study. For example, this study found 14 domains of quality of life including psychological well-being, independence and autonomy, social relationships and interaction, meaningful activities, care from the facility, comfort, cognitive memory/functioning, sleep, food, connectedness to community outside the facility, physical functioning, religion/spirituality, physical environment, and safety and security. Although this study and the study of Ball et al. have many crossovers, it was found that comfort and physical functioning did not play a large role in this researcher's

study, as all but one resident reported that they did not feel pain and were satisfied with their health. In addition, it was found in this study that more than anything, rather than the physical environment of the facility, it seemed to be the general attitudes and perceptions of residents that determined the quality of their time spent in the ALFs. In the study of Ball et al., it was found that 94% of residents had a general attitude of satisfaction toward the facility they lived in but the attitudes of the residents ranged from resignation to happiness, and that is almost exactly what was found in this study with four out of five residents being satisfied with their life at the facility while Resident 3 showed a more pessimistic attitude and feelings of resignation to his situation (Ball et al.). However, it is important to note that the study of Ball et al. included 55 residents compared to this study of five, but it is significant that despite a 23-year age gap between the two studies, many of the results remain the same.

Implications

Since it was found in this study that a sense of community, activities, staff, and positive attitudes was beneficial to the quality of life in assisted living, a few recommendations can be made to see a continuation and even improvement of quality of life in assisted living facilities. One thing that was said in the study was how the community in the assisted living facility felt like a family, and to promote this aspect of ALFs, this researcher believes it would be beneficial to see something like a partner program set up in the assisted living facilities right from the moment the resident moves in. For example, it could be very beneficial to the resident if an interview very similar to the one performed in this study was done for every resident in assisted living to find out their life story, their interests, their hobbies, etc., and then match them up with a fellow resident or staff member with similar interests. In addition, this researcher believes that since food was associated most of the time with a negative quality of life, the kitchen staff could

send out slips to residents so they could provide suggestions on what they would like to see for meals in the facility. In addition, one resident suggested that residents be part of cooking certain meals, and this may make a positive change in how the residents view the food that they are eating. All in all, it is important to incorporate the opinions of residents in the day-to-day of the facility as it is not only a business, but it is their home.

Limitations

Due to the small research team performing the study, this research study was limited to a small number of interviews with residents. In addition, this study was constrained by time, as there were only a few weeks available to perform the studies. Because of this limited amount of time to perform the studies, the researcher was only able to capture information and responses from residents throughout one time of the year; however, it may have benefitted this study to review responses in every season of the year as some perceptions may change, as seasonal depression could take effect in an area such as Grand Rapids. In addition, during one interview, there was the presence of a staff member throughout the whole interview which could have skewed responses to questions that specifically targeted staff or the facility itself. In addition, this study only included residents who still were cognitively healthy, and since many assisted living facilities include residents who suffer from dementia and other age-related mental illnesses, it is important to note that this cuts a significant portion of responses from residents of assisted living facilities.

Recommendations for Future Study

In future studies, it would be beneficial to increase the number of interviews performed in the study to capture a wider variety of responses. In addition, more information could be

gathered if a study like this could capture different areas of Michigan and compare the data in each of these sub-populations to determine how general location can affect quality of life. An interesting point to note is that during this study almost all residents have lived their whole lives in the city where their assisted living facility is, so it may be interesting to note how long-time residence in the city where their ALF is can change the quality of life. From the data that was found in this study, it would be beneficial to build upon it by not only using a larger population size but possibly doing a before and after type of case study on a single ALF where the changes recommended in this study were implanted in the facility to see if they had any effect on the quality of life of the residents.

Conclusion

This study intended to study the determinants of quality of life in assisted living facilities in Grand Rapids. This study has importance due to the growing population of the older generation combined with the increase in assisted living facilities which brings concerns for quality assurance in assisted living facilities. This qualitative study listened to residents of ALFs in an interview format to determine what makes a quality of life in assisted living facilities, and 13 overarching domains of quality of life were determined, with the main emerging domains being a sense of community, activities, food, attitude and perception, and staff. Overall, the findings of this study provide important insights into the relationship between these determinants and the quality of residents in assisted living facilities, and this study highlights where improvements could be made and what further research could be done in the realm of assisted living facilities. Because although this was a general study determining all realms of quality of life, each one found in this study could be studied in-depth.

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Appendix A: Interview Used for Data Collection

Generalized background information:

1. Tell me about yourself.
2. Where are you from?
3. How old are you?

Family/friends:

4. Tell me about your family. Do your family members live close to you?
5. Describe your relationship with your family members in the home. Do they visit you/how often?
6. Tell me about your relationship with friends.
7. How did/do you stay connected with your friends?
8. Tell me about your friendships within the facility.
9. Do you feel connected to a community in this home? Why or why not?
10. Describe your relationship with the staff here.

Work:

11. Tell me about your work experience.
12. How did you enjoy your years after retirement?

ALF Info:

13. How long have you lived in this home?
14. What are your views on the facility you live in?
15. What do you like best/worst about living here?
16. Describe your routine here.
17. How do you feel about your schedule?
18. What is your favorite part of the day?

Independence and autonomy:

19. How do you feel about your independence in the home?
20. What kind of care do you receive at the facility?
21. Are you satisfied with the care you receive? Why or why not?
22. How would you describe "good care"?

Activities

23. What kind of activities do you participate in? Do you enjoy them?
24. What is your favorite thing to do here?
25. Describe how you socialize with the other residents.

Food:

26. Do you like to cook? Why or why not?
27. Describe how meals looked before moving into the home.
28. Describe meal times here.
29. What kinds of foods do you eat?
30. Do you have a say in what you eat for your meals?

Safety and security:

31. Do you feel safe in this environment? Why or why not?

Psychological Well-being:

32. How would you describe your mood most days?
33. Do you ever feel isolated or lonely?
34. Describe your memory.

35. How does your memory affect you?

Physical well-being:

36. How would you describe your health status?
37. Do you have any pain?
38. What gives you comfort?
39. Describe your sleep habits. Are you able to get good sleep?

Values/Religion

40. What do you appreciate/ value most in life?
41. Do you have any religious beliefs? Describe them.
42. Have you been able to pursue your faith in this home?

Appendix B: Recruitment Script

The researcher reaching out initially to ALF (or the community director of ALF) via phone: "Hello! My name is Nina Alpers, and I am an honors student at Grand Valley State University. As an honors student, I am required to do a final project about a subject that I am passionate about, and I chose to do a research study on the determinants of quality of life in residents of assisted living facilities. I have randomly selected a few assisted living facilities in the area to contact about possible participation in the study, including your facility. I was wondering if you are willing to hear more about the research study and what it involves…all this study involves is a 30–45-minute interview with one or two residents. The interview questions will include a variety of topics, such as routines, feelings, values, personal facts, health status, care provided, relationships, and views on the facility. You will recommend a resident or two that you believe will be fitting for this type of study and have the cognitive capabilities to answer these types of questions, and all residents will receive consent forms with details of this study. The study has been approved by the IRB at Grand Valley State University. Is this something that you believe you and the residents of your facility would like to participate in?... Do you have any questions?... When would be a good time to greet the residents about possible participation? Thank you!"

The researcher reaching out initially to the resident: "Hello! My name is Nina Alpers, and I am an honors student at Grand Valley State University. As an honors student, I am required to do a final project about a subject that I am passionate about, and I chose to do a research study on the determinants of quality of life in residents of assisted living facilities. Does the sound interesting and like something you would like to hear more about? This study involves a 30–45-minute interview with questions that include a variety of topics, such as routines, feelings, values, personal facts, health status, care provided, relationships, and views on the facility. This is a study that has been approved by the IRB at Grand Valley. You will receive a consent form that I will talk you through before starting the interview. Would you like to participate in this study?"

Appendix C: Consent Form

Determinants of Life Satisfaction in Residents of Assisted Living Facilities in Grand Rapids: Consent to Take Part in Research

Researchers: Dr. Sally Pelon, professor in the department of social work, and student Nina Alpers

The purpose of this research study is to consider the life satisfaction of residents of assisted living facilities in Grand Rapids and explore the determinants that can make their time spent at assisted living facilities as enjoyable as possible. This study will consist of a 30–45-minute interview with questions related to your life in assisted living and beyond, taking into account your history, feelings, and interests.

- You voluntarily agree to participate in this research study.
- Even if you agree to participate now, you are able to withdraw at any time or refuse to answer any questions without consequence.
- You can withdraw permission to use data from the interview within two weeks of the interview.
- You will have the purpose of this study explained to you and have the opportunity to ask questions about the study.
- You will not directly benefit from participating in this study.
- In any report on the results of this research, your identity will remain anonymous. This will be done by changing your name and disguising any details of your interview that may reveal your identity or the identity of the people you speak about.
- Anonymous quotes from the interview may be used in the published honors project.
- All the information you provide for the study will be treated confidentially and no one other than the researchers will have access to the transcripts of your interview.
- Your name will not be given to anyone other than the research team. All information collected from you or about you is for the sole purpose of this research study and will be kept confidential to the fullest extent allowed by law. In very rare circumstances specially authorized university or government officials may be given access to our research records for the

purposes of protecting your rights and welfare or to make sure the research was done properly.

- Signed consent forms and original audio recordings will be retained in our possession until the honors project is completed in December and the only people who have access to it will be the researcher and research advisor and no other people will have access to it.
- You are free to contact any of the people involved in the research to seek further clarification and information.
- There could be the possibility of having some slight negative emotions that may arise as part of the study and the researcher will provide a list of support resources if requested or needed.
- Do you agree to this interview being audio-recorded?

  Yes No

- The research has been reviewed by the IRB at Grand Valley State University and the protocol number of the study is #24-060-H

External resources:

-social support services from assisted living facilities can be provided including counselors and social workers.
-Services provided by Grand Rapids Senior Neighbor Center.
-Services provided by the Area Agency on Aging of Western Michigan

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