ASSISTED LIVING IN BC: EFFECTS OF ORGANIZATIONAL FACTORS ON RESIDENTS' SATISFACTION

by

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The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

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or

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ABSTRACT

In British Columbia, Assisted Living has been at the forefront of housing options for older adults due to their growing numbers and inadequate housing and health care resources to accommodate them. Assisted Living is a potential viable alternative for relatively high functioning seniors. Fraser Health Authority, one of the largest health regions, anticipates the creation of up to 1200 units by the end of 2007.

This study examines residents' satisfaction levels in Assisted Living facilities in Fraser Health Authority, and the extent to which organizational factors influence their satisfaction. Data were collected in interviews with 52 residents residing in funded beds in 10 for-profit and non-profit Assisted Living facilities. Site managers/administrators completed organizational factors' surveys. Results indicate that residents were generally satisfied with the care received. Organizational factors did not appear to influence residents' satisfaction. This study assists in exploring AL residents' experiences and identifies areas for further study.

DEDICATION

This project is dedicated to my sister Sarah, and to my wonderful husband, Alim.

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GLOSSARY

The Assisted Living Centre of Excellence (ALCE): Non-profit society that was created by operators of Assisted Living; specifically, the BC Care Providers Association, BC Retirement Communities Association , BC Non-Profit Housing Association, Okanagan Private Supportive Living Association and the Supportive Assisted Living Association. It is dedicated to promoting excellence in assisted living services. ALCE's activities are intended to meet the educational needs of the provider, the public, and a number of other stakeholders. ALCE is also available to address the need for public accountability by providing third party complaint investigation. ALCE is governed by a volunteer Board of Directors composed of provider, Health Authority and community representatives. This governance model is designed to bring together a variety of perspectives.

Fraser Health Authority: Fraser Health provides hospital care, residential care, home support, home care nursing, public health, environmental health, and mental health and addictions services in clients' homes and at more than 100 facilities across the health authority. It maintains more than 7,000 residential complex care beds alongside hospitals or in the community and is working with BC Housing to develop 1,176 assisted living units to be completed by early 2007

Independent Living BC: A housing and health partnership between BC Housing, Canada Mortgage and Housing Corporation, the five regional health authorities in British Columbia, and non-profit and private housing providers.

CHAPTER 1: INTRODUCTION

1.1 Political Context

Assisted Living (AL) has been on the forefront of housing options for older adults in the last few years. The growing older adult population, inadequate housing and health care resources to accommodate them, and changes in government policy have led to an increased focus on potential solutions for British Columbia (BC). AL in particular, has been seen as one viable alternative.

In April 2002, the province, in conjunction with the leaders of the health authorities, announced their intention to provide services along a new model of care. The new policy on long-term care that was brought forth was a major shift from the proposals and plans put forward prior to this announcement. For instance, previous documents had indicated a need for additional long-term care beds to meet the service requirements due to population growth and aging. A 1999 document from the Ministry of Health stated, "An additional 4,495 beds are needed in 2001/2002, and an additional 1000-1,400 beds every year after that" (Cohen, 2003).

Not withstanding the announcement in 2002, 3,111 long- term care beds were actually closed across the province. In addition, guidelines that determined resident admission to these facilities were revised, thereby limiting access to fewer individuals with more complex medical needs. AL was presented as a positive alternative to the cut in long-term care beds. The government had

committed to providing 3500 AL units by 2005. This would double the amount of AL units in the province at the time of the announcement. This new direction indicated that the AL model was seen as a "substitute" or alternative to long-term care beds (now classified as "complex care"). This shift was designed to offer individuals with disabilities and older adults more options than previously available.

The development of AL beds would occur through either new construction or the conversion of existing care facilities and housing spaces. To accommodate this new model of care, closure of long-term care beds and restructuring of the delivery of home care services would be required (www.canadianelderlaw.ca). This enterprise would be funded through the money received by the provincial government under the Canada-British Columbia Affordable Housing Agreement.

A major player in this initiative was BC Housing which operates the *Independent Living Program*: a "housing for health" program for seniors and people with disabilities who require some care, but do not need 24 hour nursing professional level of care. BC Housing collaborated with the following organizations: the Canada Mortgage and Housing Corporation, the five regional health authorities, non-profit societies, and the private sector. The goal of Independent Living BC (ILBC) was to create 3500 independent living units with support services. The provincial government would provide rent supplements to seniors and people with disabilities in the low to moderate-income category. A total of 1000 rent supplements would be provided for units in pre-existing private AL developments while 2500 units would be developed by non-profit societies

and funded by the provincial and federal governments (www.bchousing.org). In response to these commitments, Fraser Health Authority (FHA) set a goal of providing 1,100 AL units by 2006/2007. The current goal is to provide 1,167 units by 2006/2007 with approximately 50% of the total units opening between 2006/2007. At the time of this study, there were approximately 400 units open, and by November 2007, over 800 are open.

This use of federal funds in this manner resulted in mixed feelings from the public. On the one hand, individuals such as Crawford (2003) stress the benefits of utilizing provincial affordable housing funding for AL developments. These benefits are seen as being twofold. First, the creation of AL funded beds relieve the cost and capacity pressures being experienced by the province's health care system. Secondly, the development of AL can be used to illustrate the province's continued support in the development of affordable housing. Similarily the BC Housing website provides a positive perspective:

> The seniors' population in B.C. is projected to double in the next 30 years. At the same time, B.C. seniors are living longer, healthier lives, and want to remain independent as long as possible. But as seniors age, their health needs can change and many need help with activities of daily living. Today, seniors are asking for more choice with housing and care. Until recently, most people had just two options when they needed support: home care or residential care. *Independent Living BC* offers a middle option to bridge the gap between home care and residential care for those who need some assistance, but don't want or need 24-hour care. (www.bchousing.com retrieved May 28, 2006)

In contrast, during this period, concerns were also expressed regarding lack of regulation. AL was defined as "housing" rather than "facility type" care and as such would be regulated by standards of care rather than regulations.

Concerns were expressed (e.g. Gutman, 2003; Spencer, 2003) as to how these standards would be managed without an enforcement mechanism. To address these concerns, legislation was implemented in May 2004 to regulate the industry in BC and set standards on what types of services and housing options qualify as AL. The *Community Care and Assisted Living Act* set the parameters that needed to be met in order to qualify as AL. All providers of AL services within the province were required to register with the AL Registrar's office. Under section 25 (1) *Subject to this Act and the regulations, the registrar may register an assisted living residence if the registrar is satisfied that the housing, hospitality services and prescribed services will be provided to residents in a manner that will not jeopardize their health and safety.*

In addition, the Assisted Living Centre for Excellence (ALCE) was created by operators of AL; specifically, the BC Care Providers Association, the BC Retirement Communities Association , BC Non-Profit Housing Association, Okanagan Private Supportive Living Association and the Supportive Assisted Living Association. This was developed in response to concerns regarding lack of consumer advocacy.

> "ALCE is a non-profit society dedicated to promoting excellence in assisted living services. ALCE's activities are designed to meet the educational needs of the provider, the public, and a number of other stakeholders. ALCE is also available to address the need for public accountability by providing third party complaint investigation" (www.alce.info retrieved May 21, 2006).

1.2 Purpose of this Study

BC is the first Canadian province to regulate AL. Since the implementation of legislation, and creation of new units under the ILBC program, there have been no studies in AL settings evaluating residents' satisfaction levels. One of the primary motivations for conducting resident satisfaction surveys is to identify improvement opportunities (Applebaum, Straker, and Geron, 2000). Organizations can attempt to improve quality of care by utilizing objective measures such as surveys which provide information regarding resident's needs and expectations. (Soberman, Murray, Norton, and Van-Maris, 2000). Information on quality also assists potential residents and their advocates in their choice of facilities (Curtis,Sales, Sullivan, Gray and Hedrick, 2005). Furthermore, an exploration of possible differences in perception of quality of care among consumers of for-profit compared with non-profit settings would be of great benefit to a population that is traditionally accustomed to receiving services from the public sectors.

This study was designed to collect information on facility characteristics along with measures of residents' satisfaction under this new model of care. Furthermore, an attempt was made to identify potential organizational factors that may be impacting residents' satisfaction within AL. More specifically, the purpose of the study was to explore:

1) Resident satisfaction levels in Assisted Living within the Fraser Health Authority, and

2) Within this jurisdiction, the organizational characteristics and policies of AL and their possible influence on resident satisfaction.

CHAPTER 2: REVIEW OF THE LITERATURE

2.1 Definition of Assisted Living: United States

The Assisted Living Federation of America (ALFA) defines AL as "... a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who require help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Supportive services are available, 24 hours a day, to meet scheduled and unscheduled needs, in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbours, and friends" (Regnier, 2002, p.3). According to Regnier and Scott (2001), AL is designed to provide long-term services in an environment that appears residential in both character and appearance with an emphasis on shifting away from design elements incorporated in traditional institutional type settings.

Golant (2001) describes the history of AL as a category of housing, having first evolved in the US in the late 1980's. At the time, it was seen as a new and progressive approach to the needs of individuals with limited abilities. AL is described as serving those individuals experiencing physical and or cognitive difficulties, who require some assistance but not to the level obtained in a nursing home. AL falls in the continuum between community dwelling individuals receiving supports and people receiving complex care in an institutional setting. AL in BC varies from AL as it is defined in the US. This difference lies primarily in

the resident's cognitive ability. Residents residing in AL in BC are required to meet the provincial eligibility criteria and must have the ability and desire to self-direct their care.

Previous models of care for the elder and disabled populations have consisted of nursing homes, congregate style housing, and board and care facilities. AL is considered a paradigm shift from the previous models of care. In addition to care provision, features such as autonomy, privacy, personalization, family involvement in care, and socialization are promoted.

2.1.1 Assisted Living in British Columbia

The *Community Care and Assisted Living Act* outlines AL in detail. An AL residence in this *Act* is defined as *a premises or part of a premises, other than a community care facility, (a) in which housing, hospitality services and at least one but not more than two prescribed services are provided by or through the operator to three or more adults who are not related by blood or marriage to the operator of the premises, (b) or designated by the Lieutenant Governor in Council to be an assisted living residence.* Care is defined as *supervision that is provided to (c) an adult who is (i) vulnerable because of family circumstances, age, disability, illness or frailty, and (ii) dependent on caregivers for continuing assistance or direction in the form of three or more prescribed services.* AL also pertains to adults with mental disorders or substance abuse disorders.

Services provided in AL are broken down into Housing services, Hospitality services, Support services and Prescribed services. Hospitality

services are defined as "meal services, housekeeping services, laundry services, social and recreational opportunities, and a *24 hour emergency response system*. Housing Services in this context are described as follows: "Accommodations range from private, lockable room to self-contained suites, with common dining and recreational space". AL has generally been marketed as a residential or homelike setting. *The Act* does not provide any specifications as to what facilities need to incorporate either in building design or in making the environment more homelike or residential.

Personal Assistance Services encompass the Support services and Prescribed services. These are broken down into six areas. These include *1) Activities of Daily Living, 2) Medication Administration and Monitoring, Central Storage and Distribution of Medications, 3) Maintenance of Cash Resources or Property, 4) Monitoring of Food Intake or Therapeutic Diets, 5)Structured Behavioral program, and 6) either Psychosocial Rehabilitation or Intensive Physical Rehabilitation* (www.healthservices.gov.bc.ca retrieved April 2006).

These services vary in intensity between Supportive (less intense, minimal level of services) to Prescribed level (maximum assistance). The operator is allowed to provide support level services in all six areas mentioned above. However, the operator can only provide service at the prescribed level in two of the areas mentioned above. In other words, a resident can obtain support services in all areas, but more intense (prescribed service) in only two of these.

Upon or prior to admission, *the Act* specifies that a Personal Services plan needs to be in place. This is defined as an agreement between the occupant

and the operator, and involves an assessment of the occupant's needs and service requests, the risks facing the occupant, and a plan of delivery for services, which is acceptable to both the operator and occupant. This plan is a guideline for service delivery by staff. This ensures that both parties have clearly defined expectations.

2.2 Studies in British Columbia

Crawford (2003) explored the emergence of the AL industry from a policy perspective. He described this development as part of a strategy to reduce institutionalization rates for BC seniors. This service is seen as an appropriate setting for those who no longer require acute care yet do not require the level of care provided in residential care. This approach is thought to be appealing to consumers as it provides services to seniors in a housing based model and to governments as costs associated with AL are significantly lower than in traditional residential care.

Araki (2004) explored the characteristics of AL settings operating in the province prior to the implementation of legislation. Specifically, she examined the fit between the policy goals of *the Act* and the services offered. Her study also explored the influence of the social and political context as well as individual level factors. Some of the issues identified in Araki's study have been resolved as a result of the implementation of legislation. For example, one issue she identified as problematic was the variability in services and supports provided by settings

that categorized themselves as AL. For instance, differences were found in the following areas: fees for services, availability of personal care services, type of care delivery, inclusion of services in the base rate, staffing levels, availability of equipment, and variable regulatory approaches by the Health Authority. After legislation however, settings defining themselves as AL must adhere to criteria set out in the legislation, therefore, entrance/exit criteria for residents are more explicit. In addition, the definition of AL within the legislation does not allow for aging-in-place, which was also identified in Araki's study as being a significant issue.

As Canadian data is limited, this writer has turned to the US where a wealth of data exists. US studies that have specifically assessed resident satisfaction within AL facilities have identified a number of factors that influence resident satisfaction. These fall into two categories: organizational factors (physical aspects of the facility, staffing, policies, and services); and individual factors (client socio-demographic characteristics, health status, and psychological well-being). The following summarizes the findings concerning each category.

2.3 Factors influencing Residents' Satisfaction

Many studies have been conducted in an attempt to identify organizational factors that may influence resident satisfaction in AL (Chapin, 2001; Chou et al, 2003; Crook et al, 2001; Mitchell et al, 2000; Phillips et al, 2003; Robinson et al,

2004; Sikorska,1999; and Utz, 2003). These include: facility size, physical environment, resident autonomy, availability of services, for-profit versus non-profit, and staffing. Other variables to consider include the facility's management style, philosophy of aging-in-place versus fixed entrance/exit criteria, managed risk agreements, and social climate/ programming. Some studies have found associations between organizational factors and resident satisfaction and others have not (Curtis, Sales, Sullivan, Gray, and Hedrick 2005).

2.3.1 Facility type

As previously noted, AL facilities range in type and services provided. Utz (2003) described AL in the US as falling into one of the following four categories: freestanding facilities; AL facilities within continuing care retirement communities (CCRCs-in BC known as campus of care); AL within independent living complexes; and AL facilities within nursing homes. The literature indicates that freestanding facilities are less likely to have a nursing home administrator, more likely to be for-profit, and more likely to cost more in comparison to AL within CCRCs (Utz, 2003).

Araki (2004) identified the various settings in BC that described themselves as AL prior to the implementation of legislation in 2004 as being of five types: Type 1 included AL units licensed as intermediate care (IC) beds, found in a freestanding project. Type 2 included AL units licensed as IC beds but as part of a multi level campus that typically included AL and independent living. Type 3 included settings where non-licensed AL units were part of a multi-level campus that included extended care (EC). Type 4 facilities included non-licensed

AL units offering personal care services by own staff. Type 5 units included Independent Living units subcontracting personal care services. The implementation of legislation has led to changes in the categories identified by Araki. All AL settings now must be registered. Presently, AL services are provided by both for-profit and non-profit groups using a variety of funding sources. These settings are found either in a campus of care setting or are free standing

What does this mean for the consumer? One can assume that choosing an AL program within a campus of care increases the resident's chance of aging-in-place, whether within the AL setting or within the campus of care. Literature reveals that AL facilities within a campus of care are more likely to be flexible and have staffing resources to accommodate clients with changing service needs than freestanding facilities. One can deduce that a facility run by an administrator with a nursing background may be more likely to appropriately assess changes as a result of client's physical or cognitive decline and have the potential to offer the appropriate services as compared to an administrator with a background unrelated to direct patient care, such as hospitality or property management.

2.3.2 Facility size

Sikorska (1999) found that after controlling for resident characteristics, higher levels of satisfaction with AL were found among residents of smaller facilities as compared with larger facilities. Moos and Lemke (1992) define their social climate measure of "cohesion" as the perceptual experience that people have with facets of the facility environment. Highly cohesive environments will

have increased involvement between staff and residents, as well as between residents. Facilities experiencing high levels of conflict however tend to have people expressing anger and criticism of each other and the facility. Mitchell and Kemp (2000) found that larger size facilities were positively correlated with levels of conflict as measured on social climate scales.

These studies suggest that smaller facilities are more likely to provide a cohesive environment as compared to large facilities. Smaller facilities may enhance quality of social interactions, and provide decreased stimulation. Smaller facility size is also more likely to appear residential and "homelike" when compared to larger facilities.

2.3.3 Profit versus non-profit

Research suggests that individuals in non-profit facilities tend to be more satisfied than consumers residing in for-profit facilities. There are a number of possible reasons why individuals might be more satisfied with a non-profit facility. Cost is one factor as the facility may be run with less of a profit intention in mind. The non-profit may run its facility along a different work ethic and philosophy, focusing on "ethos of service to the consumer rather than profit for the owner" (Sikorska, 1999, p.455) thereby appealing more to residents. Residents may experience increased satisfaction related to pre-existing ties to the sponsoring agency of the non-profit facility.

Phillips et al (2003) examined the effects of facility characteristics on resident discharges and found that residents in for-profit AL facilities were three

times more likely to move to some other setting compared to residents in non-profit facilities. The for-profit sector may "...be less capable of meeting residents' increasing care needs over time or less committed to the philosophy of aging in place" (Phillips et al, 2003, p.695).

Crook and Vinton (2001) found that decisions regarding retention varied between for-profit and non-profit facilities. Whereas 79% of non-profits involved residents in such decisions, only 50% did so in the for-profit sector. These results are important as resident moves are found to be difficult and stressful.

Mitchell and Kemp (2000) found that non-profit facilities were positively correlated with Cohesion and Independence suggesting that residents are experiencing more meaningful interactions.

2.3.4 Privacy

One of the tenets of assisted living is "Privacy and personal control". Privacy is usually taken for granted until one moves into a congregate housing alternative. Decreased privacy in contexts such as institutional settings can lead to feelings of decreased control and autonomy.

The main ways to achieve privacy in AL is through the provision of private rooms and bathrooms. Privacy is important for individuals during personal care tasks such as toileting, grooming and bathing (Sloane et al, 2001). In the study conducted by Sikorska (1999), it was found that after controlling for resident characteristics, moderate level of physical amenities and availability of personal space remained significant predictors of satisfaction.

2.3.5 Social Climate / Programming

AL philosophy encourages involvement of family and friends in an individual's care plan as appropriate. The social climate will determine the extent to which residents, family and staff are involved in socialization and recreational activities (Moos and Lemke, as cited in Mitchell and Kemp, 2000). Studies of residents in AL settings indicate that they experience depression at a higher rate than their community-dwelling counterparts (Cummings, 2002). Family contact and participation in social activities were identified as predictors of quality of life of individuals. Participation in social activities was predictive of higher life satisfaction and lower depression scores (Mitchell and Kemp, 2000).

A facility's commitment towards social climate is reflected in the quality and level of programming, policies encouraging family involvement, and physical design features (i.e. furniture arrangement, social areas, alcoves, and grouping of rooms into small subunits) (Sloane, 2001).

2.3.6 Staffing

Staffing in an AL facility is associated with a number of challenges. These include: staff training and qualifications, staffing levels, staffing mix, and staff turnover. One critical way that philosophy manifests itself in everyday practice is through staff training. Training will, in turn, impact staff attitudes and actions.

Training can consist of imbuing staff with the importance of resident rights such as "...treating residents with respect and dignity, ensuring confidentiality and privacy, preserving independence and autonomy, and acknowledging the individual and dynamic preferences of residents" (Utz, 2003, p 394). Training

also refers to the required qualifications of staff being hired by facilities. Minimum qualifications vary between states, and regulations focus on ensuring minimum levels of staff competency and training (Hodlewsky, 2001).

Other relevant staff qualifications that are not often assessed are traits such as staff flexibility, empathy and warmth. These qualities along with intelligence and communication skills tend to impact job performance. However, employers do not always have choices, especially if there are shortages of eligible employees (Hodlewsky, 2001).

Families also expressed concerns about the influence of staff training on resident quality of life. One study revealed that families felt that staff knowledge with regards to dementia, attitude, and communication with the resident and family was relevant (Greene, Hawes, Wood, and Woodsong, 1998). These family members also felt it was important that aides be certified, and that supervision be provided by a registered nurse.

Staffing mix is another factor to consider, as this is not consistent between facilities. The range of staff roles in an AL facility may include some or all of the following: administration, registered nursing, licensed practical nursing, personal care attendants, individuals who provide planned activities, food services, housekeeping, maintenance, and transportation (Stearns and Morgan, 2001). Some facilities hire staff directly while others contract out staff. The latter facilities will have limited influence on staff training. When contract staff are not consistent, it is difficult to maintain continuity of care and familiarity for the residents. Some residents may also choose to hire privately further decreasing

the amount of control that providers have over training. Staffing may be more of an issue in a small facility where there may be less staff flexibility and fewer benefits when compared to a larger organization (Pousada, 2003).

Variations occur in state regulations governing the mandatory levels of RN coverage, with some states requiring an RN presence on site versus RN availability on-call 24 hours a day. Phillips et al. (2003) found that residents in a facility that employed a full time RN had less than half the odds of moving to a nursing home compared with facilities that were staffed differently.

Another issue identified in the literature was staff/resident ratios. The literature reveals that staffing levels have a direct impact on quality of care. For example, staffing is considered particularly important to families at certain times such as when the resident's condition declines (Greene et al, 1998). Most states specify minimum staffing ratios but the ratios vary between states.

Due to the heterogeneity of facilities, services provided, and their residents it is difficult to set prescribed staffing levels (Hodlewsky, 2001). Minimum staffing levels regulated by states/provinces ensure some consistency, though these levels may not be adequate. In practice, staffing levels vary according to the time of day, with higher levels of staff present during the day than at night. Staffing levels also tend to be higher for resident populations with greater physical needs and cognitive impairments.

Staff turnover may influence continuity of care. Staff turnover rates are reported to range from 30 percent to more than 60 percent resulting in high recruitment and training costs (Hodlewsky, 2001). A facility with a high staff

turnover may have difficulty implementing AL philosophy with all staff. Difficulties in retaining staff are related to low wages for care aide positions, few benefits, and higher incidences of injuries related to transferring or lifting residents. Other factors mentioned in the literature as contributing to job dissatisfaction are as follows: negative peer attitudes, lack of assistance with heavy-care residents, not being valued by the professional nursing staff, and lack of proper equipment hindering abilities to perform duties in a timely fashion (Hodlewsky, 2001, Stearns and Morgan, 2001).

2.3.7 Management Style

Currently there are no mandatory or standardized training programs for AL providers. As a result, AL administrators may come from different backgrounds, whether it be nursing home management, hospitality/hotel industry or property development among others. The management style of the facility administrator/ organization may influence the extent to which the philosophy of AL is implemented. As the literature indicates, differences in philosophy and provision of care do exist between facilities labelling themselves as AL. This is to a certain extent influenced by management who determine the appropriate staffing levels/training, flexibility of care, the availability of resident choices, and overall commitment to resident well being. A greater emphasis may be placed on a medical model of care as opposed to a social model of care, by administrators with a background in facility management (Utz, 2003). As Golant (2001) notes, "The quality of a facility's management practices may make all the difference between a profitable and unprofitable organization".

2.3.8 Autonomy/ Services

Autonomy refers to the resident's right to make choices. Regimented schedules and practices lead to a decreased sense of independence, autonomy and identity. Autonomy within AL can be limited as certain aspects of daily routine are set by the facility. These include scheduled wake times, meal times, meal menus, and limits on certain behaviors. A resident's autonomy can be decreased when operators only provide certain service packages. Yee and Capitman (1999) found that "... most facilities had fewer than three service package options, increasing the likelihood that residents will buy and receive more or less care than they want". Curtis et al, (2005) found that, contrary to their hypotheses, there was no association between facility policies designed to foster resident autonomy or amount of health related services and overall resident satisfaction.

A challenge identified by providers is the balance between providing autonomy and providing security and safety. Safety issues may arise as a result of such unsafe practices as smoking, and leaving burners on. These situations may result in decreased autonomy for the individual resident in order to enhance the safety of all (Utz, 2003; Yee and Capitman, 1999).

2.3.9 Aging-in-Place

Proponents of AL state that this model facilitates aging-in-place. Promoting aging-in-place and increased length of stay has benefits and drawbacks. A major benefit of aging-in-place is the decreased possibility of relocation stress. Relocation can cause stress, isolation, grieving and an overall

decline in physical and psychological functioning in older adults. Relocation places frail adults at risk for developing depression and suicidal ideation (Chapin and Dobbs-Kepper, 2001). Frank (2001) argues that fear of potential eviction places undue stress on residents, as they are uncertain as to how long they may remain in that setting. Residents are therefore in a constant state of limbo and it is difficult for them to feel "at home." An aging-in-place policy enables residents to feel at ease; that they are not under the threat of being discharged if their condition deteriorates.

A drawback is that residents would prefer not to watch others become frailer and more impaired. The decline of fellow residents reinforces an image of a nursing home setting as well as the potential vulnerability of the well residents who are viewing these changes (Frank, 2001).

Despite a philosophy of aging-in-place, the reality is that the average length of stay in an AL facility is just under two years. Most residents are discharged for the following reasons: healthcare needs became too great for the facility to meet, behaviour problems, death, and dissatisfaction related to either quality of care, price, or some other aspect of the facility. Common discharge destinations include: nursing facilities, other assisting living facilities, hospitals, and less commonly, home (Chapin and Dobbs-Kepper, 2001; Phillips et al, 2003; Frank, 2001; Kissam, Gifford, Mor, and Patry, 2003).

2.4 Resident Satisfaction

Resident satisfaction can be defined in a number of ways. According to the Expectancy Disconfirmation Model, satisfaction results from "1) a cognitive evaluation of the perceived performance or quality of the various attributes of a service compared to expectations about those attributes and 2) an affective response to that evaluation. Satisfaction (or dissatisfaction) with a service occurs when there is a "disconfirmation" between expectations and actual performance" (Applebaum, et al., 2000, p 18). According to Pascoe and his Contrast Model, individuals experience satisfaction if their experiences are greater than their expectations. In contrast, when they are confronted with an unfamiliar event, they may choose to alter their expectations downward to match the situation (Steiber and Krowinski, 1990). Satisfaction therefore is the product of an event and each individual's interpretation of the event.

Perception of a place is influenced by factors specific to the individual such as personality characteristics, life experiences, socio-demographic characteristics, and individuals' expectations of their experiences (Sikorska-Simmons, 2001; Sikorska 1999; Mitchell and Kemp, 2000). Measures of satisfaction can be challenging as it is sometimes unclear whether an instrument is measuring satisfaction or if it is reflecting an individual's overall psychological well being (Sikorska-Simmons, 2001). In addition, most satisfaction instruments are used with individuals who are cognitively intact. Research indicates that individuals that experience physical and/or cognitive limitations are more likely to

experience a lower quality of care (Soberman et al, 2000). This may be due to decreased ability to direct and articulate their care needs.

2.5 Resident Satisfaction Instruments

Some satisfaction instruments focus on the "... affective part of the concept, whereas others stress the cognitive or judging component" (Kruzich, 2000). The measure of satisfaction can be variable depending on whoever the respondents are, residents, families, frequent visitors, or staff.

A review of the literature produced a number of satisfaction surveys developed for nursing homes. Instruments that specifically focused on measures of satisfaction for individuals residing in AL facilities were limited in number. Previous studies assessing satisfaction within AL have used in-person interviews (Curtis et al, 2005), "in-house", non-standardized satisfactions scales or satisfaction scales specifically designed for nursing home settings.

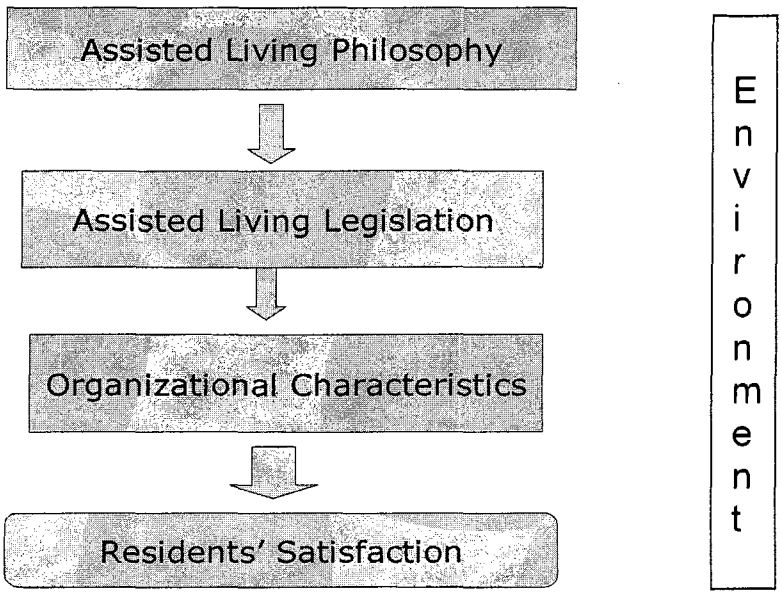
As Robinson, Lucas, Castle, Lowe and Crystal (2004) note, satisfaction surveys vary in content and scope, suggesting a lack of consensus on areas of resident satisfaction that are important to assess. These authors found that satisfaction surveys utilized in nursing homes and AL facilities tended to focus on items such as marketing issues and facility appearance. In addition, little to no attention had been paid to the psychometric qualities of the instruments. Finally, these studies used surveys primarily for administrative purposes (I.e. marketing) rather than for improving quality of care.

A review of the major databases produced one instrument, designed by Sikorska-Simmons (2001) that is applicable to AL settings: The Resident Satisfaction Index (RSI). The RSI includes major characteristics/ concepts described in the literature. These include provision of health care, housekeeping services, physical environment, relationships with staff, and social life/ activities. As this instrument appeared to be the most relevant, it was selected for this study.

CHAPTER 3: CONCEPTUAL FRAMEWORK

A conceptual framework to illustrate the factors influencing resident satisfaction was developed for this study (Figure 1). The framework consists of the following characteristics arranged in a hierarchy denoting their level of influence. The uppermost level consists of AL philosophy. The basis of AL is to provide an environment that promotes congruence between the individual and their environments. Philosophy, in turn influences the development of AL legislation. Organizational level characteristics are impacted by legislation, yet are unique in each AL setting. Together, these three levels interact to influence residents' satisfaction levels. The environment, which is a common thread running through all levels of the hierarchy, is designed to represent the appropriate amount of "press" which maintains the resident at an optimal level of functioning.

Figure 1 Conceptual Framework



3.1 Environmental Models

There are a number of models seeking to explain the interaction between the individual and the environment. The basic tenet of these models is that "... performance and adaptation are maximized where characteristics of the environment are consonant with individual needs and preferences and complementary of deficits" (Parmelee et al, 1990, p.469). The basis of the above framework is derived from the Congruence Model and Lawton's Ecological Model. In Lawton's Ecological model, environment has been conceptualized in terms of demand on competence. "Excessive environmental demand in relation to an individual's competence leads to stress and negative outcomes" (Cited in

Carp, 1987, p.337). The Congruence Model seeks congruence or fit between the characteristics of the individual and the environmental demands for activity. "Persons feel most satisfied with themselves and their living conditions when there is congruency between what is expected of them by others of significance and what they may expect of themselves" (Carp, 1987, p.337)

The significance of these conceptual models to residents of AL is that one of the tenets of AL is the belief that it is important to maintain individuals' independence and autonomy. This is accomplished by providing a modified environment and services to increase congruency between the individual and their environment. The assumption is that residents will be more satisfied if there is congruence between their abilities and the services offered by AL.

3.2 Assisted Living Philosophy

AL has been described as a new paradigm of care that emphasizes non-institutional living, resident autonomy, and is committed to meeting the preferences and needs of all individuals (Yee et al, 1999). The Assisted Living Federation of America has developed a 10-point philosophy that is designed to guide AL providers through their everyday operations. These include the following:

1) Offering cost-effective quality of care that is personalized for individualized needs

2) Fostering independence for each resident

3) Treating each resident with dignity and respect

4) Promoting individuality of each resident

5) Allowing each resident choice of care and lifestyle

6) Protecting each resident's right to privacy

7) Nurturing the spirit of each resident

8) Involving family and friends, as appropriate, in care planning and implementation

9) Providing a safe, residential environment and

10) Making the Assisted Living residence a valuable community asset *(Cummings, 2003).*

Supporters market AL as an appealing choice for consumers as it enables them to receive additional care while they continue to reside within a home-like environment. It focuses on consumer rights and choices. Applebaum et al (2000) suggests that "the philosophy of AL is very consumer focused".

3.3 Assisted Living Legislation

Regulations set the parameters of what facilities can and cannot offer. Regnier and Scott (2001) describe the role of rules and regulations as to guide practice, ensure safety, and provide a reasonable level of quality assurance. Governmental regulations outline the minimum and maximum levels of services

to be provided in a facility. Operators can then set their policies to fall within the acceptable range according to the regulations.

According to BC Provincial Bill 73: *Community Care and Assisted Living Act,* once individuals require more than the minimum levels of prescribed services, or are unable to make decisions on their own, they no longer qualify for AL. This regulation, if not adhered to, can result in poor quality of care and violation of consumers' rights.

3.4 Organizational Factors of Assisted Living Providers

The influence of AL philosophy and legislation is reflected in the organizations' policies, physical layout, provision of services, staffing, management styles and philosophy of care, among other things. An assessment of providers' organizational type characteristics can assist in determining the satisfaction levels that resident may experience. Identification of factors through which resident satisfaction is achieved can assist both for-profit and non-profit facilities to create experiences of resident satisfaction within their facilities.

3.5 Assisted Living Consumer

Resident characteristics in interaction with the AL environment has been shown to be associated with residents satisfaction. Sikorska (1999) found that "... residents who were happier, more functionally independent, and had

participated in the decision regarding relocation were significantly more satisfied with AL when compared to their counterparts. Education was inversely related to satisfaction, indicating that more educated residents were less satisfied" (p. 452). Another study suggested that residents who had chronic health problems had both lower life satisfaction and lower facility satisfaction (Mitchell and Kemp, 2000). Finally, residents who are older tend to be more satisfied with care than younger residents (Chou et al, 2003). However, although resident aggregate characteristics have been shown to be associated with resident satisfaction, these factors will not be assessed in this study. Rather, the following research questions and hypotheses were identified based on the conceptual framework and previous studies of residents' satisfaction in AL.

3.6 Study Purpose

3.6.1 Research Questions

1) What are the levels of resident satisfaction in AL settings within Fraser Health Authority in British Columbia?

2) What are the organizational factors that influence residents' satisfaction in AL facilities within FHA?

3.6.2 Hypotheses

1) Facilities that offer higher levels of social programming are more likely to have satisfied residents than those that offer minimal programming.

2) Individuals residing in smaller, non-profit facilities located within a community of care setting will be more satisfied with care than residents residing in larger, for-profit, free standing facilities.

3) Facilities whose staffing mix includes RN coverage as opposed to only LPN coverage will have residents who are more satisfied.

CHAPTER 4: METHOD

Data were collected from 52 residents of 55 residents identified by administrators between October 2005 and April 2006. Sample size per facility ranged from 4 to 6. Sampling frame for this study were 11 AL facilities within FHA that were operational at the start of this study. The geographic region of FHA contains both small rural towns and larger urban centres and has a total population of approximately 1.6 million. This study utilized a combination of quantitative and qualitative methods. Participants included both administrators and residents of AL settings. Residents were interviewed in-person by the researcher using a quantitative questionnaire and open-ended questions to elicit qualitative data. Questionnaires were mailed to administrators to obtain data on organizational characteristics. The independent variables for this study consisted of the following organizational characteristics: facility size, facility ownership, discretionary costs (i.e. extra meal, laundry, cable/TV), services offered, staff resources, and programming. Settings were categorized according to facility size and facility ownership, i.e. for-profit vs. non-profit. Residents' satisfaction levels served as the dependent variable. It should be noted that the sample was not representative of all residents living in AL settings.

4.1 Instruments

The two instruments used in this study consisted of the Organizational Factors' Survey, designed by the investigator and the *Resident Satisfaction Index*, designed by Sikorska-Simmons (2001). Facility administrators completed the former while the latter was administered by the researcher to residents of AL along with several open-ended questions.

4.1.1 Organizational Factors' Survey

To obtain data on organizational characteristics of the AL facilities, a questionnaire (Appendix A) was developed that explored facility physical characteristics, funding status, programming, and staffing characteristics. Also included in the survey was a section on residents' characteristics. In total, there were 29 questions. This questionnaire was designed with the intent of being self-completed by AL facility administrators. The decision to utilize a questionnaire in this study was based on a related study (e.g. Araki, 2003) that utilized similar methods to elicit data about facility and resident characteristics.

4.1.2 Resident Satisfaction Instrument

As indicated previously, a review of major databases produced only one instrument that was applicable to AL settings. This instrument was designed by Sikorska-Simmons (2001) and is entitled *The Resident Satisfaction Index* (RSI) (Appendix B). The Short Portable Mental Status Questionnaire (Appendix C) serves as a screening tool to identify individuals cognitively able to complete the RSI. Participants who obtained a score of 4 or above on the SPMSQ were

selected. The RSI includes major characteristics/ concepts described in the literature, including provision of health care, housekeeping services, physical environment, relationships with staff, and social life/ activities. Each RSI item is scored on a 4-point scale with answers: 3= always, 2=usually, 1= sometimes, 0=never. A higher score on an item indicates greater satisfaction. The RSI subscales can be used separately or summed to obtain a total satisfaction score of 66 (Sikorska-Simmons, unpublished). The RSI includes the following subscales: health care (maximum score=12), housekeeping (maximum score=12), physical environment (maximum score=9), relationship with staff (maximum score=15), social life/activities (maximum score=18). Sikorska-Simmons (2001) reports that the reliability estimates for the index is Cronbach's alpha=. 92, with reliability for the subscales ranging from .77 to .86. Internal consistency and validity in measuring resident satisfaction in AL are strengths of this instrument.

Limitations of assessing resident satisfaction include self-report biases. For instance, "... the opposition response which is defined as the tendency to disagree with statements, regardless of content or contrary to this is the socially desirable response set which refers to the tendency to respond in a manner that will please the provider and the researcher" (Dansky et al., 1996). As the RSI contains mostly positively worded items, this was a factor to be aware of in using this instrument (Sikorska-Simmons, 2001). To address this, the investigator provided residents with opportunity to express additional thoughts in response to a set of open-ended questions.

Sikorska-Simmons (2001) identifies: (1) the need for further investigation to identify the validity of this instrument as a quality of care indicator, (2) further assessment as required to determine the instrument's predictability of specific sources of satisfaction, (3) the instrument's use being limited to relatively cognitively intact residents, and lastly (4) lack of an autonomy- related subscale which is an important facet of AL. Residents' opinions regarding issues of autonomy were expected to be revealed in this particular study through the use of semi-structured questions.

4.1.3 Open Ended Questions

In addition to the RSI, data about residents' socio-demographic characteristics were collected during the interview. Six open-ended questions were asked at the end of the interview to elicit additional feedback. These questions were as follows:

1) Tell me about the sequence of events leading up to the move to AL.
2) If you had concerns about this place, how willing would the manager or owner be to listen to your concerns?
3) If your health deteriorates, how confident are you that this place can continue to meet your needs?
4) How much of the time is there enough staff on duty?
5) How homelike does this place feel like to you?
6) Is there anything that you would like to add that we haven't covered thus far?

These questions were developed to gather information regarding the precipitating factors leading up to the decision to move: Was the move to AL within residents' control, and what were their feelings after living in AL for some time? Did residents feel they had someone to speak to if they had any

concerns? As the new legislation enforces the criteria for admission and exit from AL, residents were questioned about their feelings about aging-in-place. Did residents feel that this was now their home? Did residents feel that current staffing levels adequately meet their needs? Were there gaps in the care that was provided?

4.2 Sample

4.2.1 Sampling Frame

The sampling frame for this study included the eleven designated AL facilities that were operational in fall 2006 and affiliated with FHA (Appendix D). To qualify, facilities had to meet the criteria for AL under the recent legislation and had been awarded contracts by FHA to operate as an AL facility in the region. Although a number of additional facilities had opened or were scheduled to open during the completion of this study, only the initial 11 AL facilities were selected. AL facilities were categorized based on: profit versus non-profit status and size (large being defined as greater than 75 beds). For a list of these categories see Table 2. Sample size per facility was designated at 10% of each settings total number of ILBC funded units or a minimum of 4 residents.

4.2.2 Participant Recruitment

An introductory letter (Appendix E), the Organizational Factors Survey (Appendix A), and a self-addressed stamped envelope were mailed to administrators of all 11 facilities in October 2005. Along with their completed

survey, each setting was asked to enclose an activity calendar, facility specific information and to identify names of prospective participants for this study.

Administrators/staff of each facility were asked to select six to eight residents who met the following criteria: a) spoke English, b) had resided in the facility for at least 3 months, c) were alert and oriented, d) had minimal confusion, e) were able to converse appropriately and follow directions, f) were designated by facility as requiring AL services, and g) who were residing in a bed funded through the ILBC program. As previously mentioned, the cost of AL for individuals in the ILBC program is 70% of after-tax income.

The first follow-up phone calls were made two weeks after the initial mail out to confirm that the survey had been received. Follow-up phone calls occurred between November 2005 and April 2006. Data collection was terminated April 2006. Ten of the 11 facilities participated in the study. Of the 55 residents whose names were provided by administrators, 52 participated in the study. Of the remainder, one refused to participate and two residents were unavailable at the time of the interview. All 52 resident participants had fewer than four errors on the SPMSQ therefore none of the residents were screened out of the study. This sample was biased in favour of cognitively intact residents. Resident specific characteristics were not controlled for in this study (i.e. psychological well-being, health status, socio-economic status etc).

4.2.3 Resident Interviews

A majority (85%) of the resident interviews took place in their rooms; 15% took place in lounges/ social areas located within the facility. Each interview took 35-40 minutes to complete. Signed informed consent (Appendix F) was obtained prior to initiating the interview. The entire interview was conducted orally with responses being recorded manually by the researcher. Interviews were initiated with a verbal description of the study. The researcher then screened participants by going through the SPMSQ (Appendix C). Following the screening, the researcher collected demographic data. This was followed by a semi-structured interview using the RSI. The researcher ensured all questions on the RSI were asked. In instances where it appeared that participants had additional information, the researcher encouraged them to go into more detail. The open-ended responses were recorded as close to verbatim as possible. These responses were later analyzed and coded into categories. Six additional open-ended questions were used to allow participants to give unbiased feedback and opportunities to detail experiences that would not be captured in the structure of the RSI. At the end of the interview, participants were asked to provide feedback on any items that may have been missed, or whether there were any other topics that they would have liked to add. The common response to this question was that the researcher had been thorough in the interview.

To qualify for an AL unit, individuals are screened through a standardized admission process. The AL Case Manager and operator assess priority for entry. Criteria for entry include the following: ability to make decisions on one's behalf,

must be able to communicate, cannot be at risk to themselves or others, and must be able to respond to directions in the event of an emergency. Residents are assessed on a continuous basis for appropriateness in AL

4.2.4 Characteristics of Residents

The average age of the 52 residents interviewed was 82; ages ranged from 56-95 years old. A majority (83%) of the sample was female; 79% (n=41) were widowed, with an average education level of grade 10. As shown in Table 1, residents of for-profit and non-profit settings shared similar characteristics.

Table 1: Resident Characteristics by Facility Ownership Type

Resident Characteristics	***For- Profit Facilities*** *N:6 Facilities Sample Size: 31*	***Non- Profit Facilities*** *N:4 Facilities Sample Size: 21*	***Total*** *N: 10 Facilities Total Sample Size:52*
Mean Age in Years	*81*	*83*	*82*
Gender			
Females	*27*	*16*	*43*
Males	*4*	*5*	*9*
Marital Status			
Widowed	*22*	*19*	*41*
Married	*4*	*0*	*5*
Single	*1*	*1*	*1*
Separated/Divorced	*4*	*1*	*5*
Mean Education	*Grade 10*	*Grade 11*	*Grade 10*

4.2.5 Characteristics of Facilities

The 10 participating facilities ranged in size from 30 units to 217 units (Table 2) with the number of ILBC-funded units ranging from 5-60. AL length of operations was variable. For the purposes of this study AL length of operation was defined as being from the time the facilities were registered. These periods ranged from approximately March 2002 to October 2005 (length of operation therefore ranging between 4 months to 4 years). Over 50% of the facilities were part of campuses of care.

Table 2: Facility Ownership

Facility Ownership	*Facility Names*
For- Profit Large	*Fleetwood Villa 166 units (60 ILBC)* *Bevan Lodge 150 units (5 ILBC temporary)*
For- Profit Small	*Royal Crescent Gardens 46 units (ILBC 46)* *Waverly 66 units (40 ILBC)* *Riverside Manor 30 units (10 ILBC)* *Gateway 60 units (60 ILBC)*
Non- Profit Large	*Seton Villa 217 units (ILBC 28)*
Non- Profit Small	*Dania Manor 50 units (ILBC 40)* *Augustine House 60 units (20 ILBC)* *Nikkei Home 59 units*

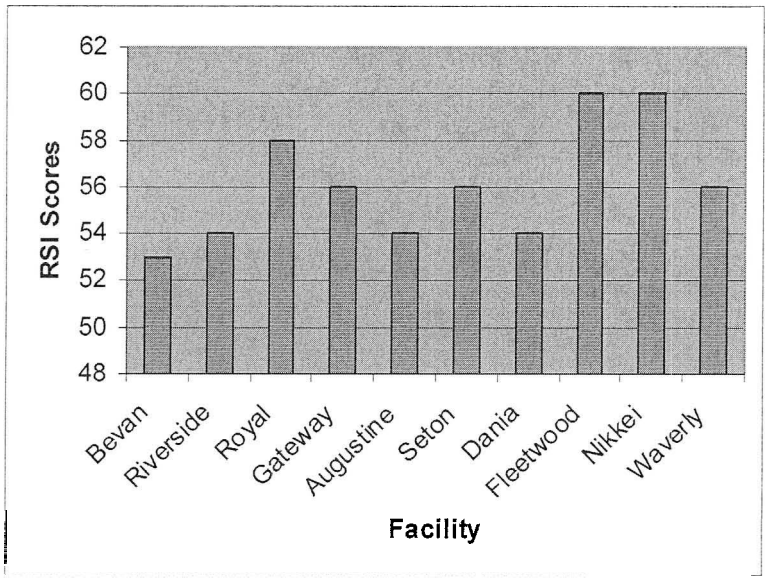
CHAPTER 5: RESULTS

5.1 Resident Satisfaction Scores

The mean satisfaction scores for the ten facilities that participated in this study were similar across facilities, with a range of 53 to 60 (Figure 2). Mean facility scores for this study were calculated by adding the values of participants' RSI scores and dividing that number by the total number of participants in that facility. No other statistical tests were used, given the small sample size. Overall, the average satisfaction score was 56 (highest satisfaction level would be indicated by a score of 66). Resident satisfaction scores ranged from 39 to 66. Overall, residents appeared to be satisfied with their experience in AL. Apparent differences were not found between residents of non-profit facilities versus for profit facilities (Figure 3).

The findings do not support the initial hypothesis, which stated that individuals residing in smaller, non-profit facilities located within a community of care setting would be more satisfied with care than residents residing in larger, for profit freestanding facilities. It is important to note that the sample for this study consisted of residents residing in ILBC funded units. This meant that all were subject to standardized rates (70% of after-tax income) even when residing in a for-profit facility. Secondly, all residents selected in this sample were selected by administrators. There may have been a certain degree of bias in the selection process and is therefore a limitation of this study.

Figure 2 Mean RSI Scores by Facility



5.2 Facility Size and Resident Satisfaction

In this sample, three facilities were classified as large (>75 beds) and the remaining seven facilities as small. There were no differences between mean RSI scores of large versus small facilities (Figure 3). Repeated comments were made by residents regarding their room sizes. Comments expressing satisfaction or dissatisfaction were made spontaneously. Comments ranged from "I have a good sized room" to "This space is like being in the black hole of Calcutta" (Appendix G)

5.3 Privacy

In the AL settings examined in this study, none of the facilities had semi-private rooms other than instances in which the resident was sharing space with their spouse. Therefore, many of the privacy limitations described in the literature are not an issue for this sample.

5.4 Service levels

Within the FHA, staffing levels are calculated according to the acuity of residents. An individual designated at an AL Level is allocated a maximum of 1.5 hours of scheduled and unscheduled care per day, whereas an individual classified as Supportive Level category receives a maximum of .7 hours of scheduled care per day. Each facility within FHA is required to have a minimum of 12 hours of LPN coverage/ day. The legislation allows for nursing care to be provided by either RNs or LPNs. Service levels of various facilities was difficult to assess, as most settings were multi-level care and staffing ratios specific to AL residents was not clear. As a result, the data do not allow the researcher to address hypothesis 3 in this particular study.

5.5 Social Programming and Resident Satisfaction

The next hypothesis stated that facilities that offer higher levels of social programming are more likely to have satisfied residents than those that do not offer such programming. All facilities included in this study were found to offer

some social programming. The number of programs offered by the 10 facilities ranged from one to eight. Figure 4 shows mean social activity subscale scores by facility. As can be seen these ranged from 8 to 14 out of a possible total of 18.

Figure 3 Mean RSI Scores by Facility Ownership and Size

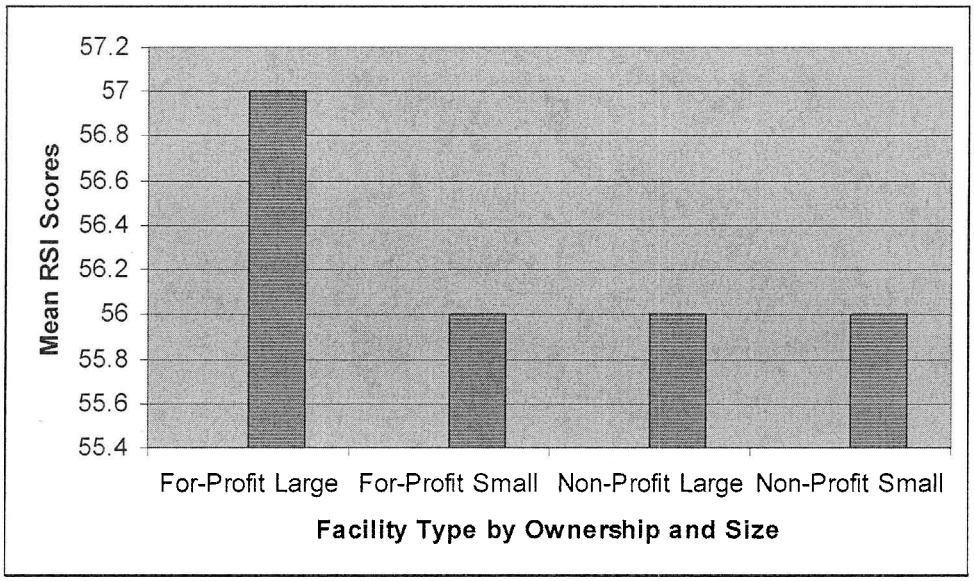


Figure 4 Mean Social Activity Subscale Scores by Facility

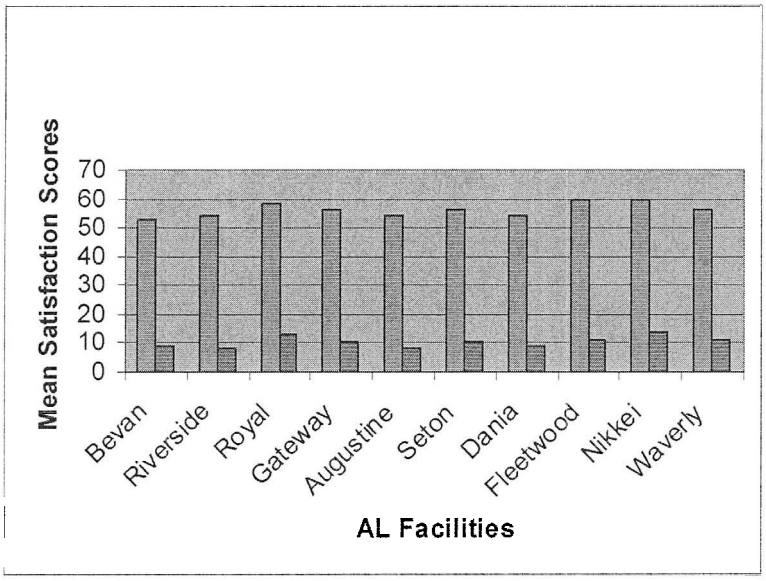


Table 3 illustrates the number of programs that each facility provides. The mean social activity subscale scores, the mean total RSI Index scores, and additional comments are provided in the adjacent columns. There did not appear to be any direct relation between the number of social programs and resident satisfaction scores. Therefore, this hypothesis was not supported by the findings of this study. It must be noted however that within the Organizational Factors Survey, the term "social program" was not defined. Therefore this term may have been subject to individual interpretation thereby explaining the inconsistent results that were found. Appendix G has a full list of comments made by participants. In Table 3, an attempt was made to choose comments that reflected a range of responses. Table 3 illustrates that regardless of the number of programs that are provided, mean scores on the social activity subscale do not greatly vary between facilities.

Table 3: Social Programs and Mean Satisfaction Scores by Facility

Facility	Number of Programs	Mean Social Activity Subscale Score	Mean Resident Satisfaction Scale Score	Sample Responses from Participants During the Interview
Bevan Lodge	8	9/18	53/66	*The activities here are developed for people in their late nineties- it is pathetic. And they tried to start a Men's social. Well that program was not great. It lacked stimulation. The entertainment try hard but they can't beat what's on the box (TV)* *Lots of activities*
Gateway	Not available	10/18	56	*The nights are long and lonely. There aren't many people around in the lounge* *The recreation is good as can be expected. The activity person is first rate. She is very compassionate and the programs are well run*
Seton Villa	4	10/18	56	*I don't socialize much. I have difficulty hearing and trouble walking so I don't bother much* *I am not really into socializing. However if I feel lonely I can go up to the penthouse and there is always someone that will come by and talk to you. And we play cards up there twice a week. There is a group of us. Last night we had 11 people playing cards. Have you been to the penthouse? It is really quite something. They have everything up there... pool table, shuffleboard, everything*

Dania Manor	5	9/18	54	*I like the afternoon programs-the singing and memory games. I can't attend to many programs because my eyesight is failing. That's also why I don't socialize much with others. I can't see them unless they are close to me* *I don't participate in social activities- it is just a bunch of old farts sitting around listening to some lady on the piano. It would be nice if we had a pool table or shuffleboard, or even a dart board*
Augustine House	4	8/18	54/66	*I like some programs. I help out with a couple of programs. I think it helps the staff out* *Only thing is that it is lonesome. People don't seem to want to click together. A lot of people here have family and children that live close by. These people don't like to bother with others. Some of us try. We are lonely and we don't have family who visit as frequently. And there are a lot of groups of people who know each other from before. I am from out of town and so I don't know anybody*
Royal Crescent Gardens	3	13/18	58/66	*Not impressed with the programs. There are some groups of ladies here. And they always play games of their choice. Unless you are into cards... there is not much else you can do. There is a seniors place outside that you can participate in if you pay a small fee. I usually attend that* *Sometimes lacking*

Waverly	2	11/18	56/66	*This place helps with loneliness-you can go to social areas and socialize with others when you feel the need.* *I don't participate much in social activities- I am happy in my own room*
Fleetwood Villa	4	11/18	60/66	*They celebrate and decorate for all the holidays. The decorations are costly looking... like a big hotel. It makes you feel like you are in a ritzy place.* *Can't always participate in activities because I have had 2 strokes... and my balance is not good.*
Nikkei Home	4-5	14/18	60	*Don't attend programs much because I can't hear very well* *One thing they could really improve is adding an exercise room with more equipment*
Riverside Manor	1	8/18	54	*Don't enjoy going to activities because I can't see well* *We play card games and do various things to entertain ourselves*

Three categories of residents became apparent during the course of the interviews. All three categories were evenly divided. The first group consisted of residents who actively participated in programs, and appeared to be influenced to a certain extent by the number and quality of programs. These regular participants of activities either felt satisfied or dissatisfied with the number of program provided. Other residents felt that the programs were geared for a different population. Alternatively, they felt that the activities were not appealing. The second category of residents defined themselves as "loners" who preferred to remain in their rooms. These residents were satisfied with their own company, and did not care to participate in the organized activities. The third category of residents stated that their attendance in social activities was limited because their physical status (mobility, decreased vision, and decreased hearing) affected their ability to participate in the programs. Individuals experiencing physical limitations appeared to be accepting of the associated consequences. Certain residents within the previously identified categories described feelings of loneliness. In those cases, the social programs and being able to congregate in the lounges appeared to alleviate some of this feeling.

Similar categories of residents have been found in a previous study. Gutman, Mercer and Fullick (1979) in their study of residential and life satisfaction of elderly in institutions identified four distinguishable groups in terms of mobility. These were the "institutional roomers", "institutionally oriented", the "out and abouts", and the "gadabouts" (p.63). This may lead us to conclude that

similar groups of residents occur across institutional type settings, regardless of level of social programming.

5.6 Issues identified in responses to open-ended questions

5.6.1 Reasons for admission to AL

Based on the residents' responses, it appeared that a majority had not developed a long-term plan with a goal to move to AL. For the most part, the occurrence of a significant event/incident was the trigger resulting in the move. Commonly cited examples included the following: 1) families inability to cope with resident's ongoing cognitive/physical decline; 2) acute medical event resulting in admission to hospital; 3) transfer from another facility related to increased care needs, increased costs, or desire to be closer to family; 4) spouse requiring more care-therefore both resident and spouse being admitted to AL; and lastly, 5) the death of a spouse, family member or close friend (Appendix G).

5.6.2 Management Style and Resident Satisfaction

Over half the administrators had some amount of nursing background. Some of them had management experience in areas ranging from residential care, marketing, or community health (Appendix H). Although there were no apparent differences in participants' satisfaction levels as a function of management's expertise, it was evident from the comments that participants had a good understanding of their manager's skill level. In addition, participants were

able to articulate the degree of interaction that each manager had with the residents of their facilities.

When participants were questioned about willingness of managers to listen to residents' concerns, the responses fell into one of the following four categories: 1) The manager would listen and follow through on suggestions; 2) the manager would listen, but would not follow through; 3) residents were encouraged to take their problems to the resident council, or 4) residents didn't know how managers would respond.

5.6.3 Aging-in-Place

The current legislation on AL does not support aging-in-place. To ascertain residents' understanding of their future care, they were asked if they felt that the facility would be able to meet their care needs should their health deteriorate. Based on the interviews, it became apparent that there were two categories of residents. The first group had a clear understanding of the exit criteria. They were able to articulate that AL provided services up to a point. They mentioned instances where other residents had to leave as their health deteriorated. The second category of residents were vague in their understanding of AL. They felt that the facility would accommodate their changing needs, or they were not quite sure, or they had never thought about it. Residents who had clear understanding stated that this information was explained to them during the admission process. Table 4 shows the number of residents who appeared to have a clear understanding of this process by facility ownership type and size.

Table 4: Awareness of Exit Criteria by Facility Ownership Type and Size

Facility Ownership And Size	*Facility*	*Residents aware of facility limitations in meeting care*
For Profit Large	*Fleetwood Villa*	*3/6*
	Bevan	*0/4*
For Profit Small	*Royal Crescent Gardens*	*4/5*
	Waverly	*3/5*
	Riverside Manor	*2/5*
	Gateway	*4/6*
Non Profit Large	*Seton Villa*	*3/5*
Non Profit Small	*Dania Manor*	*3/5*
	Augustine House	*3/5*
	Nikkei Home	*5/6*

5.6.4 Staffing and Resident Satisfaction

Residents were questioned about their perspectives on staffing levels. Overall, residents appeared to be satisfied with the quality of nursing services provided. The emergency call bell system, which alerted staff, appeared to be valued highly by residents. Responses to this question can be classified into three categories. 1) Staffing is adequate; 2) do not know; and 3) staffing is not adequate. For this last category, specific times were generally identified as being problematic. Concerns were repeatedly voiced throughout the interviews about the staffing levels during the night. Most of these facilities were staffed with only one person at night. Participants felt this level of staffing was not adequate when emergencies arose and they described situations where this had occurred.

Another key period appeared to be mealtimes. Staff responsibilities during this time ranged from bringing residents down to the dining room to serving the meal. Finally, some individuals felt that staffing was an issue at all times.

5.6.5 Homelike Environment

Residents were asked whether they felt that the setting felt homelike. Residents articulated that though staying in a facility was not the same as being at home, their surroundings had become homelike as they adapted to life in AL. Residents whose living quarters had room for a bed and some additional furniture such as chairs, appeared to be more satisfied than residents who were restricted in their space. Some residents felt quite differently stating that no place will ever be like home, but as far as places went, this setting was adequate. Overall, it appeared that time was an important factor. Residents who had been in the setting longer were more settled than those that had recently been admitted.

5.6.6 Comments relating to food

The open-ended questions did not include a section of food. However, this topic was brought up frequently during the interviews. Therefore, the information collected was included, as it appeared to be important for most residents. Overall, residents appeared to have mixed reaction to the food served in the facility. The following themes were identified: 1) Food was good; 2) food was not great; 3) food was variable; and 4) one has to adapt to the food served. Residents were aware that institutional food would not taste the same as home-

cooked food. The focus on food and/or mealtimes was prevalent perhaps because it may have been one activity that most residents looked forward to. Mealtimes were likely seen as a time for social interaction with others in the facility.

CHAPTER 6: DISCUSSION AND CONCLUSION

6.1 Facility Size versus Room Size

One of the hypotheses stated that individuals residing in smaller, non-profit facilities would be more satisfied than residents of larger for-profit facilities. In this study, it did not appear that facility size had an influence on residents' satisfaction. It was the size of individual's room/apartment that appeared to have a greater impact on residents' satisfaction than the size of the facility. Residents spent the majority of their day in their rooms, which represented their home and was their personal space. In the discussion of spaces, residents frequently referred to their room size to express their satisfaction or dissatisfaction.

6.2 Social Programming

A majority of the residents that were interviewed were quite willing to engage in conversation. These residents appeared to enjoy the interaction, and a number of residents issued invitations to the researcher to come back at a later date to visit with them. The information collected along with this investigator's personal experience with these residents would lead me to conclude that residents do benefit from socialization/activities, and there appears to be a need for it despite negative comments made by some residents. The term social programming in the Organizational Factors Survey was not defined. Social

programming can refer to both organized programming or spontaneous unplanned social interactions. As this term was not clearly defined at the outset, it is possible that lack of variation in the social activities subscale may be attributed to occurrences of spontaneous interactions as opposed to formal social programs. This is an area that does require further study.

Based on participants' comments, the following potential limitations of current formal programming at facilities were identified: residents may need reminders or encouragement from staff to attend programs, current type of programming may not be meeting some residents' needs, an alternative delivery of programs may be more successful such as 1:1 visits or small group programs. Many residents stated that their attendance at programs was limited by their physical functioning. Those residents should be identified to the activity staff in order that they receive the appropriate assistance/encouragement. Challenges of implementing these recommendations would be the costs associated with additional staffing or staff time. These cost pressures may potentially be addressed by utilizing community based resources as a source of programming (i.e. volunteer visits from local seniors and intergenerational programs involving local schools).

6.3 Staffing Mix

The facilities in this study varied in the level of care provided. Some settings were multi-level care, and therefore had residents designated as

requiring supportive living level of care, AL level of care, or complex care. Staffing mix across facilities was difficult to assess as each facility had residents falling into various categories. Although participants of this study did not fall into the complex care category, the data (i.e. staffing levels) provided by administrators pertained to the facility as a whole, and were not specific to AL residents. For the most part, residents did not appear to be aware of the credentials of their care providers.

The presence of RNs versus LPNs may be more relevant with individuals who have higher care need. Legislation in BC clearly outlines the care parameters that residents can receive. Therefore, residents with complex acute care needs do not remain in AL, but are transferred immediately to a hospital or complex care. Those with complex chronic conditions may qualify for a complex care facility. The issue of staffing mix that has been identified in the literature is therefore, not relevant.

6.4 Limitations of the RSI

A major limitation of the RSI instrument was found to be in the social activities subscale. Satisfaction in the RSI is based on the residents' participation levels and opportunities to participate in activities. For a variety of reasons, many residents did not attend social programs on a regular basis, therefore the RSI was probably not the optimal instrument to test the hypothesis. This is an important area for future research in order to develop an instrument that will be

more sensitive to the wide variability of level of resident participation in social programs.

There was only one question in the scale related to food. This question was grouped in the social activity subscale. The dining experience and food appeared to be an important component of most residents' days. Residents commented at great length on the quality and quantity of food. Both positive and negative comments were also made regarding the interactions with their dining companions. This area could be explored further.

The inverse wording of one question in particular caused difficulty for all residents every time: "Do you think you are not receiving the medical assistance you require?" The researcher frequently had to re-word this question to clarify residents' answers. Overall, the RSI appeared to cover all relevant areas. Residents' frequently commented that I had covered everything that they could think of.

Satisfaction instruments designed for long-term care (i.e. Meap designed by Moos and Lemke) may contain questions that can be used to further develop the RSI. These satisfaction instruments contain sections on food and programming in institutional environments and can therefore be used to enhance the RSI.

6.5 Conceptual Framework

Overall, residents appeared to experience satisfaction with AL. The levels of influence described in the conceptual framework that were evident influences on residents' satisfaction levels were: AL philosophy and legislation.

The influence of legislation became evident in the open-ended questions. A portion of residents had a clear understanding of the extent to which AL could meet their needs. One can infer that those who had an awareness of exit criteria had a greater sense of control in their environment, as their potential discharge would not be a random decision, but a result of an established process.

The literature reveals that organizational level factors influence residents' satisfaction. Based on the results of this study however, no particular organizational level factor appears to have an impact on the residents' satisfaction scores.

Having a supportive environment that encourages residents to continue to be as independent as possible, is likely to maintain or increase residents' feelings of "competence". Based on the Congruence model, we can deduce that the AL environment is congruent with residents' needs and expectations. According to the Competence-Press model, the following factors may be contributing to additional press for residents of AL. For instance, the lack of the number or quality of social programming, staffing levels at night, and small room size. These areas may contribute to press for some- not necessarily all residents. For instance, residents who are physically stable, and active participants may not be as affected by staffing at night or social programming as they are likely to create

their own opportunities for socialization and are able to manage the majority of their care needs as compared to less mobile residents with greater physical limitations. For the most part, AL does appear to be providing the appropriate amount of press for a majority of residents.

6.6 Implications

This study has potential implications for the direction of care delivery for older adults. As was previously mentioned, there is a growing older adult population and a shift towards placing individuals in supportive/assisted living settings. As this is an increasingly popular alternative in BC over the past few years, a study evaluating resident satisfaction is timely. This study provides support for the initiative within FHA. In addition, for individuals in funded units, this study suggests that differences in satisfaction levels were not evident between residents of for-profit versus non-profit facilities. This is a relevant finding, given that a growing number of projects within the health care system are based on private public partnerships. The findings cannot be generalized to the residents of these settings who are residing in private pay-units as these individuals may have a different perspective of the care that they receive based on their particular experience.

A potential area for further study is to explore residents' experience of aging-in-place between residents in campus of care setting as compared to residents residing in stand alone facilities.

6.7 Conclusion

One primary purpose of this study was to examine resident satisfaction levels in AL. Based on the scores obtained and on the responses recorded in response to the open-ended questions, it is apparent that a majority of residents were satisfied with this service. There were individuals who stated that they felt lonely, or that the food wasn't good, or that the staff was overworked. Despite these issues, most residents were thankful and grateful to have a place to stay. They were appreciative of being in a safe, secure environment along with provision of services. They recognized that it was not home but appeared to be the next best thing to it.

Further study involving residents of both funded and non-funded units along with a larger sample size could potentially provide results that are more nuanced as well as generalizable. In addition, a tool that delves further into the social programming aspects in AL would be of benefit. Finally this study suggests that with some facility-specific changes (based on residents' feedback), AL should continue to be offered as it appears to be an important and valuable resource for individuals who have difficulty managing independently at home.

APPENDICES

Appendix A: Survey of Assisted Living Settings within Fraser Health Authority: Organizational Characteristics

1) Name of residence
2) Total number of units:
3) Size of facility (i.e. square footage, number of floors etc)? Availability of space for amenities?
4) Availability of outdoor spaces (i.e. gardens).
5) Is this residence part of a multi-level project? _____. If "Yes", please indicate, what other services are offered.
6) How long has this residence been operating as Assisted Living?
7) What is the name of your sponsoring agency?
8) Which of the following best describes your organization?

For- profit Non-profit

9) Are hospitality services provided by your own staff or by an outside agency? Please indicate name of outside agency if applicable.
10) Are personal care services offered by your own staff or by outside agencies? Please indicate name of agency if applicable.
11) What is the rent cost?
12) What is the cost of personal care?
13) How many units have you registered with the AL Registrar?

Resident Characteristics

14) How many residents currently reside in this facility?

15)Average age of resident?

16) How many residents are married: _____ widowed: _____separated or divorced: _____ and single: _____.

17) How many residents receive additional home care arranged by FHA?

18) Under the CCALA, what prescribed services are you offering?

19) What supportive services are you offering?

20)What is the resident average length of stay?

21)What percentage of residents generally leave this facility to move to

Complex care facilities: _____ Home: _____

Assisted living: _____ Death: _____

Other: _____ Hospital: _____

22) How do you assess a potential tenant's functional status? For example, do you use standard forms or assessment instruments? If so, please attach a copy of the instrument.

23) Please indicate who typically is involved in assessments for resident admissions and for discharges?

Other Services

24) What is the average number of social programs provided on a daily basis?

25) From the list below, please indicate which of the following programs are offered at your facility: *Exercise groups* *Arts & Crafts*

Cooking/baking groups *Bingo* *Outings* *Entertainment* *Reading/ news groups* *Religious Services*

Other (please specify)

26) Is there an additional cost associated with these programs? If yes, please attach list of programs with cost.

Staffing

28) Please indicate the staffing levels (FTE's) on site for the following health care workers, and whether they are on-site or available on call.

Registered nurse:

Licensed practical nurse:

Resident Care attendant:

Occupational Therapist/ Physical Therapist:

Activity Director/ Recreation Therapist or Programmer:

Staff for hospitality services:

Other:

Manager/ Administrator:

27) Please describe manager/administrator education, qualifications and work experiences that are relevant to their current position.

Please attach "menu" of hospitality services, personal care services, and other activities/ programs offered with associated fees/costs.

Appendix B: Resident Interviews and RSI

1) Facility Name:
2) Date
3) Resident Name
4) Age:
5) Marital Status:
6) Race:
7) Education level
8) Length of stay
9) Medical conditions:
10) Functional status:

Resident Satisfaction Index (RSI)

Health Care	Always=3	Usually/ Most of the Time=2	Rarely/ Sometime =1	Never =0
1) Is the staff making every effort to keep you healthy as possible?				
2) Do you think that you are not receiving the medical attention you need?				
3) Are you satisfied with skills of nursing assistants?				
4) Are the nursing assistants nice and courteous?				
5) Do you feel like talking to the staff if you have any health concerns?				
Housekeeping Services				
6) Is the cleaning of your apartment done well?				
7) Are you satisfied with skills of people who do the cleaning?				
8) Is this facility a well-maintained and clean facility?				
9) Are the people who do the cleaning nice and courteous?				

Physical Environment				
10) Do you feel a lack of personal space?				
11) Are you satisfied with your apartment/ room?				
12) Is this facility a comfortable place to live?				
13) Do you feel at "home" here?				
Relationships with Staff				
14) Is the staff kind and caring?				
15) Are the people who serve the food nice and courteous?				
16) Are you unhappy with staff's attitude or behavior?				
17) Do you think that you have dependable staff taking care of you?				
18) Do you feel that you have friends among staff members?				
19) Are you satisfied with personal assistance you are getting here?				
20) Do you see some staff treating residents in a rude way?				
21) Is the staff slow to respond to your requests?				
Social Life/ Activities				
22) Do you like social activities here (are they interesting)?				
23) How often do you attend social activities?				
24) Do you have opportunities to participate in interesting activities?				
25) Do you meet residents here with whom you share similar interests?				
26) Do you have enough opportunities to participate in activities outside the facility?				
27) Do you like the food here?				

Additional Questions (Curtis, 2005)

28) Did you have control over the decision to move into assisted living?

29) If you had concerns about this place, how willing do you think the manager or owner would be to listen to you?

30) If your health deteriorates, how confident are you that the facility will be able to meet your future needs?

31) How much of the time is there enough staff on duty?

32) How much of the time is the food here something you like?

33) How homelike does this place feel to you?

Appendix C : Short Portable Mental Status Questionnaire (SPMSQ)
Adapted from Pfeiffer

1) What is the date today? (Day, month, year)

2) What day of the week is it?

3) What is the name of this place

4) What is your telephone number?

4a) What is your street address

5) How old are you?

6) When were you born?

7) Who is the Prime Minister of Canada?

8) Who was the Prime Minister of Canada just before him?

9) What was your mother's maiden name?

10) Subtract 3 from 20 and keep subtracting by 3.

The resident's ability to participate in the study was defined as achieving at least 4 out of 10 correct answers.

Appendix D: Fraser Health Authority: Assisted Living Facilities

FACILITY	Type	Units	Other
Dania Home 4279 Norland Avenue Burnaby,BC V5G 3Z6	Non-Profit	40	Open
Nikkei Home 6680 SouthOaks Crescent Burnaby, BC V5E 4N3	Non-Profit	59	Open
Seton Villa 3755 McGill Street Burnaby, BC V5C1M2	Non- Profit	28 - 108 AL registered	20 Open now. 8 more Feb 2006
Augustine House 3820 Arthur Drive Delta, BC V4K 5E6	Non-Profit	20- 60 registered	Open
Gateway 13787-100th Avenue Surrey, BC V3T 1J3	For-Profit	60	Open Jan 15, 2005
Fleetwood Villa 16028- 83rd Avenue Surrey, BC V3S 8M2	For-Profit	60	Open Feb 2005
Bevan Lodge 33386 Bevan Ave Abbotsford, B.C. V2S 5G8	For-Profit	5	Open
Royal Crescent Gardens '11698-226th Street Maple Ridge, BC V2X 6H1	For-Profit	46	Open
Logan Manor 2770 Elm Road Agassiz, BC V0M 1A2	For-Profit	10- 32 registered	Open
Riverside Manor 765 Hope Princeton Way Hope	For-Profit	10	Open
The Waverly 8445 Young Rd, South Chilliwack, BC V2P-4P2	For-Profit	40	Open Jan 2005

***Under Construction at the time of this study: Mennonite Benevolent Society (Abbotsford); Central Park Manor (Burnaby); Sto:lo Nation ; Cascades (Chilliwack);

Kinsmen Retirement Centre Association (Delta); Good Samaritan Canada (New Westminster); Hawthorne Lodge (Port Coquitlam);Progressive Inter-cultural Community Services Society(Surrey); South Surrey Seniors Village (Surrey); Evergreen Baptist Home (White Rock)

Appendix E: Letter to Administrators

October 2005

Dear Sir/ Madam

I am a MA candidate in the Department of Gerontology at Simon Fraser University. For my final project in the academic program, I am conducting a study titled "Assisted Living in BC: Effects of Organizational Factors on Residents' Satisfaction". The purpose of this study is to assess resident satisfaction levels in Assisted Living within Fraser Health Authority. This study will also explore organizational characteristics and policies of Assisted Living and their possible influences on resident satisfaction.

This is the first study in Assisted Living within FHA looking at resident satisfaction issues and will assist in providing a baseline measure for providers of AL. Findings from this study will assist in determining organizational factors that are likely to influence resident satisfaction.

This study consists of two parts: The Assisted Living Survey is designed to be completed by the facility administrator. Survey is intended to collect data on organizational characteristics. These include: physical facility characteristics, funding status, programming, staffing characteristics. Also included is a section on residents' characteristics. In total, there are 29 questions. This survey will be useful in obtaining information about the key organizational factors of the facilities and the resident characteristics. This will take approximately twenty minutes. Facility administrators are also requested to select six to eight residents whom they feel are alert and oriented, speak English, have resided in facility for at least three months, are designated as "Assisted Living level", and are in an ILBC bed.

These pre-selected residents will be screened by myself (as the researcher) to determine suitability for participation in the study. The second portion will involve a one-session, face-to-face semi-structured interviews with approximately 6 residents at each facility and will last no more than one hour. The Resident Satisfaction Index will be administered followed by a few open-ended questions. These interviews will be conducted after consent has been obtained.

Please mail completed questionnaires at your earliest convenience in the pre-paid enclosed envelope. I will be contacting you in the next month, via telephone to set up a date to interview prospective residents. Should you have any questions or concerns, I may be reached at (604) 376-2852 or (604) 469-3218. My academic supervisor is Habib Chaudhury, Assistant Professor in the Department of Gerontology at SFU and he may be reached at (604)291-5232. Your participation in this study is greatly appreciated

Thank you

Sincerely,

Salima Karmali

Appendix: F Consent Form

Dear Participant,

This form indicates that you have agreed to participate in the interview as part of the study titled: "Assisted Living in British Columbia: Effects of Organizational Factors on Residents' Satisfaction". Your signature below indicates that you understand that the information you provide is confidential and your name will not appear on any written publications. You may refuse to answer any questions, or withdraw from the study completely if you choose to do so.

The research material will be held strictly confidential to the extent provided by the law. Independent analyses on the information you provide will be performed by Salima Karmali, a graduate student in the Gerontology program at Simon Fraser University for the purposes of her Master's degree requirements.

If you have any questions or concerns regarding the study, please contact Salima Karmali at (604) 376-2852 or Habib Chaudhury at (604) 291-5232.

Participant's name

Signature

Date

Appendix G: RESPONSES TO OPEN ENDED QUESTIONS

Tell me about the sequence of events leading up to your admission to this facility
• *I had a mild stroke- the authorities reckoned I would be better off living here versus with my daughter. I had no choice. However anything my daughter does is okay with me. This place is okay* • *I lived at home for 64 years because I am handicapped. After my parents passed away- the estate had to be settled. I have two brothers and they have their own families. There is no place for me. I had no choice really. I had no where else to go* • *I couldn't look after myself. I was forgetting things. I became really sick. And than my last best friend died. I found it really hard to get over it. My daughter said I couldn't live alone. I wasn't happy about the decision. I like it here now. It is a lovely place* • *I was in the hospital for three weeks. I came back to my apartment and was getting home care. I put my name down in a couple of places and this became available. I didn't want to be a burden on my sister anymore- I was falling a lot and having difficulty with meals* • *I watched this place being built. I didn't need help then but I thought the day would come when I would eventually need help- so I thought I would rather have the choice of picking a place now versus having no choices later on. I was also aware of the subsidies. I am more than happy now. Mind you the social worker had told me that I would like it here, as "most of them are lucid". She was exaggerating-lots of people are "not quite there" if you know what I mean* • *Had prostate cancer over ten years ago. About eight years ago I lost my wife- and I wasn't doing too well. I was sleeping all the time. I ended up in hospital and they put me in palliative care. They didn't have any room there so I ended up here. I have improved greatly since I came in-everyone is surprised. But I have a really good doctor who visits me regularly. I didn't have much of a choice about coming here* • *I was at MSA manor for 3-4 years. The community person came to see me there and told me that the government had better facilities for me to come to while they complete the apartments (where she can live with her husband who requires more care). Once they have a room I am moving back* • *I came here a couple of times before I actually moved in. I came in first when I had my hip replacement and then I fell and broke my arm so I came back. Then I decided I was ready to come here on my own free will. I was having trouble managing at home with my arm. I moved in with my daughter for 3-4 months until a bed opened up here. My daughter works here* • *I was at this place and I got kicked out because of inappropriate sexual behaviors-I think they were trying to get me into a mental home- but I ended up here- it wasn't my decision* • *I was living in St Mary's Hospital. It shut down and I had to move here* • *I was at BUH for two months. I couldn't cook for myself before that. They suggested this place and I decided to try it out. I am happy with my decision. I can walk around and do things for myself and my daughter takes me to my appointments and for other things that I need.* • *I had no option- I had a house and my husband was in extended care. I couldn't manage. My daughter helped me. I am deprived of my home and books. I am now quite accepting of my circumstances and realize that I am fortunate* • *I was at my daughter's house living in the basement. It became too much for both my daughter and I. I moved to a facility that shut down. I came to look at this place. I was familiar with it since my aunt had lived here.* • *I lived in a facility in White rock. They raised the prices ridiculously high. My nephew – he does some work for facilities and he suggested this place to me, as it is cheaper. It is nice here… I have a nice view* • *Yes. I was living in my daughter's basement. It felt like a dungeon. I wanted to move to a*

place that I could look out. My daughter heard about this place. I am happy with the decision. The residents are pleasant

- *Yes. I was on the waiting list for a nursing home. The community care worker suggested that I think about AL. I was living alone with assistance through DVA*
- *No. My kids were worried about me. I am glad that my kids picked this one*
- *This was my idea. My family was happy that I did this on my own. I lost my husband. I was too far from the store and other things. I relied on my family. I am very fortunate to be here.*
- *Yes. I needed more care and this is less rent than the previous place I was at. The last place had less assistance.*
- *I had two strokes. I kept falling. My daughters were extremely worried about me. They wanted to put me somewhere where they wouldn't be worried about me. The doctor, my daughters and government wanted me to move here so I went along. I wasn't for it. My daughters live half an hour away. I didn't want to go so far away. I cried a lot to start with. Now I am happy.*
- *I was in hospital for a bit. While I was there a nurse interviewed me. She felt I would need more help. I was living at home and my daughter helped me a lot. Anyways the nurse at the hospital suggested that I consider this place. I went home. At home I was interviewed by the health authority and then I moved here. . I felt good about this decision because my daughter lives far and she was doing way too much for me*
- *I was living in another facility. I had to go to hospital for an amputation and I moved here right after*
- *I was living in a boarding home. I was very SOB ++. I couldn't bathe and the lady I was boarding with couldn't help me either. My daughter in law found this place. I love it here*
- *I was in another place (IL). It was an old place and things weren't run right. I found out about this place through X (another resident). The kids wanted me to move. I wasn't cooking. I am happy here*
- *My wife has Alzheimer's. She was having difficulty with meals and wouldn't let me in the kitchen to cook. She was pretty useless in the kitchen and that was a great blow to her pride. She is a nurse you know. We decided to move here because I can move in with her. That was the main reason. We get along with everyone here. I think it was the right decision taking everything into consideration*
- *I had lived in a number of different places. I had tried living with various family members but it was difficult because I need my space. My ability to care for myself was getting worse. I couldn't bathe myself and was getting home care. The FHA caregiver suggested that I put my name in for this place. I liked the concept, the philosophy of it. I liked having my own apartment..it is nice to have your own space after such a long time. I get the assistance I need here. It has made my life easier and has given me Quality of life. It is a vast improvement over my previous living conditions. I had no room space, no privacy. It was like a nightmare. I really need my own space to psychologically cope with my life*
- *Yes I did have control. I applied prior to the building of this facility. I had applied when my husband had a stroke. He passed away. I was grief stricken... Couldn't look after myself. My daughter suggested that I move here*
- *Yes I decided to move here. I was at Queen's Park for approximately 6 months. I had been at home- I was eating less, I was not eating on time. I came to the realization that I would need assistance*
- *It was my idea to move here. My two sons helped me*
- *My wife needed home support. We therefore decided to move into AL*
- *I saw them building this place and I put my name down right away*
- *My husband and I split up and our house was sold. I decided to move here*
- *My husband was ill. I moved here with him. Our children arranged fro us to come here. My husband left after a few weeks (to move to a higher level of care). I am very happy about the move- who couldn't be happy.*
- *I was in Park Manor (when I had fallen and broken my hip). I had to leave because of the stairs there. I really didn't want to leave but this was my only option-to come here. I am*

happy here now

- *I moved here to be closer to my daughter. I was living in a condo and my close friend passed away. I was left on my own*
- *My husband had emphysema- we sold our home and moved in here. (He lived here for 3 years before he passed away). I don't have any other family. I like it here*
- *I passed out at home and ended up in hospital. My children chose this place- I don't remember too much about how I got here. I am happy here*
- *I was in my seventies when I started to explore my options and check out various homes. Although I was not from this neighborhood I always wanted to live out here on this hill. I had always wanted to move into this building and I had applied a few times in the past. However every time they had a spot available-it was in a room with another individual. I refuse to move in with a perfect stranger. So I moved to another senior's home. One day there was a spot in a private room and I took it. I have been here for seven years and I am extremely happy.*
- *I was driving by one day and I took a look at the building. I decided to move in right away. I had been living at home prior to that and I was having difficulty managing.*
- *I was told that I had to move out of my home. I didn't want to-it is hard to give up your home and family. I was hold to check out this place and here I am. At first I was in a tiny room on another floor. I was very unhappy with it and I asked to move. So I am now in this apartment, which is bigger.*
- *I was living at home and doing quite poorly. I ended up in St. Mary's for couple of months. They told me that I couldn't go back home. They gave my family and I a list of places that I could go to. I didn't feel like moving out at the time but I am happy now. I am very fortunate to be here*
- *I was living at home. My husband passed away and my children had all left home. Where was I supposed to go? I looked at various places and picked this place*
- *I was in a nursing home- hated it. Social worker helped me to get into this place*
- *I was in another facility with homemaker support. Nurse suggested putting my name into the new place. I am happy here.*
- *Lived in substandard housing with mold in the bedrooms and ceilings. My landlord was blaming me for everything that breaks down. It was very stressful. My daughter couldn't cope with me living there. Dtr heard about Waverly. I didn't really have any choices in my previous housing*
- *We lived in a small facility in Agassiz because we couldn't take care of ourselves. My son found this place and we moved here.*
- *My sight was decreasing and I was having difficulty with meals. It was a great distance to get to the grocery store. My sister heard about this place and put my name on the waiting list right away. I was happy with this decision*
- *I was receiving a considerable amount of home care. Home care was getting pricey for me. The person in charge called me to tell me about this place that was opening up. It was really the only decision that I could make. And my family approved. I am happy enough here*
- *I was at the Willows (another private care facility). It wasn't subsidized. I couldn't afford it. The leader of long term care- he told me this place was opening up. I moved here. I didn't have any other choice as there isn't any other place in Maple Ridge.*
- *It was suggested to me by the social worker. I was living with my family- it wasn't a good mix. They are good to visit but it is different living with them. I had control over moving here. I am pretty well satisfied with the way things are going. I can leave the facility and go out when I decide*
- *I did have control over the decision to move here. I found this place through a social worker. I was assessed by a lady. And then I toured this place and moved in. I'm quite happy, very content. I like this place as it allows me to continue to lead a normal life and receive assistance whenever I need it. It helps me to be more independent.*
- *I was living at home. I wasn't eating properly. I am diabetic. So I was crashing a lot and making a lot of trips in the ambulance. The public health nurse recommended this place. I*

was receiving home care at home with my needles. I couldn't take them myself cause my hands shake real bad. They help me with that here and I get regular meals which is good for me because I am a diabetic. I wasn't thrilled about the decision at first. The rooms are very small. But I am lucky- I am at the lower level and I have a bedroom and a kitchen. It is designed for two people- so I am lucky that way.

If you had concerns about this place-how willing would the manager be to listen to your concerns?

- *I think she would listen. I would keep trying until she did*
- *They would listen. The manager is very outgoing and open. Her door is always open. And the owner is a kind gentleman. So is his wife. They pop in quite regularly. They aren't standoffish. You can definitely approach them*
- *I find no trouble talking to them*
- *They'd listen to me. I think. I don't know if it would do any good- not quite sure*
- *They will listen though they are not organized. Whenever the fire alarm goes off-no one knows what to do.*
- *I think that they would listen*
- *Hard question. Yes. And we have resident councils once a month*
- *Sure they would be willing*
- *Manager was willing to listen-what they are doing about it- I have no idea*
- *Oh yes. I complained about my previous room and how small it was. They always respond to my requests. There was this one time a while ago. I normally get my pills three times a day. I didn't see anybody for two whole days. I finally went down to complain that I hadn't seen a nurse for two days and what am I paying all this money for. They sent someone up right away. I think that nurse was let go since I never saw them again*
- *Yes she will- both X and Y will listen*
- *Very much so*
- *I am sure that concerns would be well taken care of*
- *Very very willing. I've met up with her a number of times*
- *Well there are monthly meetings to discuss resident concerns. The only problem here is the food*
- *Well the manager does not respond to me as a manager. 2-3 months ago- the suppers were really getting to me and I approached the cook and the manager and I explained to them about the suppers. Nothing really changed. We had a meeting 3-4 days ago in which people really spoke up*
- *Any time you need*
- *Don't know- I complained about the food and they didn't follow through. The manager – she locks her door at 4pm and won't even respond when people knock on the door. She is not very good-not a managerial type. She is not there for the residents. I notice because I could compare to previous managers (though some residents don't notice because they don't know what to expect).*
- *I'm sure I would have no problem talking to her*
  Very She would be willing to listen to me. She is very open
- *They will listen but cannot always respond. I feel comfortable speaking to them. Plus we have resident meetings and bring up things such as food*
- *They would be willing to listen. I do feel comfortable speaking to them. Food has really been my only concern*
- *She would listen to concerns*
- *Very willing. Manager wants everyone to be happy*
- *Yes*
- *She is very good*
- *You can't have it perfect – I 'm sure it is worse in other places.*

- *In two minutes- very well. The management is good. If you want something done. They do it. If they can't they tell you that.*
- *I'm sure she would- I'm not a complainer anyways*
- *We would make sure we were listened to. I am sure she would listen. I think we were fortunate to be able to get in here*
- *I think she would listen. At one point I was concerned about that fence and they fixed the problem*
- *I think they would be willing*
- *Yes they would be*
- *They hold monthly meetings during which you can vote on concerns. Or you can meet one to one*
- *You do have control. For example they have a store here that was selling milk that was really expensive. I approached the desk and complained about the price. The girl buying the milk was buying it from the drugstore. Now they buy it from the same supplier for the kitchen. Within a week they changed the price of milk*
- *We've been told if we aren't satisfied with the food we should complain- I complained of the red apples we get. You need your own knife to cut it. Nothing has been changed about the apples. Otherwise I am quite satisfied*
- *Yes. The manager/cook comes into the dining room every couple of weeks and checks to see what we like and what we want. And we see the results one week later.*
- *Very much so*
- *If they have time, I am sure they will*
- *There is a presence in the office. We can contact them if we so wish*
- *Sure... I am sure that X would be willing to listen to me*
- *Very willing*
- *Bottom line is the almighty dollar. I am pretty spoiled here- I am low maintenance so I am kind of like teacher's pet*
- *Particularly me- She (manager) doesn't like me and I don't like her. She walks by me dozens of times and never says hello. A lot of people have issues with her*
- *I suppose they would be fine*
- *Yes they would be willing to listen*
- *She is marvelous. I haven't discussed anything with her that she hasn't tried to solve-she is efficient-it is the residents who are difficult*
- *I don't know. They have meetings every month. I have had no complaints*
- *I suppose she'd be alright*
- *I don't know how to answer that question. This is the only facility that I have been in.*
- *Quite willingly*

If your health were to deteriorate how confident are you that this facility would be able to meet your future needs?

- *They can't. This is not what the purpose of this place is. I would be sent elsewhere. This has already happened with a few of the ladies here. They have had to move to a place that can meet their needs.*
- *It wouldn't. I would have to move*
- *If I needed more care- it wouldn't be their fault. It would be my changing needs and they would not be able to help me*
- *I imagine I would still be able to stay here for a while. I don't require much assistance right now. I haven't really thought about the future*
- *I think they could to a certain extent. They can only do so much. I am afraid if I get really bad I would have to move elsewhere*
- *Don't feel confident*
- *I don't know*

- *They can meet needs to a point*
- *That- I don't know*
- *Can't be confident- don't know what's going to happen, however they looked after me okay when I had pneumonia*
- *Well I am in a wheelchair and I am here. They have renovated some rooms and this renovated room is okay with my wheelchair (resident had recently moved to a larger renovated room)*
- *They can handle me now but I imagine one day they won't*
- *That's when I would have to be moved*
- *I am hoping that I won't deteriorate any further. I have had a few bad spells and they have been very good at helping me through these spells. It would be very hard to move from here*
- *I have no idea*
- *Depends on how drastically my health changes. All you need to be able to do is walk here*
- *I feel quite sure- I just had a complete check up. I think they would- plus I don't plan on getting very sick. When I had a cold a little while back- they brought my meals to my room*
- *Very confident*
- *Get good care here. The girls check on me and will sit and talk for a while*
- *My family would decide where I should go*
- *They can meet my needs to a certain point. I am aware that if you need extra assistance- they won't keep you here. You have to move to a nursing home*
- *Can't say. Know that I will have to move if I need more help. I have no concerns- what will be will be*
- *Helps to find another place as once you reach a certain point you need to go to extended care*
- *At a certain point must go to another facility with a greater level of care... for example if you need to be spoon fed*
- *Can stay until you need to be fed etc...then you have to move into another facility*
- *They could meet my needs*
- *You have to be able to manage on your own here*
- *I don't know- I might have to move-not much you can do about it. Prices here are decent- other places are six times as much*
- *That's a mean question. We have our taxi waiting to take us to the hospital*
- *That's a good question. They are only allowed here to a certain stage until you have to be moved*
- *It is minimum assistance – I don't think they can supply additional assistance-though it would be nice. Another move would be difficult*
- *I'd have to talk it over. I don't know what point you would have to move. It is scary. You get settled in and then you have to move. But there are some people here who are worse than I am and they are getting the assistance that they need.*
- *I don't know*
- *I know the limitations of AL. Can't stay here if your health care needs increase*
- *I have no idea what more they can possibly do. I know I have to be able to take care of myself-it was one of the questions during my admission*
- *100%*
- *It depends on my condition. I'm sure they would look after me.*
- *No. You have to be able to dress yourself. They will give you a bath*
- *Sure – I am currently not receiving any type of personal assistance*
- *There are no nurses in this place. It is our responsibility to procure and keep in our rooms any over the counter drugs. The nurses won't give you something if you have a cold. You have to take care of yourself. They won't even do CPR*
- *This place is no different from any other. I take care of myself and can continue to do so*

- *To a limit- they don't give as much care as a nursing home. Anyways I haven't needed much help*
- *I think they would be able to do it*
- *Well it is set up for it. I wasn't feeling well a while back-so they moved me to the third floor until I recovered then I moved back down (first floor –AL). There is a process here… first you require a cane, then a walker. Once you require a wheelchair- you have to move to another facility.*
- *I have become worse in the last six months-I am always in hospital. but yes I do feel comfortable*
- *I don't know. I suppose I would be well looked after if needed*
- *Don't know*
- *Very confident*
- *They would move you if you can't cope- they have moved a lot of other people*
- *I think they could*
- *You are out the door if you can't hack it. I have seen a lot of people leave. If you can't look after yourself you have to get yourself a dr. This is AL*
- *They don't give you any care here. You have to be able to get to the dining room on your own. If you can't – you can't stay*

How much of the time is there enough staff on duty?

- *For me- there is enough staff on. It would be nice to have a nurse on after 9pm. They only have one care person on at night*
- *All the shifts are covered. For me- I am satisfied. It is sufficient for me. I can't speak for others however who may need more. I don't know about them.*
- *I don't find them too rushed. I find them obliging when I request assistance*
- *Pretty good. Only one on at night. Don't think it is right myself. Don't think that they should be alone- it is a lot of responsibility for one person*
  It is good. In the weekends it is particularly poor in my estimation. Especially since there is no one at the front desk- and there are a lot of visitors on the weekends. The thing that bothers me the most is that after 9 pm there is only one person. And that person is usually in the basement doing the common laundry. If someone should call for help, she has to come to the front desk to see who has rung. The girls should have direct access to the bells to know who needs help
- *Most of the time-though they are frequently short staffed in the kitchen due to people calling in sick etc*
- *They are always short staffed- this hasn't bothered me however*
- *I don't know. They could do with a few more-though the staff does manage. However wouldn't want our rent to go up just to have more staff.*
- *They could do with extra staff*
- *No not enough staff on duty. No staff present in the AL portion at night. There are no patrols occurring at night. There is not enough staff in the dining room*
- *Always plenty of staff*
- *Pretty well all the time- they can't have too many staff. It is a dollar factor*
- *Yes*
- *They do very well depending on how many people need help in the morning. I know that the night staff overlap with the day staff to help me with my bath in the mornings*
- *Yes as far as I can see*
- *All the time*

- *They seem to be short staffed right now even though the place is full. There is only one waitress in the dining room and our meals are sometimes cold*
- *There is enough as far as I am concerned*
- *Nursing staff is always around. Now that the room is filled (dining room)- the waitress is very busy and we have to wait at least 20 minutes at times before being served.*
- *I don't know*
- *Always*
- *Seems enough but I don't really require much assistance except for bathing*
- *There is always lots of staff 24 hours- I have a button that I push if I need anything from the staff and they respond promptly*
- *Good-staff is helpful and available*
- *Couldn't tell you. I don't know the schedule. Only know when my staff visits*
- *Always There is staff all the time*
- *At night there is only one person. It is hard to divide yourself between emergencies*
- *I don't know, they seem to get around to everything. The people here are supposed to be independent- the staff do more than they say. There are a lot of bells ringing- keeps the staff busy*
- *How would I know that? I have had no troubles*
- *Basically all good. There is one girl on at night. It is not enough. Just to give you an example... I fell out of bed a while ago and I buzzed her with this thing here. She arrived but was looking after someone else. She couldn't lift me. She was a slight thing just like you are. She called the ambulance. They had to come and lift me up. I was on the floor for at least 20 minutes*
- *I am concerned at night as there is only 1 staff. At breakfast I am concerned as well. It is a continental breakfast and it is self-serve. I am okay but the rest line up with their walkers and wheelchairs and have to serve themselves. Many can't help themselves because they can't see or move properly. There is one person helping out but they have to prepare the food and help with those who require assistance. I would feel better if they had an extra person. Especially if something happened*
- *I think there is a staff shortage. They are pushing the staff as hard as they can. I'm not sure about how much they are supposed to do. I don't know the levels. At what level is it classified as too much? They do provide meals in the room though when you are not feeling well*
- *They are here all the time. I haven't needed them*
- *This is a 5 star*
- *So far it has been good*
- *I don't really need that much help*
- *I had a fall- it was seconds before staff turned up*
- *There is only so much that they can do in AL*
- *I can't speak for the staff- they are not always in the staff so they must be busy. I can't complain. I don't feel that I am being deprived of the assistance I need.*
- *They appear to be short staffed at mealtimes. I think it is because they have to bring residents from their rooms and then they have to double up in the dining room.*
- *Ample as far as I am concerned- though they are short staffed sometimes*
- *There is always staff*
- *Most of the time. Sometimes at night and when they are serving dinner they could use an extra staff member. The girls work pretty hard here*
- *They are all rushed off their feet-there is not much help*
- *They are short staffed all the time. A lot of the staff are worn out*
- *Don't know – haven't got a clue*
- *Would like to see more staff on duty. I don't think there is enough staff*
- *I personally haven't had any problems. There is staff till 12. If I need an ambulance I call it myself. It is quicker for me to dial 911 versus dialling the numbers of the front desk. No I don't like to wear the alarm to call for assistance. I have one in the bathroom and that is*

sufficient for me

- *All the time except at night. From midnight till 8 there is only one girl in the building. If you are sick they send you to the hospital right away*
- *Enough- they have recently hired a lot and they have done wonderful here lately*
- *Anytime*
- *I don't know*

How homelike does this place feel like to you?

- *Not quite home yet*
- *Very much now- I've gotten used to it gradually. I am happy here- all that I can say about it- that's why I wouldn't want to leave*
- *I'm comfortable. I find this a good place. There is always someone I can talk to*
- *Feels very homelike. I am very content. There is a lounge upstairs with movies and activities. The building is well kept*
- *You can't have anyone staying over. Outside of that it is okay. It's basically a good place- and the people are mostly nice. Staff in nice-some of the tenants are grouchy- but you find this anywhere. If you have to give up your home-this is the place to go. There are lots of good things. The foot man comes here, there is a hairdresser- and we have an activity lady- she is young- she is quite good*
- *My room feels fine- though I would like more space*
- *Yes it feels like home*
- *The security is great- I can sleep at night not worrying about my room being broken into. This is the best thing that has come to Canada*
- *Feels pretty homelike- more so than in Agassiz*
- *It feels comfortable. I feel quite satisfied and I visit with others in here. Quite similar to where I came from*
- *Yes- it is home. I am very happy here*
- *I have no other home. This is home. Look at my place. I have a nice apartment and a wonderful view. Can't beat that. Of course they want me to move soon because of the renovations and I will have to move to a lower floor. I don't want to but oh well.*
- *It is lonely – I am very lonely. It is not home. There is nothing wrong with this place. I am quite fortunate to be here. But it is hard not to be in your home and with your family. This place is fine-but the problem is with me*
- *It's very good. Like any place it takes a while to settle in. I am quite pleased that I moved here. This place serves the purpose it is supposed to. They have been good about helping me through my bad spells. They have helped me whenever I come out of the hospital- they make sure I can get to the dining room for the first few days. I have seen them do that with others as well*
- *It's a good place*
- *Very homelike, everything is very good.*
- *Now it really feels like home. I am satisfied- staff here treats you like you are a person. I feel safe here*
- *I am very secure. I am on my own; I can get as much help as I need.*
- *Not really homelike*
- *I like it very well*
- *I feel comfortable. If I was living by myself I would be so lonely. You can meet people by going to the dining room and activities.*
- *Pretty good- I have more of my stuff here. Will be happy when I am totally unpacked*
- *Feels like home*
- *It is homelike and very multi-cultural. Organized, nice staff and good attitude*
- *Feels like home now*

- *Yes it feels like home*
- *Gosh- I'm right at home. You can have visitors and family all the time. I am very pleased with this place. I didn't know it existed and I didn't want to go to a nursing home*
- *Well I don't know. No place is like your home. I had a place in a trailer park before. Not to many people there- it was nice*
- *I guess it does*
- *Now it feels like home. It is a nice apartment, airy.*
- *Up to a point. It's not home. It is hard*
- *It has become home for me. I am looking a this as a place to live in- not as a community to socialize with. I don't like hanging out in the lobby like others do*
- *Very much like home*
- *It is home*
- *I call it home*
- *Not really like home but a good place that I needed/ I don't know if I 'd feel at home any place*
- *It is like home-getting more like it every day. I feel quite restless now when I visit my daughters-though I don't tell them that.*
- *Very much like home. There are not to many places like this*
- *As homelike as it could be*
- *I feel comfortable approaching staff here*
- *I don't know how you could compare it to your home. Other than that I am quite comfortable*
- *In so far as someone could feel at home. I am accustomed to living here and I am fortunate to be here*
- *It doesn't feel like home at all. Bevan seems to be the dumping ground for people with Alzheimer's and dementia. It is hard to communicate with people. Especially in the dining room-it is hard to carry on a conversation if they can't remember. It is not pleasant- it is hard to take. I am looking for another place*
- *Haven't got a home-my room is my room..... I stayed with my daughter for a year and nothing compares. I would like to go back to my daughter but she can't take care of me*
- *It feels like home*
- *It's starting to feel like home, it is a safe place. No one can bother me here-I can come to my room if I need my space*
- *Nothing seems like home but you get used to it. I am fine here. I know I have to accept it*
- *There is no comparison. You can't compare because you are alone here all the time. Nothing to do- the days are long here. It is hard*
- *I don't have a choice do I? My parents passed away and I have nowhere to go. My family can't take care of me*
- *It is very homely. I am very satisfied*
- *It's home.. As places go nothing is like home. I can't fault it. It is we who have to change*

Food

- *It can't be a winner all the time*
- *Excellent, no complaints. They always accommodate you*
- *Sometimes find it repetitive*
- *It couldn't be better*
- *There is the odd day. The cooks try hard to please everyone*

Not bad at all

Is very well done. I have a lot of allergies and they help me out. I meet with them often

- *They have had the same chef for 30 years*
- *I have difficult seeing and I was having difficulty chewing my food. I lost quite a bit of weight. The staff here bent over backwards to try to come up with a solution. Now they blenderize my food and place it in one bowl. Now I don't have to worry about having my food on different plates or chewing it. They came up with the idea- otherwise I would have had to leave. Yes I do like the food*
- *Food here is dull/not interesting*
- *Sometimes meals are poor-pretty hard to satisfy everybody- however there is more choice of Japanese food*
- *There are a few things I don't like... so the chef makes me something else. He is very accommodating*
- *I love it*
- *We are used to spicy food so we find this food drab. It is very bland. It is institutional food-can't expect home cooking. It could be more varied*
- *They cater to diet preferences and allergies. It is a personal touch.*
- *The tray service is good*
- *Re: food: You can't please everyone- when it comes to food it is great 95% of the time*
- *The food here is very good*
- *Meals are really good. All of us are complaining because we are going to be fat*
- *I have noticed some accidental slips in the last little while. Meals are being rotated more frequently than the 4-week menu that they are supposed to stick to. However the food is adequate here. We aren't starved. There is no shortage of actual food. They give a lot of meat. I don't eat meat. The summer is better because they offer a two vegetables and a potato. In the winter we only get one vegetable*
- *We get too much chicken here*
- *I have met with the cook. When we complain about the food-it improves for a short while and then reverts back to the original. The man who orders the food tries real hard-but I'm tired of eating steamed vegetables. I have a fridge in my room and it is pretty much filled up*
- *The food is very good. There are more things that I do like versus don't. I have put on lots of weight. We have a chef here-not a cook.*
- *They try their best*
- *You can't please everyone*
- *You have to learn to like it*

Social

- *Not impressed with the programs. There are some groups of ladies here. And they always play games of their choice. Unless you are into cards... there is not much else you can do. There is a seniors place outside that you can participate in if you pay a small fee. I usually attend that*
- *Sometimes lacking*
- *I would like to move somewhere where there are people my age. It is difficult day in and day out to live with older people. They are nice. I am existing-not living- it is a good thing that I have friends that live in the area*
- *Attendance in social activities is limited by my decreased vision*
- *It would be nice if there were more activities*
- *Would like better entertainment- don't have much social activities here*
- *This place helps with loneliness-you can go to social areas and socialize with others when you feel the need.*
- *I don't participate much in social activities- I am happy in my own room*
- *I don't socialize much. I have difficulty hearing and trouble walking so I don't bother much*
- *I am not really into socializing. However if I feel lonely I can go up to the penthouse and*

there is always someone that will come by and talk to you. And we play cards up there twice a week. There is a group of us. Last night we had 11 people playing cards. Have you been to the penthouse? It is really quite something. They have everything up there… pool table, shuffleboard, everything.

- *I haven't participated much because of my medical condition*
- *Don't enjoy going to activities because I can't see well*
- *We play card games and do various things to entertain ourselves*
- *Limited to participating in activities because of my leg*
- *I don't like to participate in activities*
- *Can't do the exercises*
- *There aren't too many activities here*
- *I try to get interesting things going but a lot of people don't participate- I'm not bored I would rather be left alone than bothered*
- *I don't really attend activities-I spend most of my time in bed*
- *Don't attend programs much because I can't hear very well*
- *There are many rumors here between residents-especially at mealtime. It makes me uncomfortable-but I feel like I have to handle it myself*
- *There are many people here but they have nothing interesting to say. A lot of them are confused*
- *It is hard to develop a relationship with others here. You begin a topic of conversation at one meal, and by the next meal they have forgotten your name and what you had discussed*
- *Some resident's behaviors are difficult. They can ask the same question so many times and they don't remember from one minute to the next*
- *The nights are long and lonely. There aren't many people around in the lounge*
- *The recreation is good as can be expected. The activity person is first rate. She is very compassionate and the programs are well run*
- *I find other peoples memory very frustrating. I will have a conversation with them, and they won't remember your name the next time around. There really isn't anyone in my peer group here. It is like a different generation- my mom's generation. It isn't bad. It is just different. It doesn't bother me though.*
- *I can't participate in activities outside the facility because of my physical condition*
- *I don't participate in social activities- I prefer my own company*
- *My participation in activities is limited by my pain, endurance and disability*
- *Can't always participate in activities because I have had 2 strokes… and my balance is not good.*
- *I haven't been able to join the social activities- too sore*
- *I'm quite content*
- *Not involved with activities-not my thing*
- *They celebrate and decorate for all the holidays. The decorations are costly looking… like a big hotel. It makes you feel like you are in a ritzy place. And you can distinguish the staff because the girls are in uniform. They look very nice*
- *I like the afternoon programs-the singing and memory games. I can't attend to many programs because my eyesight is failing. That's also why I don't socialize much with others. I can't see them unless they are close to me*
- *I don't participate in social activities- it is just a bunch of old farts sitting around listening to some lady on the piano. It would be nice if we had a pool table or shuffleboard, or even a dart board*
- *There is one resident that is quite a nuisance. Apart from that everyone is friendly*
- *I don't participate much. I can't see very well. I can be alone and it never bothers me*
- *The activities here are developed for people in their late nineties- it is pathetic. And they tried to start a Men's social. Well that program was not great. It lacked stimulation. The entertainment try hard but they can't beat what's on the box (TV)*
- *I don't attend much because of my hands.. I can't do much with them. plus I am a loner*

- *Lots of activities*
- *I am quite happy with my own company. I hate gossip. Plus there are more deaf people here than you can believe. And the bus trips- I don't like the running commentary that they do. I can't even hear the half of it!*
- *I like some programs. I help out with a couple of programs. I think it helps the staff out*
- *Only thing is that it is lonesome. People don't seem to want to click together. A lot of people here have family and children that live close by. These people don't like to bother with others. Some of us try. We are lonely and we don't have family who visit as frequently. And there are a lot of groups of people who know each other from before. I am from out of town and so I don't know anybody*
- *I don't like to sit in the lounge. I don't like talking to people all the time. I like my TV, paper etc. I will go to the entertainment and exercises.*
- *There are lots of things to do if you can do them. I can't do a lot of the activities i.e. dancing. And I am very scared of falling. I have fallen so many times. So I don't go to many activities*
- *I miss being able to go out in a car and get what I need. There isn't much in the store downstairs. Like toothpaste or milk. My daughters are too busy so they can't make it here often*

OTHER

- *It is an interesting place. It is between living at home and a nursing home. It is very much needed. I am on the boundary... If I can't transfer myself to the wheelchair... I will have to move. I don't want to move*
- *I think there are some ladies here who are afraid of voicing their opinion to staff. It is because they have put up with a lot in their lives*
- *Room is too small*
- *If they had a fire here- I don't know how they would get everyone out. The exit doors are locked and there is only one person here at night.*
- *Things are safe in my room. I don't lock my door- and nothing goes missing*
- *This is a wonderful way to live. If you can't live at home-this is the best way to live... you can continue to have a normal life*
- *Fortunate to have this much room*
- *Dissatisfied with the physical set up of the shower*
- *Medical attention is better than what it was*
- *Residents treat staff poorly*
- *Staff not consistent- high turnover*
- *Staff go out of their way to be nice and courteous*
- *I would like a one bedroom apartment instead of this studio. Not enough space*
- *I am thankful for this place. I have had a difficult life and lived in many situations. I am happy to have a roof over my head and food on my plate*
- *The food- how it is cooked doesn't please me- though I have plenty to eat*
- *I do a lot of my own cleaning (I am not supposed to but I like to keep active)*
- *They don't have enough salad and never any leftovers. You should always have leftovers-not getting your money's worth- not enough food. They should have a kardex in the kitchen to indicate what residents' needs are*
- *Staff are very accommodating*
- *Staff is very courteous. Even if things aren't their job- they will always try to help out*

- *Staff is terrific*
- *If the staff cannot respond, they usually tell you why*

Housekeeping

- *I hire a lady to do my cleaning the way I like it*
- *It is mediocre*
- *Sometimes not done to my satisfaction*
- *Depends on the staff*
- *Sometimes the staff are really busy but they get to you as soon as they can*
- *FHA care attendant*
- *Personal alarm is located at bedside and in the bathroom. If person falls in any other location there is no way for them to call for help*
- *Poor maintenance*
- *Facility trying to cut costs*
- *Have to now request drinks*
- *Carpet hasn't been shampooed in four years*
- *Re: Cleaning of apartment- "can improve"*
- *One thing they could really improve is adding an exercise room with more equipment*
- *Staff is organized- for example if an ambulance comes for a patient, staff has all the forms ready to speed up the process*
- *There are many rumors here between residents-especially at mealtime. It makes me uncomfortable-but I feel like I have to handle it myself*
- *Sometimes meals are poor-pretty hard to satisfy everybody- however there is more choice of Japanese food*
- *Don't attend programs much because I can't hear very well*
- *It is nice to know that you don't have to rely on family or friends*
- *Re: Cleaning staff...They can only do so much. there is only two of them*
- *This place is not designed for wheelchairs. Everything is really high*
- *There were thefts before. Our big screen TV was stolen*
- *It is hard to propel on the carpets*
- *Re: housekeeping: See here, we are lucky to have them. They used to make my bed and clean my apartment. Now they can't make my bed because there is too much work for them now.*
- *Re: housekeeping: Not that good but good as any*
- *How can I complain about this place? They clean my room, I get served my meals. The staff is wonderful. It is better than anything I have had before.*
- *The water pressure here is no good. It just dribbles.*
- *The dining staff initially lacked etiquette. They are improving though. They try hard.*
- *They heat this place well*
- *I would feel better if DVA assisted me more*
- *I don't think there is a person in here that I dislike*
- *I would recommend this place to anybody*
- *Housekeeping- I used to have a set definite time during which they cleaned my apartment. They changed the system a week ago. I don't know when they clean anymore.*
- *The bathroom where I am bathed is very chilly*
- *I know some people are shocked when I say this... but I am here and I am just waiting to die*
- *The only problem I have is the carpet in the hallway. I have difficulty propelling my wheelchair on that carpet. I don't have trouble with the carpet in my room however*
- *When I first came in here I was very nervous about being on the main floor. I was afraid of someone breaking in. but the staff are very good about coming to check on you if you push the button. Plus they changed all the keys yesterday*
- *Wide range of staff-the services they provide is variable*

- *I don't get a lot of personal assistance. They just help me with my bra and socks. And I get pericare at night-the girls do my pericare very inconsistently. And I asked the RCA for a certain size pad.. it has been three days and I still haven't got the pads.*
- *Staff is to busy to be personal*
- *Initially felt pressure after admission. I felt trapped-all the others are older than I am by at least 30-50 years. I miss not being able to cook, or look after myself. I miss living alone. I miss doing things for myself like the laundry*
- *You know that this is the East wing. I call it the poor relations side. The West wing-now that's where all the rich people live. But you are allowed to go anywhere in the building. And people don't really know what side you are from*
- *One room this size is pretty small. I would like larger*
- *Mind you this small room got to me. Some people like to sit- I don't. I was driving till this past June when I lost my eyesight. So it is even harder. I was going to move to this other facility but now they are going to move me into a studio. It is absolute cruelty to put people into a small room. And look at my view. It is like being in the black hole of Calcutta*
- *They don't care for wheelchairs here*
- *If you are sick they send for an ambulance right away*

Staffing

- *The majority of them are delightful other than the odd one here and there. But that's anywhere*
- *Cleaning: did you know that the staff has only 20 minutes to clean the entire room. That is not enough time to do a proper job. See that TV there. The dust behind it hasn't been cleaned in two years. They don't do the job that I would like them to do*
- *They are the only people I see*
- *Some of the staff are quite fun*
- *Beautiful staff*
- *You know they aren't nurses- no one is a nurse. They can't give you advice. You have to go to your doctor*

Appendix H

Facility	Waverly	Fleetwood Villa	Nikkei Home	Riverside Manor	Seton Villa	Dania Manor	Augustine House	Bevan Lodge	Royal Crescent Gardens
Total units and number registered	*66 Units* *40 Registered*	*166 Units* *80 Registered*	*59 Units* *34 Registered*	*30 Units* *10 Registered*	*217 Units* *ILBC: 28* *(20 AL & 8 SL)*	*50 Units* *40 AL/SL* *10 Private*	*60 Units* *20 ILBC*	*150 Units*	*46 Units*
Size of facility	*4 Floors*	*3 Floors + Basement 106,680 Sq ft*	*4 Floors 54,492 sq ft*	*1 floor*	*19 Floors*	*3 Floors 29,500 Sq. feet*	*4 Floors 115, 637 Sq feet*	*N/A*	*3 Floors 32,000 Sq.feet*
Amenities	*Exercise room, 30 seat theatre, country kitchen, spa, library /games room*	*Exercise, woodwork, media & craft room, billiard lounge with ext patio, bistro, hair salon*	*Offices, dining area, kitchen*		*Swimming pool, jacuzzi, tuck shop, wood working shop, lounge, reception area, dining room, multipurpose room, bistro, games area, library, activity space, TV area, kitchen, & beauty parlor*	*Lounge for recreational /social activities, exercise room*	*Lounges, dining room*	*Compliant with CCFL*	*Lounges, dining room*

Outdoor Spaces	*Large courtyard off dining area paved walkway with periodic seating around building*	*Enclosed courtyard with water feature and rear ext patio with gazebo for smokers*	*Terrace, outdoor seating, garden next door*		*Common and individual garden plots, & pond*	*Greenbelt and large garden area*	*73,080 Sq Ft(excluding private balconies and patios*	*4-5 acres*	*Gardens, patio, gazebo, covered seating area*
Multi-level project?	*Yes-attached to residential care facility*	*N/A*	*No*	*Yes*	*Yes* *Supportive housing cluster care*	*Yes. Dania Home care facility and Carl Mortenson Manor(IL)*	*Yes* *12 Private pay dementia unit & 102 SL/AL units*	*Yes, Independent living through complex care*	*No*
Length of operation	*Jan-05*	*14-Feb-05*	*Sep-02*	*1.5 years*	*1993* *2005 for ILBC*	*Mar-02*	*Jan-04*	*3 years*	*Oct-05*
Sponsoring **Agency**	*Retirement Concepts*	*FHA*	*Nikkei Seniors Health Care and Housing Society*	*?FVHA*	*Action Line Housing Society*	*Dania Society*		*Private pay and 5 FHA/* *government funded*	*FHA/ BC Housing*
Funding Status	*For-profit*	*For-profit*	*Non-profit*		*Non-profit*	*Non-profit*	*Non-Profit*	*For profit*	*For-Profit*
Hospitality **services**	*Outside agency* *Sempe Q*	*Own staff*	*Hi Genki Food Services*	*Our staff*	*Own staff*	*Dietary and House* *keeping:* *Laundry: own staff*	*Own staff*	*Own staff*	*Own staff*
Personal Care Services	*Outside agency* *Sempe Q*	*Own staff*	*Own staff*	*Outside agency*	*Own staff*	*Own staff*	*Own staff*	*Own*	*N/A*

Rent	*Studio-$1600* *1 Bedroom-$1900*	*Private funded is $1227*	*30% of monthly income* *Hospitality + activities($490-650)*	*Studio:$1385* *1 BR: $1585*	*AL: $1735* *SL: $500*	*70% of after tax income for funded beds*	*$1300/ month ILBC*	*AL private pay is $1900/month*	*N/A*
Cost: Personal care	*Private pay: $28/hour* *Funded: FHA formula*	*Included in funded- otherwise varies depending on packages and services*	*NA*	*N/A*	*N/A*	*Included in the rent*	*$500/month SL* *$1735 AL*	*Included in the $1900*	*N/A*
Total number of residents	*76*	*165*	*67*	*27*	*228*	*49*	*148* *20 ILBC*	*35 units registered with AL Registrar* *(133 residents)*	*47*
Average age	*N/A*	*84*	*85*	*80*	*84*	*83.8*	*86.4 years (ILBC)*	*87*	*82*
Average marital status	*N/A*	*Married:13* *Widowed: 136* *Single: 2*	*N/A*	*N/A*	*N/A*	*Married: 10.6%* *Widowed: 57.4%* *Separated: 4.3% Divorced: 10.6%, Single 17%*	*N/A*	*23 married* *4 single* *rest unknown*	*Married:4.2%* *Widowed:66%* *Divorced:2.1%* *Single: 9%*
Prescribed Services offered	*Medication Assistance* *Personal care*	*Medication Assistance* *ADL assistance*	*Medication Assistance* *Personal support*		*Medication Assistance* *Personal care*	*Medication Assistance* *ADL assistance*	*Medication assistance* *ADL* *assistance*	*Personal care* *Meals* *Bathing assistance* *Medication* *Activities* *Laundry housekeeping*	

Supportive Services offered	*Foot care Massage, Monthly BP Bus Outings Store 24 hour on call*	*Housekeeping Meals Recreational Activities*	*Housekeeping Meals Recreational Activities*	*Housekeeping Meals Laundry Taxi Service*	*3 Meals/Day, weekly housekeeping personal & flat laundry, recreation programs, 24 hour staff*	*Housekeeping Laundry Meals 24 hr emergency response, recreational activities*	*Laundry, housekeeping, meal service, social & recreational opportunities, 24 hour emergency response*	*Pearle vision eye care, hairdressing, foot care, hearing testing through London Drugs, physiotherapy, massage therapy, dietician*	*Housekeeping, meals, laundry, social programs*
Average length of stay	*N/A*	*N/A*	*N/A however 60% of current residents since 2002*	*?2years*		*1.25 years (15 months)*	*15.2 months*	*2 years for AL*	*N/A*
Common discharge destination	*Complex care: 2; Home: 2; Death: 3* *Hospital:1*	*N/A*	*Complex care 37%* *Home: 4.5%* *Death: 55% (44 total)*	*Assisted Living:80%* *Death:10%* *Hospital:10%*	*Complex Care: 40 %* *Death: 55%*	*Complex Care: 46%* *Death: 26%* *Other 28%*	*Death : 100%*		*Complex Care: 98%* *Death: 1%* *Hospital: 1%*
Pre-admission assessment	*Standardized forms*	*BCAL software* *& "apartment living" assessment tool*	*Case manager uses standard MDS Form*	*No*	*ILBC residents are assessed by FHA; Remainder assessed based on ADL needs*	*FHA assessment* *Tour interview*	*No*	*For private pay: use internal 8 page assessment. For funded beds: use Regional forms*	*Case manage: Use Risk Assessment form*

Individual involved in assessment process	*Continuing Care Case manager and facility admin.*	*Marketing director/ wellness director*	*FHA Case manager, Manager of Resident Services, & Team Leader coordinator*		*Office manager, Personal Services Coordinator- and referral to case manager if resident requires care services*	*Team Coordinator(RN) Director of Properties*	*General Manager, Manager of Resident Services*	*Facility manager, Manager of Residential services, physicians, nurses.Funded beds: Access and Case managers in addition to above*	*Manager, Case manager for FHA*
Number of programs offered daily	*2*	*4*	*4-5 (M-F)*	*1*	*4*	*5*	*4*	*8*	*3*
List of programs	*Exercise, Arts and Crafts, Baking, Bingo, Entertainers, Reading, Outings and Religious services*	*Exercise, Arts &Crafts, Bingo, Outings, Entertaners, Socials, Religious services, card groups, clinics, banking*	*Exercise, Arts & Crafts, Cooking/Baking, Bingo, Outings, Entertainment, Religious services Traveling library, Shopping*	*Exercise, Crafts, Baking, Bingo, Outings, Entertainment, Reading, Religious services*	*Exercise, Bingo, Outings, Entertainment, Reading group, Religious Services*	*Exercise, Bingo, Arts & Crafts, Outings, Table games Entertainment, Reading group, Religious Services*	*Exercise groups, Bingo, Outings, Entertainment, Reading group, Religious services, Internet café, Cards, Pool*	*Arts & Crafts Bingo, Outings Exercise groups Entertainment Reading/news group, Socials, religious services, cooking, ladies spa day, mens activities, armchair travel*	*Exercise groups, Bingo, Entertainment, Reading group, Religious services,Lawn bowling, walking, bocci*
Cost associated with programs	*None*	*For outings only* *Approximate cost $3.00*	*For some outings*	*No*	*No*	*Outings only*	*No*	*For bus outings and special meals*	*No*
Staffing levels of : RN	*LPN: Dailyx7.5hrs onsite, 4 hrs on call*	*RN=Wellness Director(o/c on w/e)*	*LPN: 4*	*RCA*	*(ILBC)LPN: 2.2*	*RN (Team Coordinator on call pager)*	*RN (General managers): 2*	*RN: days:3*	*LPN:1FTE(Part time, 4 shifts daily)*
LPN	*RCA:Days:2x7.5*	*LPN: 1per shift x24hrs*	*RCA: 7*	*Hospitality:2*	*RCA: 3.4*	*LPN: 4.2*	*LPN: 3*	*Evening: 1*	*RCA: 1 FTE, 24 hrs/day*

Rehab	*E:2x7.5*	*RCA: Days: 4, Evenings: 2*	*Recreation: 1*	*Manager*	*Activity: .3*	*RCA: 3.5*	*RCA: 20*	*Nights:1*	*Activity: 1 FTE*
Recreation Hospitality	*N:1/7.5*	*Act director 7.5 x 5*	*House*		*Hospitality: 5.1*	*Activity: .5*	*Activity: 2*	*LPN: Days 1*	*Manager: 1 FTE*
Manager	*Act.director:14hrs/wk*	*Act aide: 20hrs/wk*	*keeping: 2*		*Maintenance:.66*	*Hospitality: Contracted*	*Hospitality: 24*	*Nights:1*	
Other	*Act.aide: 20hrs/wk*	*House*	*Manager: 1*		*Accounting:.35*	*Manager:1*	*Manager: 1*	*RCA: Days: 8*	
	Hospitality: 3.47 FTE	*keeping: 2/day, 1/night*			*Office Manager: .3*			*Evenings: 6*	
	Receptionist: 6hrsx 5 days *Manager: 5dx7.5, on call 24 hrs*	*Hospitality: Manager-Dailyx5* *Cooks:1/day* *FSA's: 17 over course of the day (06:30-2000hrs)* *Manager: Daily x5, On call w/e*			*Manager: .13*			*Nights:2* *PT: 4 hours/week* *Hospitality: Days 8, evening 2* *Activities: 3/day* *Manager: 5 days* *Food service manager: 2 days* *Dietician: 2 days* *Recreation manager: 3 days* *Business manager (2-3 days)* *Manager residential services: 5 days* *Receptionist: 5 daysBookkeeper: 5 days*	

Manager s' Credentials	*Registered Psychiatric Nurse16 yrs Health care management experience Admin. residential care x 3 yrs*	*Management experience, experience with seniors/ health care, Marketing Manager Wellness director must be RN/RPN with experience Environmental director-prev mgmt experience knowledge of all building issues Food director- experience, RDN helpful, and prev mgmt*			*RN, MHA, Community Health & Administration Mgmt x 20yrs*	*RN, 7 years experience in AL & Seniors Living. Preferred Master degree, experience in the community*	*RN, Executive director non-profit H/S agency x 15 yrs, Manager home support x 2 yrs*	*Facility manager: RPN*	*Provincial Instructors Diploma, Nursing supervisor, RCA instructor*

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