Mistreatment in Assisted Living Facilities: Complaints, Substantiations, and Risk Factors

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Purpose of the Study: Use archived public data from Arizona to explore relationships among selected institutional and resident risk and situation-specific factors and complaints and substantiated allegations of various types of mistreatment in assisted living facilities (ALFs). Design and Methods: An exploratory/descriptive 2-group design was used. Facilities in the complaint group were identified from narrative data that appeared suspicious for mistreatment based on definitions for physical, verbal, psychological, medication, sexual abuse, neglect, financial exploitation, and physical restraint. Facilities in the comparison group were those that had no citations or complaints in 2007–2008. Narrative data were content analyzed, and chi-square analysis was used to answer 3 research questions. Results: The complaint group was comprised of significantly more assisted living centers, large facilities (51–101+), facilities licensed to provide personal care services, and facilities owned by national corporations. Substantiated allegations were significantly more frequent in assisted living centers, facilities with more than 51 beds, and those owned by national corporations. Facility risk factors were related to some types of substantiated mistreatment and not others. Implications: Findings suggest the need to evaluate use of only unlicensed assistive personnel in facilities, increase oversight of care by professional nurses, rethink the practice of not licensing small facilities, and monitor more closely practices and procedures in facilities operated by national corporations.

This paper presents data on the relationships among selected risk factors and elder mistreatment in assisted living facilities (ALFs). Despite sparse scientific data, multiple reports provide anecdotal evidence that mistreatment of older adults living in residential care settings is persistent and serious (Consumer Reports, 2005; U.S. Government Accountability Office (GAO), 1997, 1999, 2002a, 2002b, 2003, 2004, 2005, 2007, 2009a, 2010; U.S. House of Representatives, 2002; U.S. Senate Special Committee on Aging, 1999, 2002). One report (U.S. House of Representatives, 2001) showed that in 2000, more than 30% of nursing homes in the United States received abuse citations for incidents that had the potential to cause more than minimal harm to a resident.

Although there has been a recent increase in the number of studies on quality of care and mistreatment in nursing homes (Lindbloom, Brandt, Hough, & Meadows, 2007), studies of mistreatment of older adults living in other residential care settings, such as ALFs, which serve close to 1 million older adults in the United States on any given day (Assisted Living Federation of America, 2009), are virtually nonexistent. A MEDLINE search yielded only two studies on elder mistreatment in ALFs. The first (Wood & Stephens, 2003) explored the abilities of older adults in assisted living to recognize mistreatment and make plans to protect themselves. The second study compared the rates of elder mistreatment in domestic settings, nursing homes, and ALFs in Michigan and found that
ALFs had a high rate of neglect (Page, Conner, Prokhorov, Fang, & Post, 2009). A third study, which was found on the National Institute of Justice Web site but not in MEDLINE (Hawes & Kimbell, 2009), focused on identifying barriers to detecting, addressing, and preventing elder abuse in ALFs.

Because of the lack of scientific attention to mistreatment in ALFs, the scope of the problem is unknown. However, five factors suggest that it could be significant enough to be of concern. First, although ALFs were originally designed to serve older adults requiring minimal assistance, the ALF population increasingly resembles the nursing home population with regard to physical and cognitive problems (Boustani et al., 2005; Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004; Hawes et al., 2000; Magsi & Malloy, 2005; McNabney et al., 2008; Rao et al., 2008; Rosenblatt et al., 2004). Some evidence suggests that physical and cognitive problems are associated with mistreatment in nursing homes and other settings (Burgess, Dowdell, & Prentky, 2000; Dyer, Pavlik, Murphy, & Hyman, 2000; Lachs, Williams, O’Brien, Hurst, & Horwitz, 1997; Pillemer & Suitor, 1992). Second, in a majority of states, staff in ALFs are unlicensed assistive personnel who have even less education than certified nursing assistants (Carlson, 2005; Munroe, 2003). Staff education about managing the problems of nursing home residents is seen as critical to preventing mistreatment (Hawes & Kimbell, 2009; Maas, Specht, Buckwalter, Gittler, & Bechen, 2008; Pillemer & Hudson, 1993; Pillemer, Menio, & Keller, 2003). Third, ALFs are not federally regulated. Some evidence suggests that the uniform regulation and monitoring provided by the federal government is a major deterrent to mistreatment of nursing home residents (U.S. GAO, 2003). Fourth, although there are large ALFs (>50 residents), many are small, isolated, and relatively invisible. Isolation is an important risk factor for mistreatment of all kinds (Hawes & Kimbell, 2009; U.S. GAO, 1997). Finally, most ALFs operate for profit. The profit motive has been implicated as a risk factor for mistreatment of residents in nursing homes (U.S. GAO, 2009). These factors suggest a pressing need to scientifically examine elder mistreatment in ALFs. In particular, to guide policy and interventions, a better understanding of institutional and resident-related risk factors associated with mistreatment is needed.

### Institutional Risk Factors

Studies of institutional risk factors for mistreatment in ALFs are virtually nonexistent, although there is speculation in the literature about what factors might be involved (Carlson, 2005; Consumer Reports, 2005; Hawes, 2003; U.S. GAO, 1997). In addition, there have been some studies of institutional risk factors associated with mistreatment in nursing homes (Jogerst, Daly, Dawson, Peek-Asa, & Schmuck, 2006; Jogerst, Daly, & Hartz, 2008; Kayser-Jones, 2002; Kayser-Jones et al., 2003) that are applicable to ALFs. Although most literature divides institutional risk factors into two interrelated categories, staff and institutional characteristics, only the latter was relevant to this investigation.

Facility size is an institutional risk factor for mistreatment that has been studied in nursing homes. Jogerst and colleagues (2006), for example, found that more reports of mistreatment and higher substantiation rates were associated with higher numbers of residents and Medicare-certified beds, which was consistent with studies by Allen, Kellett, and Gruman (2003) and Riportella-Muller and Slesinger (1982). The key dynamic in this relationship might be staff workload with larger facilities having higher staff workloads in relationship to staffing levels. The relationship of inadequate nursing home staffing and mistreatment has been documented in several studies (Kayser-Jones, 2002; Kayser-Jones et al., 2003) as has the relationship between staff workload, staff burnout, and mistreatment (Goergen, 2001; Pillemer, 1988; Pillemer & Bachman-Prehn, 1991; Shaw, 1998, 2004; Shinan-Alman & Cohen, 2009).

Ownership/for-profit status is another variable that has been considered in studies of mistreatment in nursing homes. The GAO (U.S. GAO, 2009) has reported that poor quality of care in nursing homes is associated with corporate for-profit ownership status. Higher rates of mistreatment in nursing homes have also been associated with for-profit status (Jogerst et al., 2006). Indexing for-profit status in ALFs is difficult because there is little variability and most ALFs are for-profit businesses (Hawes, Phillips, Rose, Holan, & Sherman, 2003). However, it is possible to categorize ALFs according to whether the owner is an individual who operates one or multiple small facilities, whether the facility is owned by a corporation that operates only in-state facilities, or whether the owner
is a corporation that operates multiple facilities nationwide.

Geographic location, urban or rural, is also a variable that has received some attention in relationship to mistreatment. Jogerst and colleagues (2006) found higher rates of mistreatment in nursing homes in metropolitan areas. How this applies to ALFs is not exactly clear. On the one hand, the relationship between geographic location and mistreatment might be the same. On the other hand, however, the reality of the ALF market is that, in rural areas, often ALFs are the only residential long-term care alternatives available. Market competition is a factor that influences quality of care and likely mistreatment in nursing homes (Consumer reports, 2005; Jogerst et al., 2006, U.S. GAO, 1997). Therefore, with less competition and fewer care alternatives, residents and family members may be less critical of the care and less likely to complain about problems in rural as opposed to urban settings.

Types of services offered is not a variable that is particularly relevant to studies of mistreatment in nursing homes although there has been consideration given to whether facilities offer skilled nursing services under Medicare (Jogerst et al., 2006). For ALFs, however, the types of services vary widely (Hawes et al., 2000) with some facilities providing high-intensity services such as dementia care as opposed to low-intensity services to, as Hawes and Kimbell (2009) have termed them “the canasta crowd.” One way to differentiate among the types of services is whether the facility provides general supervision, for example, monitoring medications (supervisory care), assistance with activities of daily living (personal care), or care for individuals with cognitive impairments (directed care).

Resident Risk and Situation-Specific Factors

Resident-related risk factors for elder mistreatment have been identified based on studies done in domestic settings and nursing homes. Cognitive problems are believed to be associated with mistreatment in both settings (Burgess et al., 2000; Dyer et al., 2000; Pillemer & Suitor, 1992). Functional abilities and the type of care required have also been linked to mistreatment (Lachs, Berkman, Fulmer, & Horwitz, 1994; Lachs et al., 1997), but the relationship is not consistent, and some data suggest that better functional status and less required care are related to mistreatment (Pillemer, 1985). The inconsistency might be related to the type of mistreatment with, for example, physical abuse being associated with better functional status and less required care and neglect being associated with poorer functional status and more required care. Gender is another variable that has been considered in many studies, and some evidence suggests that women are more likely to be mistreated than men (National Center on Elder Abuse at the American Public Human Services Association, 1998). Again, results are variable, and the relationship between gender and mistreatment may be a function of reporting biases or that there simply are more women in older age groups.

Situation-specific factors are defined as resident behaviors that may or may not be a characteristic of that individual but are temporarily linked to a particular instance of mistreatment, including the resident being aggressive, showing aberrant behavior (e.g., entering a restricted area of the ALF or pacing), or being uncooperative. For example, a resident may be uncooperative because s/he has a behavior or mental health problem, but s/he may also be uncooperative occasionally when s/he is angry with her/his daughter. Studies (Goodridge, Johnston, & Thomson, 1996; Hawes, 2003; Pillemer & Bachman-Prehn, 1991; Pillemer & Suitor, 1992; Shiman-Altman & Cohen, 2009) have shown a temporal association between residents’ displays of these types of behavior and certain types of mistreatment in nursing homes.

Regulations for Licensure

ALFs are state regulated. No federal mandate exists for their regular inspection, although most states have requirements for licensure that may involve inspections, and mechanisms do exist for complaint investigations. Because ALF inspections are not governed by a process like the Online Survey Certification and Reporting System (OSCAR) used for nursing homes, there is inconsistency among states about inspection schedules and protocols. Some states also have a significant problem with unlicensed facilities (Hawes & Kimbell, 2009). Because ALFs are, by and large, state regulated, mistreatment in ALFs is handled as an in-state problem; and data available on ALFs are state specific.

This investigation was confined to the state of Arizona. In Arizona, the regulatory structure of ALFs is clearly defined by state statute with licenses
required for all facilities with three or more residents. Arizona has only two types of ALFs (assisted living homes and assisted living centers), and all ALFs are licensed to provide only three types of services (supervisory, personal, and directed). The type of license reflects both the type of services and the amount of educational preparation of staff. The Arizona Department of Health Services (ADHS), the licensing agency, reports that unlicensed ALFs are not a problem in Arizona largely because the state is relatively small and competition is fierce. As a consequence, facilities operating without a license are quickly reported by competitors who can monitor the licensing of other facilities via the ADHS Web site (http://www.azdhs.gov/als/hcb/index.htm).

In Arizona, the regulatory processes are also clearly defined. All ALFs are inspected yearly, and almost all complaints are investigated. Data about regular inspections and complaint investigations are published and archived on the ADHS Web site. A process modeled after the OSCAR system guides inspections, and narrative reports of inspections and investigations are publicly available.

Although ALFs in Arizona have unique characteristics, they are also similar to ALFs in many other states. For example, ALFs in Arizona use unlicensed assistive personnel as staff, and there is no requirement for any licensed staff to be employed (National Center for Assisted Living, 2008). So although the analysis is not generalizable from a statistical point of view, findings from this investigation have relevance to many other states.

**Purpose of the Study**

Based on this background, the purpose of this investigation was to use archived public data from Arizona to explore relationships among selected institutional risk, resident risk, and situation-specific factors and complaints and substantiated allegations of various types of mistreatment in ALFs. The research questions that guided the investigation were as follows:

1. What facility characteristics differentiate ALFs that have complaints of mistreatment from those that do not?
2. What facility risk, resident risk, and situation-specific factors are associated with substantiated allegations in ALFs?
3. In ALFs, are risk and situation-specific factors different based on the type of mistreatment?

**Design and Methods**

This study used an exploratory/descriptive two-group design. Because all data were deidentified and publicly available, the Institutional Review Board at the University of California, Los Angeles, approved human subjects’ protection as exempt. Facilities in Group 1 (complaint group) were selected by reviewing survey data on the ADHS Web site to identify ALFs with complaint investigations and enforcement actions between 2007 and 2008 that appeared suspicious for mistreatment. Definitions for physical, verbal, psychological, medication, sexual abuse, neglect, financial exploitation, and physical restraint provided by the National Center on Elder Abuse (2009) and the National Citizen’s Coalition for Nursing Home Reform (2009) were used. These definitions are more specific and comprehensive than the definitions provided by the Arizona State Statutes (Arizona Secretary of State, 2009). Facilities in Group 2 (noncomplaint group) were those that had no citations or complaints in 2007–2008. Facility risk factors for both groups were coded using the definitions in Table 1.

Coding resident risk and situation-specific factors required the availability of narrative reports (statements of deficiency [SODs] and Aspen Complaint Tracking forms [ACTs]), which were only written after the inspector visited the facility to investigate a complaint. Such narrative reports were only available for Group 1 because if there was no complaint, there were no narrative reports. Complaints were calls to ADHS by an individual who had witnessed or heard about a resident-related or facility-related problem. The identity of complainants was carefully protected by ADHS, but the narrative reports suggested that many were made by family members or health care professionals. All SODs and ACTs for the 239 facilities in Group 1 were collected during field trips to the two ADHS offices by the two investigators and a research assistant. All SODs and ACTs in the redacted facility files were copied and taken to the research office for analysis. Using manifest content analysis and application of coding rules (Krippendorf, 2004), the two investigators coded all narrative data. For 10% of the facilities, coders independently coded the data and compared results. Interrater reliability was maintained at 80% or better.

The SODs and ACTs were facility and complaint specific, and each could involve multiple
residents and multiple allegations. The unit of analysis for coding was the allegation, and when possible, allegations were “deconstructed” to represent an allegation involving a unique resident. For example, one complaint could allege that Resident A had been yelled at and confined to his/her room, Resident B had been restrained, and the facility was dirty. This would have been coded as one complaint, two unique residents, and four allegations. Definitions applied to coding resident risk and situation-specific factors were that the variable (e.g., gender, level of care, mental status) was specifically mentioned in the narrative report. Substantiation of an allegation was defined as the decision made by the inspector about whether or not in his/her opinion the evidence supported the allegation.

Data were entered into SPSS for analysis. Frequency data were used to describe the facility and resident samples. All research questions were answered using chi-square analysis, a nonparametric strategy for exploring the independence of associations among categories of data based on the difference between the expected and the observed frequency distributions (Moore & McCabe, 2008).

Findings

Description of Sample

The sample consisted of 454 facilities, 239 (52.6%) in Group 1 (complaint group) and 215 (47.4%) in Group 2 (noncomplaint group). Most in both groups were assisted living homes (77.8%) versus assisted living centers (22.2%). A large percentage (92.5%) was licensed to provide directed care services. Seventy-nine percent had less than 11 beds, 25 (5.6%) had between 11 and 50 beds, 32 (7.2%) had between 51 and 100 beds, and 36 (8.1%) had 101 or more beds. A majority were small businesses with an owner with a single facility (N = 225, 54.2%), 98 (23.6%) were small businesses with an owner with multiple small facilities, in-state corporations owned 42 (10.1%), and national corporations owned 50 (12.0%). Most were located in urban areas (N = 356, 78.4%). Resident characteristics were coded from 415 complaints involving 978 allegations. Seven hundred and eight unique residents were identified, and 270 residents were involved in more than one allegation (total 978; Table 2). All types of mistreatment were represented in the allegations.
including physical abuse (N = 70, 7.2%), verbal abuse (N = 43, 4.4%), psychological abuse (N = 68, 7.0%), medication abuse (N = 27, 2.8%), sexual abuse (N = 27, 2.8%), neglect (N = 633, 64.7%), financial exploitation (N = 46, 4.7%), and physical restraint (N = 37, 3.8%). Twenty-seven allegations (2.7%) were classified as “other” because they involved problems that were suspicious for abuse and had deleterious outcomes but did not fit the definitions of elder mistreatment being used. Examples in the “other” category were unexplained injuries and medication-related problems, such as giving the wrong medicine. Between 48.8% and 66.7% of allegations were substantiated for all types of mistreatment except sexual abuse (25.9% were substantiated).

**Research Questions**

The complaint group comprised significantly more assisted living centers, large facilities (51–101+), facilities licensed to provide personal care services, and facilities owned by national corporations (Table 3). Substantiated allegations were also significantly more frequent in assisted living centers, facilities with more than 51 beds, and those owned by national corporations (Table 4). Substantiation of allegations was not associated with any resident risk or situational factors, including gender, level of care, functional status, mental status, being uncooperative, or demonstrating aberrant behavior.

Among the 168 facilities with substantiated allegations, facility risk factors were related to some types of mistreatment and not others. Type of facility was related to physical and psychological abuse and neglect with assisted living centers.
having significantly more substantiated physical abuse ($\chi^2 = 4.598$, $df = 1$, $p = .028$) and assisted living homes having significantly more substantiated psychological abuse ($\chi^2 = 7.598$, $df = 1$, $p = .006$) and neglect ($\chi^2 = 6.503$, $df = 1$, $p = .007$). Size was associated with psychological and sexual abuse and neglect. Facilities with fewer than 11 beds had more substantiated psychological abuse ($\chi^2 = 10.158$, $df = 3$, $p = .017$) and neglect ($\chi^2 = 9.736$, $df = 3$, $p = .021$) and less sexual abuse ($\chi^2 = 8.056$, $df = 3$, $p = .045$). Substantiated use of physical restraint was more frequent in facilities licensed to provide personal care services ($\chi^2 = 4.923$, $df = 1$, $p = .028$). Substantiated sexual abuse was more frequent in urban facilities ($\chi^2 = 4.641$, $df = 1$, $p = .034$), and substantiated neglect was more frequent in rural facilities ($\chi^2 = 5.580$, $df = 1$, $p = .011$). No facility risk factors were associated with verbal abuse, medication abuse, or financial exploitation.

### Discussion

This study was done to explore the relationships among selected institutional and resident risk and situation-specific factors, complaints of mistreatment, substantiation of allegations, and various types of mistreatment in ALFs. Complaints of mistreatment more commonly arose in large facilities, facilities providing personal care, and those owned by national corporations. More substantiated mistreatment was also found in assisted living centers, facilities with more than 51 beds, and those owned by national corporations.

These findings raise some interesting issues. First, the relationships of complaints and mistreatment substantiations to size are consistent with findings about nursing homes that suggest that larger nursing homes have higher rates of mistreatment (Jogerst et al., 2006). Second, the relationships among ownership status and complaints and mistreatment substantiations are also consistent with findings about nursing homes (Jogerst et al., 2006; U.S. GAO, 2009). Although not exactly comparable because virtually all ALFs operate for profit, the indication that ownership by a for-profit national chain is related to substantiation of mistreatment is support for the negative effect of the profit motive particularly when the facility owners are not part of, or sometimes even known to, the local community.

More substantiated physical abuse was found in large facilities and more substantiated psychological abuse, and neglect were found in small facilities. These findings are provocative. They lend support to suppositions made about nursing homes that suggest a link among physical abuse, staff workload, and staff burnout (Goergen, 2001; Pillemer, 1988; Pillemer & Bachman-Prehn, 1991;
Although findings support the idea that different types of mistreatment may have different origins. For example, in domestic settings, some researchers suggest that physical abuse is closely aligned to the power and control issues inherent in other types of interpersonal violence such as spouse abuse (Pillemer, 1985) and neglect is closely aligned with caregivers’ lack of knowledge or interest or burden (Fulmer, 1991). Although research done on mistreatment in domestic settings may not be fully applicable to mistreatment in ALFs, the findings suggest that it may be important to study different types of mistreatment separately. The most provocative implication of the relationship between small ALFs and certain types of mistreatment relates to policy. Currently, small ALFs exist in every state, but whether they are licensed or even considered to be “assisted living” is quite variable. As emphasized by Hawes and Kimbell (2009), these findings suggest the need to increase the involvement of professional nurses in the care of persons in ALFs.

The findings also support the idea that different types of mistreatment may have different origins. For example, in domestic settings, some researchers suggest that physical abuse is closely aligned to the power and control issues inherent in other types of interpersonal violence such as spouse abuse (Pillemer, 1985) and neglect is closely aligned with caregivers’ lack of knowledge or interest or burden (Fulmer, 1991). Although research done on mistreatment in domestic settings may not be fully applicable to mistreatment in ALFs, the findings suggest that it may be important to study different types of mistreatment separately. The most provocative implication of the relationship between small ALFs and certain types of mistreatment relates to policy. Currently, small ALFs exist in every state, but whether they are licensed or even considered to be “assisted living” is quite variable. As emphasized by Hawes and Kimbell (2009), these findings suggest the need to increase the involvement of professional nurses in the care of persons in ALFs.

More substantiated use of physical restraint was found in facilities licensed to provide personal care. In Arizona, the type of license dictates the amount and type of staff education with staff in facilities providing less-intense care (supervisory care) having fewer hours of training than those in facilities providing intense services (personal care) and those working in personal care facilities having fewer hours of training than those working in directed care facilities. Staff in personal care facilities have little education about managing the problems of residents with cognitive and behavioral problems. Theoretically, residents with severe cognitive problems should not be residing in personal care facilities. However, reading the narrative reports suggested what should have happened and what did happen were likely two different things. The reports reflected the complexities for staff and family members in determining the point at which a resident’s cognitive or behavioral problems required a higher level of care. Confronted by residents with complex problems and inexplicable behavior, it may be that one of the strategies used by staff in these facilities was physical restraint, despite state regulations that stipulate no physical restraint of any kind can be used in ALFs.

Substantiated sexual abuse was less frequent in small ALFs and more frequent in urban ALFs. Of importance is that sexual abuse is very difficult to substantiate because of the lack of forensic training of inspectors and because many times elders who report sexual abuse are simply not believed (Burgess et al., 2000; Hawes & Kimbell, 2009). The difficulty with substantiation is evidenced in this study in that the substantiation rate for sexual abuse was very low. Nevertheless, the relationships between size and substantiated sexual abuse and geographic location and substantiated sexual abuse are interesting and warrant further investigation. Compared with urban facilities, rural facilities had more substantiated neglect. Jogerst and colleagues (2006) found higher rates of mistreatment in metropolitan facilities. However, that study considered all types of mistreatment together as “abuse incidents” and focused on nursing homes rather than on ALFs. Therefore, the comparability to this study is unclear. Certainly, future research into various forms of mistreatment in rural ALFs is warranted.

Despite the provocative nature of several of the findings, limitations of the study influence interpretation of the results. One limitation relates to the nature of the data. Secondary data analysis is fraught with problems related to whether or not those who generated the data provided a complete description of what occurred and who was involved. Basically, these narrative reports contained no data about the characteristics of the involved staff. Most descriptions of residents were
incomplete as reflected by a large amount of missing data for resident and situation-specific risk factors. Although resident and situation-specific risk factors were unrelated to whether or not allegations were substantiated, it is not possible to know if this finding relates to limitations of the data or to the true absence of relationships. In addition, because of missing data and the small number of cases within cells, the relationships between resident risk and situational factors and type of mistreatment were not tested. On the one hand, the poor descriptions of residents occurred partially by design because most inspectors wrote the narrative reports in a style that purposefully obfuscated the identity of the victim. On the other hand, although protecting victims’ privacy is important, it does little for further our understanding of the relationship of resident risk and situational factors to mistreatment. The lack of descriptive data about older victims of mistreatment in currently available databases is a critical problem.

Although an acceptable range of interrater reliability was maintained, coding these data was very challenging, which is another limitation. For the inspectors, the unit of description was the “complaint.” Based on the needs of the study, complaints were “deconstructed” into separate allegations and then into allegations involving single residents. Because of the lack of identifying information (e.g., gender), it was sometimes challenging to determine whether the same resident was involved in all allegations or if different residents were involved. Agreement about these instances was reached by consensus decisions among the coders. Again, this points to the caution needed in interpreting findings about the individual residents. In addition to having scientific implications, these problems point to the critical need for us to develop ways to catalog, archive, and study mistreatment in ALFs as occurrences between individuals rather than as complaints about care in a facility.

Another limitation relates to generalizability of the findings. Because of the state-by-state uniqueness of ALFs, it will never be possible to conduct a study of mistreatment that is generalizable until there is some national agreement about definitions of ALFs, levels of care, and the regulations that govern ALFs and inspection protocols.

Reporting bias is another limitation. There are considerable problems with underreporting of mistreatment in residential settings because of resident and family fears of retaliation by staff/management, lack of housing alternatives, lack of knowledge among residents/families/staff about where/how to report, staff reluctance to report out of fear of recriminations, difficulty in substantiating mistreatment, and failing memories of victims/other residents that hinder substantiation and prosecution (Hawes & Kimbell, 2009; Hirst, 2002; McCarthy, 2002; U.S. GAO, 2002b). How these issues influenced the data reported here is unknown.

Despite these limitations, however, these findings are very important. To our knowledge, this study is among the first attempts to systematically study the problem of elder mistreatment in assisted living. The findings raise interesting questions and focus attention on a problem that has received almost no attention. In particular, the findings suggest the need to evaluate use of only unlicensed assistive personnel in facilities, to increase oversight of care by professional nurses, to rethink the practice of not licensing small facilities, and the need to monitor closely practices and procedures in facilities operated by national corporations. Data (Boustani et al., 2005; Gruber-Baldini et al., 2004; Hawes et al., 2000; Magsi & Malloy, 2005; McNabney et al., 2008; Rao et al., 2008; Rosenblatt et al., 2004) are very clear that the ALF population is increasingly resembling the nursing home population with regard to physical and cognitive problems. However, ALFs continue to be viewed as housing alternatives for relatively well older adults rather than as care alternatives for a very vulnerable group. It is likely time that this view is reevaluated, and this study serves as a starting place for documenting, exploring, and discussing some of the important policy issues that will be encountered in the future as increasing numbers of older adults receive care in ALFs.

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