DISH IT UP! THE INFLUENCE OF KIND DINING™& GREEN HOUSE MODEL FOOD
AND FOOD SERVICE INNOVATIONS ON THE RESIDENT EXPERIENCE IN
RESIDENTIAL CARE FACILITIES.

BY

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ABSTRACT

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by

Mary Elizabeth Jensen

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The purpose of this study is to understand how innovative practices affect the satisfaction elder-care facility residents have with their food-related life. The study looks through the lenses of food and food service activities, related medical care activities, and facility design.

The Older Americans Act of 1965 defined the basic rights of elders in American society. The statement and objectives codified in that Act have provided the outline for eldercare in the community and in residential care facilities ever since. Legislative updates in 2017 more clearly identified "person-centered" care as the ideal in elderly care homes. Research using the diffusion of innovation theory was pursued in two nursing homes which participated in a naturalistic inquiry. Different innovative practices regarding the food-related life of each resident was the focus. Self-efficacy theory was used to better understand the perspective of the residents and their reactions and responses to the care they receive. Ethnographic research using observations, interviews and historical and current literature over an eight-month period examined the day-to-day lives of elders in these care homes, concentrating on elements related to the food and food systems.

Results show that co-occurring innovations obscure the influence of single culture change components and also support components in ways that are not yet clearly understood. Nursing

and food services staff training is lagging behind the person-centered culture change innovations related to food and food services activities.

CHAPTER 1

<u>Overview of Research</u>

As various elder relatives have died over the past several years, I've been blessed with access to their cookbooks. These cookbooks personified the similarities, and the differences, in the foods they cooked and liked to eat. One aunt had a hunter husband and there were several venison recipes she had adopted in her favorite recipe folder. Another aunt loved to make sweets; in fact, when she was in her 90s, she kept a jar of marshmallows on her kitchen table just to eat when she felt like it. These two sisters also had recipes from a third sister, who died many years ago, in their collections. These individuals had very personalized food desires; some desires that were shared with each other and some that were developed out of their life experiences and preferred tastes.

These aunts were lucky enough to die in their homes, in their beds. They did not spend time in a nursing home or assisted-living facility. One aunt had ice cream with her granddaughters an hour before she died. My cousin David baked loaves and loaves of cinnamon bread during the last week of his mother's life. The intense smell of fresh bread and cinnamon were with her at the end. They were fortunate women. They had the physical health, up until the end, to be able to largely care for themselves. They had people who could – and did – care for them when the need arose.

In the United States, the number of people aged 65 and older is increasing quickly, with the Centers for Disease Control and Prevention (CDC) estimating that roughly 54 million Americans will be older than 65 in 2020 – and about 72 million in 2030. Of those people, more than 6 million in 2020 and 8 million in 2030 will be 85 years or older (AoA 2012). Those who are 85

years and older make up the predominant number of residents in assisted-living facilities based on current numbers (CDC, 2016).

According to the CDC's National Center for Health Statistics (NCHS) National Study of Long-Term Care Providers (NSLTCP) report released in February 2016, there are more than 15,000 licensed nursing homes in the United States and more than 30,000 licensed residential care communities (CDC, 2016). Of these, 69% and 81% respectively are operated for profit, and roughly 55% of each are owned by chains (CDC, 2016) with 8% of nursing homes government owned (Terrell, 2017). This translates to approximately one million licensed residential care community beds and 1,663,300 nursing home beds (CDC, 2016). The NSLTCPs first survey was done in 2010 and repeated every two years, with the survey results from 2016 still in process.

Determining how to accommodate the percentage of the additional two million citizens aged 85 and older who want to live in residential care communities in the next 13 years is an opportunity to review care for elders, particularly related to food. This is a time for those communities to look at the influence that healthy and culturally relevant food and food services has on the physical and mental health of their customers. This is also a time to look at the impact historical and recent legislative actions and rulemaking has in shaping elder care in the United States.

The purpose of this study is to understand how innovative practices can affect the satisfaction elder-care facility residents have with their food-related life. The study looks through the lenses of food and food services activities (e.g. diet, variety, presentation, support of agency, cultural appropriateness, food waste, etc.), related medical care activities, (e.g., restrictive diets, timing of meals, serving styles, regulatory and governmental actions, etc.), and facility design (e.g. kitchen practices, equipment, lighting, tableware, furniture, space constraints).

There are innovative elder care alternatives related to food and food services that long-term care facilities, governmental agencies and community organizations can consider, both long and short term, to effect change that could improve the health and wellness outcomes of residents in long-term care facilities and reduce waste. Many of these alternatives are supported by the Older Americans Act (OAA) – legislation originated in 1965 that defines the Federal government's position on care related to elders.

To that end, two theories are integrated into this discussion. With a focus on food and food service practices, diffusion theory is used to look at facility implemented innovations and the impacts those innovations have on the satisfaction of elders as defined by the objectives of the OAA. Self-efficacy theory is used to understand how the residents interact with and respond to the food services innovations in their care facility. These theories will frame the three related elements of interest: the impact on food and food services on current practices, related medical care activities, and facility design.

Why do this research at all? As a sustainability professional, I have seen that self-efficacy theory and diffusion theory present many opportunities to affect change in the economic, environmental and social milieus. I am taken by the possibilities offered by a deeper understanding of how these theories can interact and support each other. Positively deviant innovations are of particular interest because they use tools that are typically available in similar environments.

Food waste represents an intersection of all three of those milieus. A step back from the final scrape of food from the plate to the trash can to look at all of the choices made up to that point opens up many options. From working in a nursing-home kitchen to cooking meals for 100 people at a soup kitchen to projects reducing waste in a college dining hall that served 2,000

meals a day, I have seen many ways to reduce food waste. I suspected that there had to be more. I am intrigued at the idea of combining self-efficacy theory and diffusion theory to look for ways that support the pursuit of satisfaction with a food related life, particularly for elders in care homes.

I see elders in care homes as people marginalized and warehoused in segregated buildings while society waits for them to die. As a society, I think we can do better than that and we clearly have the tools to do it. In addition, our society cannot afford, quite literally, to support the next generation of elders in the same way. Understanding the lived experience of elders is crucial both to determining what changes should be made to use limited resources effectively and to making the time spent in a care facility as enjoyable and satisfying as is possible. My experiences as a family member of an aged relative in care home brought me to this research table. I understand that bringing an open mind to research is critical to a fuller understanding of the issues and to assuring that bias is acknowledged and managed to reduce its influence.

Nursing homes, in addition to caring for the most ill elders, also care for people who are in the care of the state. Mental health and mental capacity, disease, illness, and injury are a few of the reasons why someone other than an elder might be in a nursing home. Many nursing homes also offer rehabilitation services to people who have had surgery and need medical care before they can go home, but do not need to be in a hospital.

The concept of elder care has morphed over the years into a variety of facilities offering various levels of service, types of living arrangements and care options. In addition to Skilled Nursing Facilities (SNFs), there are Assisted-Living Facilities, Adult Care Homes, Continuing Care Retirement Communities (CCRCs) and other state specific designations. Each has different legal

boundaries for the kinds of care and services they can offer. One thing they all share is the need to feed their residents.

There are many horror stories about the food in residential care facilities. "Institutionalized" food, for many Americans, conjures up visions of gray peas, tough meat and watery oatmeal, all without the benefit of salt or spices. The combination of a larger variety of long-term care options and the inclusion of short-term rehabilitation services in nursing homes has given rise to changes in the food and food systems as facilities compete to attract elders, particularly private-pay elders, and the higher-paying rehabilitation patients.

Americans eat out significantly more now than in the past (UPI, 2011), and that is likely to influence their expectations that the same kinds of choices and variety they can find at restaurants will be available through the food and food services sector of residential care communities. In addition, elders bring to residential care their food agency – the foods they would prepare for themselves and their families if they were still living in the larger community. With aging baby boomers flooding the market during the next 20 years, residential care facilities will need to adapt to this new cohort's higher expectation of variety and choice.

Malnutrition in long-term care facilities is still a common occurrence (Crogan, 2011). In report after report, the prevalence of malnutrition and at risk of malnutrition is noted at levels up to 85% of residents in long-term care facilities (Allen, Methvan & Gosney, 2013; Crogen & Evans, 2010; Divert et al., 2015;). Malnutrition is a precursor to physical, emotional and physical decline, and most people moving into long-term care are likely already showing signs of distress in one or more parts of their lives.

The costs of malnutrition are severe – pressure sores, declining cognitive abilities, protein/energy imbalances, muscle wasting (Bernstein & Munoz, 2016) – all bad for even a young individual, but potentially catastrophic for elders. Add to that the monetary costs to improve the health outcomes of the affected elder. Many variables go into determining whether malnutrition is a result of medical or physical issues, facility practices, or resident food preferences. How much food is being wasted is a common metric for looking at malnutrition (Andrews et al,, 2003; Connors & Rozell, 2004) but it doesn't tell why the food is wasted. In addition, food waste is expensive and, in the long term, unsustainable for a business, particularly low-margin long-term care facilities. A diet that does not meet an elder's dietary needs may not meet their cultural, emotional and spiritual needs either.

In most cases, food-waste measurement is used as a proxy to look at evidence of malnutrition, or risk of malnutrition (Andrews et al., 2003; Connors & Rozell, 2004; Grieger & Nowson, 2007; Hedman, Nydahl & Faxen-Irving, 2015, Sherwin et al., 1998). In some cases, food waste was measured simply as a means to determine cost savings and efficiency in the dining services (McCaffree, 2009). Food waste can also be used to measure satisfaction with food and food services.

Satisfaction-with-life research has found the domain of "control" and the ability of people to control elements of their lives to be an important part of a satisfied person's life (Ball et al., 2000; Mallers, Claver & Lares, 2014). The combination of lack of control related to food and food services, particularly the inability to affect change, may be a powerful loss for elders who move into a residential care facility. Moving to residential-care facilities does not have to mean that an elder no longer has a voice in their life. Being recognized as an individual with a unique

history is important to well-being and good health (Fischler, 1988; Lobos, Mora, Lapo, Caligari & Schnettler, 2015; Mahadevan, Hartwell, Feldman, Ruzsilla, & Raines, 2013).

People are happier if they maintain a measure of control in their lives (in these cases, over their food and food-service-related lives), and if their experiences and knowledge are valued in their community (Bernstein & Munoz 2012). Research has shown that happier residents tend to be healthier (Lobos et al., 2015), with fewer serious facility related illnesses, including fewer incidents of malnutrition. In addition, the higher the number of interventions in practice at each facility, the less likelihood of food waste, since many of the interventions are likely to address related concerns (Crogan et al., 2006).

There are changes in long-term care that have been steadily building since the 1990s. Some of those changes are reflected in new models of care, including changes in food and food services. These changes are slowly spreading across the continuing-care facility spectrum, largely through the Centers for Medicare and Medicaid Services in partnership with change organizations, though there are models that have not diffused that also offer glimpses of a different future. We will explore two models related to changing the food and food services of residential care facilities for elders: The Green House Model and Kind Dining.

These models – showcasing innovations that involve "complex social phenomena" (Yin, 2014, p. 5) and examined here through qualitative research, using participant observation, interviews, and thorough reviews of historical and relevant current documents – are presented as case studies. Case studies, in Yin's (2014) words, allow for "explanatory and not just descriptive or exploratory functions" (p. 7) because they focus not on "whether programs work, but how they work" (p. 21) all while still following a "rigorous methodological path" (p. 3)

Research Questions:

These research questions were used to better understand the impact of current innovative practices, medical-care activities and facility design on food and food services in residential care facilities for elders.

1.) Can long-term care facilities transform dining services from a system that merely provides food to one has been tailored to an elder's food preferences, their food culture, food agency, social and historical influences and habits and that consistently provides elders with food and food services that bring them satisfaction with a food-related life?

2.) What federal, state and facility legislation and policies influence the agency of resident elders, particularly related to food and food services in long-term care facilities?

3.) What influence does the new community and a sense of place have on the acclimation of residents in their new home, particularly related to food and food services?

4.) What influence do the elders of the next 20 years have on the current food services, such as a desire for more local foods, ethnic foods, etc. in long-term care facilities?

Research goals and objectives

The goals and objectives related to the research questions are:

GOAL 1: Determine how the innovation has influenced food and food-services-related, person-centered care.

Objective: Identify the historical, medical, and cultural practices related to food in residential care for the elderly and how they have been influenced by the innovation.

GOAL 2: Determine what barriers and opportunities exist for facilities that adopt innovations related to food and food services.

Objective: Identify how staff training, traditions, and existing facility designs influence a facility's ability to adopt new models of food service and how new models are both changing and influencing typical practices in other locations.

GOAL 3: Understand and explore the influence that the new community, and a sense of place have on the acclimation of residents in their new home, particularly related to food and food services.

> Objective: Identify how community and sense of place are influenced by innovative food and food services designs.

GOAL 4: Understand changing demographics and their influence on current practices and long-term planning.

> Objective: Identify current trends in rehabilitation services and changing demographics of residents to help understand how the future of food and food services might look in long-term care for the elderly.

This limited study cannot hope to fully explicate all the goals and objectives presented here.

Instead, this is an opportunity to explore the practices of current long-term care facilities and the effects that recent changes have wrought in the industry at this point in time. In addition, there is an opportunity to assess the potential impact of a changing demographic on the future of food and food services in these facilities.

CHAPTER II

<u>Historical Context</u>

Nursing homes have been around for a long time. In 1935, the Social Security Act was passed by the United States Congress and signed into law. This legislation, which included the Old Age Assistance program, guaranteed payment for care of poor elders and kick-started private nursing home development. This began the process of moving poor elders from almshouses to care homes, or the conversion of the homes themselves. (Woods, 2016, p. 27)

In 1964, President Lyndon Johnson articulated a set of goals for his administration. His ambitious ideas became known as the "Great Society" programs in a bid to reduce poverty and racial injustice in the United States. After Medicare and Medicaid were added to the Social Security Act in 1965, as Title XVIII and XIX respectively, the Older Americans Act (OAA) was also passed. The OAA legislation set forth a series of overarching objectives at the federal level and included how funding and other resources would be made available to assist elders in their communities, and those in nursing homes and similar care facilities. (Updegrove, 2012)

In the early 1970s, legislation redefined Medicare and Medicaid-eligible care homes as Skilled Nursing Facilities (SNF). Legislative changes continue to clarify standards and regulations for facilities receiving public funds (National Academy Press, 1986).

Current elders were influenced by their childhood years in the Great Depression and the years after World War 2. They are the people who fought or supported the troops at home and in the factories. They remember Victory Gardens, rationing, and the old saying, "Use it up, wear it out, make it do or do without". Their children, the up-and-coming nursing-home generation, may have different expectations regarding their care and the foods they will want to eat. This is

already being seen in rehabilitation units as these not-quite-elders get their hips and knees replaced. Current innovations need to be investigated to help determine whether they meet the spirit of the OAA objectives, especially in their effectiveness for the elders now in care, and how well they will satisfy the next generation.

Modern day American nursing homes originated with 17th century almshouses, an idea taken from the British alms, or work, houses. It's hard to imagine what life was like in 1600s New England for the poor, widowed, orphaned, mentally ill, mentally incompetent, or elderly who had no option but to be at the mercy of fellow town members' generosity.

In the *Diary of a Common Soldier in the American Revolution, 1775-1783,* Jeremiah Greenman of Rhode Island writes about his day-to-day life as a soldier and the experience of growing old. Appendix 2 of the diary contains letters written by the court and by Captain Greenman regarding his application for the pension due him for his service as a Revolutionary war soldier. His application includes a description of all of his worldly goods, and notes that he has a wife "very much debilitated" and children "being married & large families cannot contribute towards my support without embarrassing themselves and that I have not one Solutary friend or acquaintance, that knows or ever heard of me, except such that has been made prior my migration to this country" (p. 295). There are rare few written, published, examples of the day-to-day life of everyday Americans from that time. The *Diary* highlights the difficulties of surviving into old age. Even a former soldier captured twice during his "Eight years & Siven Months service together with three wounds received whilst in that service, & one of them rendering me incapiable of <u>hard</u> labour" (p. 296), experienced a hand-to-mouth existence and insecurity in old age (Bray & Bushnell, 1978).

Every state manages its poor or otherwise needy residents somewhat differently. In New

Hampshire, until 1867 when the state moved to a county system, each town was responsible for

the indigent members of its community. Massachusetts had a state almshouse near Boston. All

13 original colonies had paupers and other residents in need of alms

(http://www.newenglandhistoricalsociety.com).

In earlier days, a person in need of alms might be vendued, or auctioned off, to someone else in

town. For example, a woman who is widowed and without family support, but able to work,

might be vendued by the town for a year to the highest bidder, to work in exchange for room and

board. For those who needed care, the town would pay someone to care for the person. Each year

a new auction was held. Eventually this practice died out and was replaced with almshouses.

One way to research the history of nursing homes in the United States is through reading town

reports. New Hampshire, for example, has a rich history of town almshouses, morphing into

county almshouses in 1867, and into county nursing homes in the early 1970s. This succession

ensures a continual record of how those in need of alms, including elders, were supported over

time. The recorded practices of New Hampshire towns and counties are fairly representative of

New England pauper management generally (http://www.newenglandhistoricalsociety.com).

Town reports today remain largely devoted to the ways in which each town spends taxpayer

money. Early town reports also included more illuminating details about who the monies were

spent on, and why.

By the late 1800s, New Hampshire had established an almshouse in every county. Many

almshouses were also farms. They were typically managed by a warden or supervisor and a

matron who were usually, but not always, a married couple. Able-bodied almshouse residents

were usually put to work. The farms grew as much food as possible for the residents and, in some cases, grew cash crops like tobacco to pay for the goods they could not grow. They also had animals for meat, dairy, eggs, wool, and leather. In most cases, a tax on other town residents paid the balance of the costs for the care and feeding of those in need of alms (Mansfield, 2006).

There were a variety of reasons why people were poor. In some cases, drought and other natural disasters ruined crops and created hardships. The American Revolution, the War of 1812, the Civil War, and subsequent wars created indigent widows, orphans, and soldiers such as Captain Greenman: "Having Devoted my youthful days to the service of my country I was deprived of the opportunity, which young men generally possess of acquiring any mechanical art or perfecting my self in any proffession" (Bray and Bushnell, 1978, p. 294). Financial panics and large influxes of immigrants also created eras of poverty. Additionally, residents in almshouses fell under categories other than poverty such as: "feeble minded, insane, epileptics, feeble minded through old age or sickness, blind, deaf, intemperance, widowed or deserted, infants and misc", as recorded in the Cheshire County (NH) county reports of the time.

At the Cheshire County Historical Society, Reg. No. 38 Series No. VII, Box #6 Folder No. 6 gives a succinct history of the care of paupers in the town of Westmoreland, NH, through the years:

> The Town Farm (Westmoreland) was the original 100-acre pitch of John Taylor. William Glazier sold May 29, 1771 to Nathanial Daggett, 100 A[acre] pitch of John Taylor and meadow lot No. 26. 18323 $2000.
>
> 1786 – Voted that the Selectmen provide a work house for the poor.
>
> 1788 – Voted not to build a work house
>
> "Sept. 2, 1791 Voted that Mr. Josiah Powers and Widow Miller be vendued to the lowest bidder. Widow Miller struck off to Mr. Joseph Buffum for two shillings nine pieces a week……."

1791 – Voted to provide a work house and the house belonging to the town where Jedidiah Chamberlain now lives to be put to that use. [not Daggert Farm which was "maintained until 1876 when it was sold".]

1831 – Town farm bought

1867 – Jedidiah and Elvira Sabin sold [to the] county [their] farm for $13,000.00

1867- County Farm established

The erection of the almshouse was at a cost of $22,710.27, and its appurtances, as reported April 1, 1869, made the total value of the building at that time $25,710.27. In 1873 the Supervisor and Matron (married) had a combined annual salary of $1,000.00.

The Cheshire County Historical Society also maintains the records of the County Commissioners – those members of the community responsible for overseeing the county budget and attendant responsibilities. Some examples of the kinds of records they kept are below:

> "and in fact, we believe it [alms house] has been, and will be, a good investment for the county……….as by having a place for taking care of those who may require public aid, we can to a large extent avoid the payment of extravagant prices for the maintenance of those who cannot take care of themselves."

The actual cost of maintaining 36 3/8 inmates (average daily number) at the almshouse for the year 1873 was $5,896.97.

> "It has been the aim of the Commissioners in all cases to properly care for and aid those in actual need of assistance. Those at the Alms House have been at all times supplied with a plenty of good and wholesome food, comfortable beds and clothing, and with such care as necessary to make them as comfortable and happy as possible under the circumstances of their condition, subject only to such restrictions as have been deemed necessary for their own good, and the proper management of the institution. And, although the idea is prevalent in places that the county Alms House is a place to be avoided,…..we may safely say that those who are there are very much better cared for, and in most instances are more contented and happier than they would be elsewhere, and in every way better situated than many of those who are assisted by the Overseer of the several towns."

> First report of the County Commissioners of Cheshire County for the year ending April 1. 1873. Keene: Sentinel Printing Company, printers, 1873.

Number of inmates at Almshouse:

April 1, 1872:	37
Number admitted during the year:	9
	46
Number of deaths:	3
Number of children provided with homes:	5
Number of adults discharged:	2
Remaining April 1, 1873	36

This report included a fair amount of detail regarding the establishment and expenses of the Cheshire County almshouse and the mindset of the community at the time.

Each of these annual records include a table with the names, ages and descriptions of the dependent poor at the almshouse under remarks: idiotic, imbecile, ran away, died, insane, blind. Some are supported by a "guard'n" or by a town or by self or family member. Ages range from 6 mos. – a child who appears to be with siblings and a mother – to age 93. The 1890 report includes a few names of people who were listed as occupants since 1877.

Below are excerpts from subsequent Cheshire County commissioners annual reports:

> Report of County Commissioners, County Treasurer, Clerk of Courts, and Master of House of Corrections, for the County of Cheshire 1877-78. Keene: Sentinel Printing Company, book and job printers, 1878.

Almshouse:

No. of paupers at Almshouse, May 1, 1877:	54
" admitted during the year:	31
" discharged during the year:	23
" who died during the year:	6
" at Almshouse, May 1, 1878:	56

Reports of the county commissioners, county treasurer, and other officers of Cheshire County of the year ending: April 30, 1890. Keene, NH. Sentinel Printing Co. book and job printers, 1890.

"Total cost for maintaining the Almshouse Poor has been $4,902.78 and the average cost for each inmate is $1.45 per week."

Number of inmates at Almshouse, not including convicts as of May 1, 1889 is 54.

Number of persons admitted: 36

"   discharged: 13

"   deaths: 12

"   escaped: 2

May 1, 1890 =   63 residents of Almshouse

Eventually the state established an asylum for the insane and a school for orphans, located in Concord, NH. The expense of moving residents to these new locations were borne by county taxpayers:

Reports of the county commissioners, county treasurer, and other officers of Cheshire County of the year ending: April 30, 1891. Keene, NH. Sentinel Printing Co. book and job printers, 1891:

Pauper expenses at Almshouse: $5,000

Outside poor: $12,000

NH Asylum for the insane (which became the NH State Hospital): $3,500

State industrial school: $500

Total pauper expenses: $21,000.

A not inconsiderable sum for that time or now.

In 1907 the name Maplewood Home was given to the Cheshire County, NH institution, and that name was retained when the "home" became a nursing home. In addition, the prison and farm remained a part of the complex until the early 2010s when the prison was moved closer to Keene and the farm was leased to local farmers (Keene Sentinel, Jan. 28, 2011).

The excellent history and genealogy of Westmoreland, NH by the Westmoreland History

Committee (1976), is located at the Cheshire County historical society and gives additional

details about the county almshouse. Maintaining a farm meant the county commissioners had to

deal with the vicissitudes of any farmer in addition to the responsibilities of caring for people.

Some examples of early 20th century discussions, with some updated details, that arose in

Cheshire County, NH:

- Hog cholera in 1913 killed many and necessitated destroying the old pens and building new ones.
- In 1914 there were 148 inmates at the almshouse: 80 Americans, the rest foreign.
- In 1919 the county Convention Committee asked that the property be sold and the institution moved to a location available to the railroad and nearer to the center of the county (which would have been Keene, NH). That discussion does not appear to have been revisited until 1924 and then again in 2011 (Keene Sentinel, 2011, July 17). In 1924 a motion of the County Delegation to purchase land elsewhere for a new almshouse was soundly defeated and again in 2017 (Keene Sentinel, 2017, May 7) when the decision was made to upgrade the current facility instead of building a new one closer to the center of the county.
- A hospital was added in 1920 and upgrades, such as the two artesian wells drilled in 1931 to replace water from the local brook, which had been deemed unfit for drinking, were made – as well as new barns when old ones burned or were deemed too small. However, the hospital license was revoked in 1954, though no reason was given. In 1956, for the first time, no children under 12 were listed as inmates.
- 1971 was the last year in which inmates at the almshouse were identified by name. The list includes two women, aged 57 and 44, and three men, aged 86, 71 and 60. Thereafter the facility began to accept applicants based on poor health rather than dire economic need. (Westmoreland History Committee, 1976)

By the early 1990s, there was enough empirical evidence to suggest that, though there had been

improvements in care since the 1970s, nursing homes in the United States were still in need of

change. Ongoing issues of malnutrition, injuries from falls, and skin wounds were gaining

attention from the Centers for Medicare and Medicaid Services and other funding sources.

Despite the ideals articulated in the OAA, nursing homes were not a looked-forward-to part of

aging.

A typical nursing home today is set up like a hospital. There are nurses' stations on each floor, fluorescent lighting, long hallways, overhead paging speakers, set meal times, and limited food choices. Often collections of residents group around the nursing station, where they can be monitored easily and because many facilities lack common spaces with comfortable chairs and couches designed for elders with walkers and wheelchairs. New approaches have more recently been explored to address malnutrition and the attendant physical impacts, as well as the social elements of residential care. These new approaches harken back to the original objectives of the OAA.

In 1995 Dr. William Thomas, a nursing-home doctor in upstate New York, had an epiphany. He saw that the elders in his care were lonely, helpless, and bored. He wanted to change these "plagues" into a culture that is more resident-centered. Dr. Thomas developed The Eden Alternative. The Eden Alternative is a training program designed to change the day-to-day culture of nursing homes by moving to a system that is an elder-centered community of care, partly focused on bringing animals and plants into the facilities and encouraging inter-generational programs, but also using food as a central focus for each facility. (Thomas, 2004) Other similar programs, such as one at the Lyngblomsten Care Center in St. Paul, MN, (Mikelson & Johnson, 2003), and WellSpring (Miller et al., 2010) were also popping up around the country.

The Eden Alternative training program is organized by the Eden Alternative Principles – a multi-step process which "provides a framework for culture change in long-term care". (Thomas, 2004, p. 188). Several of these principles are very similar to the objectives laid out in the OAA. Eventually the Robert Wood Johnson Foundation granted funds to help erect care homes based on what Dr. Thomas called the "Green House Model". The Green House Model is a long-term

care facility designed on the principles of the Eden Alternative, rather than a traditional-style home retrofitted to the Eden Alternative model.

Green House Model nursing homes are small facilities of no more than 10 residents, with each resident in a private room with a private bathroom, and a central, shared, living room and kitchen. This is a radically different model from more typical nursing homes, where personal resources determine whether an elder lives in a private room/bath, or rooms shared by two or four people all with shared baths, and which range in size from only a few people to several hundred residents. In typical homes, common space is limited and dining facilities are centralized. These are thought of as medical institutions, where the Green House model is intended to be a lowercase "home".

Kind Dining is a nine-part training program that was begun by a graduate student who examined the meal priorities of residents and staff and saw concerns that could be addressed with new training (https://www.higherstandards.org). This training program is intended to change the way meals are thought of and served in traditional nursing homes. The executive director of the traditional nursing home in this study was introduced to the Kind Dining program at a conference and decided to bring it back to her facility. Every person who works in this facility gets the Kind Dining training directly from the executive director – emphasizing that management takes the concepts of Kind Dining seriously.

Each of these innovations will be explored more fully in the case studies that follow.

CHAPTER III

<u>Theoretical Framework</u>

The Older Americans Act was signed into law in 1965 by President Lyndon B. Johnson. The

OAA articulated a vision of what life could be like for Americans as they aged. It created a

pathway for senior centers to be built, supported the formation of congregate meals and Meals on

Wheels programs and began the process of understanding the financial implications of an aging

population on the United States economy. In 1987, because of an obvious need not envisioned in

the original Act, an ombudsman program was added to the Act (National Health Policy Forum,

2009). This advocacy program created an oversight function to aide elders and their families who

have concerns about their care facility, and assured access to a mechanism by which appropriate

state and federal agencies would know when there was less-than-good care of elders in care

homes.

There are four objectives of the 10 in the OAA that are relevant to this study. They are set out in

the Act's Declaration of Objectives for Older Americans. The Act begins with Title I: "in

keeping with the traditional American concept of the inherent dignity of the individual in our

democratic society...it is the joint and several duty and responsibility...to assist our older people

to secure equal opportunity to the full and free enjoyment of the following objectives…." which

are then listed. The four of interest here are: (2) the best possible physical and mental health

which science can make available and without regard to economic status; (6) retirement in

health, honor, dignity – after years of contribution to our economy; (9) Immediate benefit from

proven research knowledge which can sustain and improve health and happiness; (10) Freedom,

independence, and the free exercise of individual initiative in planning and managing their own lives (http://uscode.house.gov).

The OAA codified the approach that the government would take regarding elder care and set out broad general objectives. While most of the direct functions of the law are geared toward community-based programs designed to support elders in their homes, it nevertheless covers all elders in all living situations.

The OAA legislation consists of seven "titles". The first section, Title I, outlines the intent of the OAA, parts of which appear above, and which needs no funds. The remaining six sections receive funding at varying levels, with Title III receiving the highest percentage (72.9%) as it deals with the congregate and home-delivered nutrition (including Meals on Wheels), as well as family caregiver support and health promotion services. The most recent reauthorization in 2016 funded programs for three years, when it will need to be reauthorized again (Colello, Napili, & Ghavalyan, 2018).

Title VII, which has two subtitles, is the only other section of the OAA that is directly relevant to elders in residential-care facilities. Subtitle A authorizes the Long-Term Care (LTC) Ombudsman Program as well as Elder Abuse, Neglect, and Exploitation Prevention Programs and the Legal Assistance Development Program. Subtitle B focuses on the Native American Elder Rights Program and grants for state elder justice systems. "The majority of Title VII funding ($16.9 million, or 78%, in FY2019) is directed at the LTC Ombudsman Program, which investigates and resolves complaints of residents in nursing facilities, board-and-care facilities, and other adult-care homes. In FY2016, ombudsmen handled more than 199,000 resident complaints and provided almost 520,000 consultations to individuals and long-term care

facilities" (Colello et al., 2018). In overall funding, the Older Americans Act programs received a fraction of what is spent on Medicaid, with an allocation of $2.06 billion for FY 2019 (Ujvari, Fox-Grage, & Houser, 2019).

Nationally, except for Title V services (administered by the Department of Labor), all Older Americans Act programs are administered by the Administration on Aging (AOA) in the Administration for Community Living (ACL) within the Department of Health and Human Services (HHS), which also administers the CMS programs (Colello et al,, 2018). Federal law requires each state to have a "State Unit on Aging" but, as with Medicaid, reporting structures and department assignments vary by state.

Medicaid is an insurance program covering far more than elders in residential care, although the residential care component is 42% of the overall budget (Rau, 2017, June 24). The rest of the programs fund residents who meet certain income guidelines, those with disabilities, pregnant women and programs focused on Native Americans.

A complete understanding of Medicaid and Medicare is not possible in this study. However, clarity related to state and federal funding mechanisms for the poorest and most vulnerable citizens in residential care facilities is important. Covering the costs of long-term care for poor elders means that Medicaid has a very large influence on residential-care facility finances. Understanding the Medicaid funding choices made by states illuminates the choices made by residential-care facility directors and boards. Each state determines how much money it wants to spend on elder care and each facility that accepts Medicaid money must work within that amount. This brief examination of Medicaid also touches on the upcoming funding complexities as baby boomers age into the system.

Medicaid programs related to the elderly work in tandem with Older Americans Act programs, where their programs overlap. For example, Medicaid funds nursing-home care for indigent elders while the Older Americans Act funds the ombudsman program. One way to keep Medicaid costs down is to keep elders in their homes and communities rather than in long-term care, which is an overarching goal of the Older Americans Act. "While funding from the OAA is small compared with the major source of long-term care (LTC) funding from Medicaid, it provides a safety net for people who might otherwise not qualify for Medicaid financed LTC support" (Thomas & Mor, 2013).

Each state has a Medicaid director who manages certain functions per federal statutes. Primarily, "CMS requires, as a condition for receiving federal funds for Medicaid, that a single state agency be the point of administrative, financial, audit, and compliance contact for the federal government" (Alison, 2015, p. 24). Other than that specific direction and a few common eligibility standards, each state is relatively free to structure Medicaid programs as it sees fit, including reporting lines, the housing of related programs, and participation requirements. In addition, state funding mechanisms related to Medicaid vary widely between states (Alison, 2015).

Key Aspects of Current Medicaid Financing System
- The federal government and states share financial responsibility for Medicaid
  - States decide how much to spend within federal rules
  - Federal government reimburses a set share of the spending based on the state's matching rate
- Federal matching funds are an open-ended entitlement to states
  - No predetermined limits on federal matching funds
  - Medicaid spending not subject to annual appropriations process
- Matching rate system plays a vital role
  - Assures federal dollars are sent to states that need Medicaid funds
  - Creates an incentive for states to take up federal options
  - Discourages cuts in Medicaid

Fig. 1 How the Federal Government Matches States Medicaid Spending, (Wachino et al., 2004, p. 3).

"Total Medicaid benefits spending for fiscal 2018, which excludes administrative costs, was $603.2 billion, with general fund spending of $166.1 billion, other state fund spending of $67.2 billion, and federal fund spending of $369.9 billion" and touches on the lives of some 75 million residents per year in the United States (Sigritz, Cummings, Gashaw, Mazur, Wavrunek, & White, 2018 p. 52). Using the formula below, the federal government reimburses states for costs associated with Medicaid programs. The formula is designed to help states with the greater number of poor residents, somewhat at the expense of states that have fewer needs.

Medicaid's open-ended federal matching is governed by formula written in the Social Security Act, the federal law that governs the Medicaid program, among others. The rate at which the federal government matches a state's Medicaid spending for services is the Federal Medical Assistance Percentage, or FMAP. Each state's FMAP is determined by the following statutory formula:

$$1 - \left[\left(\frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2} \right) * 0.45 \right]$$

Under this formula, a state's federal Medicaid matching rate is based on the ratio of its per capita income, squared, to the average per capita income of all states, squared. States with per capita incomes above the national average receive a lower federal matching percentage; states with per capita incomes below the national average receive higher percentages. A state with average per capita income will have an FMAP of 55 percent.

Fig. 2 Medicaid funding formula (Wachino, Schneider, & Rousseau 2004, p. 27).)

There is no federal cap on spending on Medicaid programs. Using the above formula, states know what percentage of their program costs will be recouped, which is by statute no less than 50% and no more than 83% (Wachino et al., 2004, p. 27). However, "[t]he FMAP formula does not apply to administrative costs. While federal matching payments for these costs, like those for the costs of covered services, are open-ended, the matching rates vary by function, not by state. The basic federal matching rate for Medicaid administrative costs is 50% in all states. The costs

of some administrative activities, such as survey and certification of nursing facilities and fraud investigations and prosecutions, are matched at higher rates" (Wachino et al., 2004, p. 28). The Medicaid budget is the first or second leading general-fund expense in many states, usually vying with K-12 education for that position. In "FY 2010, when the Affordable Care Act (ACA) was passed, Medicaid had grown to become the largest centrally administered public program in at least 40 states and was a top-three budgetary obligation in 41 out of 50 states. Since 1987, it has grown from comprising 10% of state budgets to comprising 25% in 2013. At the national level, Medicaid [is] on a path to command 9.5% of the federal budget by 2025 and [is] already the largest jointly funded federal/state program in the history of American federalism" (Alison, 2015, p. 5).

The passage of the Affordable Care Act (ACA) impacted Medicaid mostly through changes to programs for poor families and individuals. States could opt for a Medicaid waiver, which allows them, for example, to enroll new members through private insurance and pay the premiums with Medicaid money. In New Hampshire there are several waiver programs. A program called "Choices for Independence" is the elder-related Medicaid waiver. This program is designed to support elders in the community or in residential care facilities that are not skilled nursing facilities, if it costs no more than 80% of what similar services would cost in a nursing home. (Caring LLC., 2019).

States may vary their waivers or eligibility guidelines if they meet the related statutory requirements. Affordable Care Act (ACA) related waivers are still in flux; New Hampshire and several states are proposing work requirements for anyone enrolled in Medicaid through an expanded Medicaid program. A recent court ruling has halted the proposed work requirement

implementation in Arkansas. This will also have an impact on other states, like New Hampshire, that are attempting similar program changes (Goodnough, March 27, 2019).

The National Association of State Business Officers (NASBO) produces a report every three years that examines state budgets using six metrics. One of those metrics is Medicaid spending. This report tracks trends and helps make sense of state budget variability. "Funding for the state (often referred to as the nonfederal) share of Medicaid comes from a variety of sources. By law, at least 40 percent must be financed by the state and up to 60 percent may come from local governments. Medicaid's share of state budgets varies across states and differs substantially depending on how it is measured" (MACPAC, 2017). The NASBO analysis (Fig. 3) shows that the portion of the budget in each state that pays for Medicaid is increasing steadily, while state spending on areas such as education is growing much more slowly.

TABLE 5
STATE SPENDING BY FUNCTION AS A PERCENT OF TOTAL STATE EXPENDITURES, FISCAL 2014

Region/State	Elementary & Secondary Education	Higher Education	Public Assistance	Medicaid	Corrections	Transportation	All Other	Total
NEW ENGLAND								
Connecticut	14.2 %	10.6 %	1.3 %	23.2 %	2.6 %	9.5 %	38.6 %	100.0 %
Maine	17.0	3.5	2.1	34.4	2.0	7.8	33.2	100.0
Massachusetts	12.0	10.4	2.2	21.4	2.4	7.7	44.0	100.0
New Hampshire	22.2	2.5	1.5	26.8	2.0	9.8	35.2	100.0
Rhode Island	13.4	12.0	1.2	24.8	2.3	6.3	39.9	100.0
Vermont	31.7	1.8	2.2	26.8	2.8	10.4	24.4	100.0
MID-ATLANTIC								
Delaware	24.1	4.5	0.2	17.3	2.9	7.7	43.1	100.0
Maryland	18.8	14.4	3.6	22.5	3.9	10.5	26.3	100.0
New Jersey	23.6	7.7	0.8	22.5	3.1	9.9	32.5	100.0
New York	19.3	7.6	3.2	29.1	2.3	6.5	32.0	100.0
Pennsylvania	18.7	2.6	5.5	33.3	3.4	9.6	26.8	100.0
GREAT LAKES								
Illinois	14.6	4.1	0.3	26.1	2.4	9.3	43.1	100.0
Indiana	32.0	6.6	1.5	32.0	2.8	5.9	19.2	100.0
Michigan	26.9	4.3	0.5	27.6	4.4	7.5	28.7	100.0
Ohio	16.8	4.2	1.3	35.8	3.0	6.3	32.5	100.0
Wisconsin	16.1	14.2	0.4	18.4	2.8	6.6	41.5	100.0
PLAINS								
Iowa	16.6	26.7	0.5	20.9	2.3	7.2	25.8	100.0
Kansas	25.9	17.6	0.2	22.4	2.6	11.4	19.9	100.0
Minnesota	28.2	4.4	1.5	29.8	1.5	9.5	25.1	100.0
Missouri	22.8	4.8	0.8	35.8	2.8	8.5	24.5	100.0

Fig. 3 State spending by function (Sigritz, Cummings, Mazur, Wavrunek, & White, 2015)

As the baby boomer population entering residential-care facilities increases, so will Medicaid expenses. Innovative programs and practices that help keep elders in their homes and

communities will gain importance as Medicaid budgets command ever-larger portions of state and federal government funding. More and more OAA home- and community-based programs are keeping better track of metrics, which are showing cost savings to Medicaid because OAA-funded programs support elders in ways that keep them out of more expensive skilled nursing facilities.

 Medicaid spending is large enough to shift the whole medical and medical insurance systems. The billions of dollars spent annually through Medicaid programs offer opportunities to influence the supply chain, other insurance practices, health-maintenance organizations and related activities. Although not able to be examined more closely in this work, the combination of initiatives developed through OAA programs that help keep people living in the community instead of more expensive nursing homes, along with the potential to effect change in the marketplace by leveraging the financial clout of the Medicaid budget, holds promise for developing a better care system for elders while slowing the growth of Medicaid spending.

In April of 2016, the OAA was again renewed by Congress and signed by the President (https://acl.gov/about). Collectively, the four most relevant sections of the original Act encapsulate the objectives most closely related to this study. Number 10 – the freedom, independence, and the free exercise of individual initiative in planning and managing their own lives – is where this research starts.

To better understand the impact on the residents of the innovations studied here, two theories are integrated into this discussion. With a focus on food and food-service practices, diffusion theory is used to look at facility-implemented innovations and the impacts those innovations have on the satisfaction of elders as defined by Title I of the OAA. Self-efficacy theory is used to understand how the residents interact with and respond to the food-service innovations in their care facility.

These theories will frame the three related elements of interest: the impact on food and food services on current practices, related medical-care activities, and facility design.

Current residential-care facility administrators face a variety of challenges that might encourage them to seek alternatives to practices already in place. Since the early 1990s, the Centers for Medicaid and Medicare Services (CMS) have been collaborating with a wide range of stakeholders to better understand the concept of person-centered care. That language first came to be associated with elder care around 2007 and was incorporated into CMS rules in November, 2016 (Pioneer Network, 2011).

While it might seem intuitive that person-centered care would be manifest in facilities that have adopted innovative practices, particularly related to the food and food services of interest here, confusion over what person-centered care means for current elders makes it hard to recognize. Person-centered care language can be broadly defined as supporting agency and self-efficacy, but there is not a widely accepted definition and that leads to uncertainty. Studying innovative facility practices may offer an opportunity to help clarify the definition for current elders as well as offering insights into what person-centered care means to the next generation of elders. Food and food-service experiences with the increasing baby-boomer presence in residential-care facilities already indicate that person-centered care means something different for this generation. Understanding those differences will be necessary as facilities compete for their business.

Diffusion theory

New ideas rarely come out of a vacuum. From conferences, journals and interpersonal communications, residential-care facility administrators will find examples of innovative

strategies they may wish to try. At the same time, administrators will want to limit their uncertainly as they seek alternatives. "The diffusion of innovation is essentially a social process in which subjectively perceived information about a new idea is communicated. The meaning of an innovation is thus gradually worked out through a process of social construction" (Rogers 1995, p. xvii).

In addition, diffusion theory "is a conceptual paradigm with relevance for many disciplines. The multidisciplinary nature of diffusion research cuts across various scientific fields; a diffusion approach provides a common conceptual ground that bridges these divergent disciplines and methodologies" (Rogers 1995, p. 98). Residential-care facilities employ disciplines as varied as medical science, economics, political science, health science, leisure activities, and hospitality. Diffusion theory research can accommodate these multiple disciplines where other organizational and health-behavior theories do not.

Diffusion of Innovation, as noted before, is a theoretical framework developed in anthropological studies. The earliest written discussions were by European anthropological researchers. The first person known to have written about what is now called Diffusion Theory was Gabriel Tarde, a French lawyer and judge (Rogers, 1995). Not until several decades later, in 1943, was a study of hybrid corn by two young researchers, Ryan and Gross published, launching the theory in the United States (Rogers, 1995).

Previous diffusion research was sited in anthropological studies using participant observation. "This capacity of anthropologists to understand the culture of their individuals of study, coupled with their long-term data-gathering over time, proved anthropologic diffusion scholars with a unique means of understanding the consequences of innovation" (Rogers, 1995, p. 47). Ryan and

Gross used a quantitative approach to diffusion research. "The ten studies in the early sociology diffusion tradition differed from their anthropological counterparts in that they used quantitative data analysis, a methodological approach that was to be followed by most other diffusion research traditions" (Rogers, 1995, p. 52).

Since then, as diffusion research has itself diffused, communication research using a qualitative approach has been the focus. Everett Rogers (1995), a leader in understanding diffusion research methods, notes that "research on a topic like the innovation-decision process must be quite different from the variance research (quantitative) that has predominated in the diffusion field of the past" (p. 189). The return of diffusion research to the qualitative field highlights the many opportunities to use diffusion theory in research.

"Organizational reframing usually begins with a crisis that indicates that present shared understandings are no longer adequate" (Quinn & Cameron, 1988, p. 152). As we enter an era where "typical" residential-care communities may not offer the food and food services desired by their potential customers, where malnutrition is common and food waste is high, the need to understand current processes and look for examples of change, and how they spread, becomes more important. "The focus of diffusion research on tracing the spread of an innovation through a system in time and/or space has the unique quality of giving life to a behavioral change process" (Roger, 1995, p. 98).

Rogers (1995) notes that there are four main elements of diffusion, which is "a process by which an *innovation* is *communicated* through certain *channels, over time,* among the members of a *social system*" (p. 10). He goes on to say that "The heart of the diffusion process is the modeling and imitation by potential adopters of their near-peers' experiences who have previously adopted

a new idea." (p. 304). It examines the ways in which innovative ideas spread through a social system – a type of communication research. It is a "special type of communication concerned with the spread of messages that are perceived as new ideas" (Rogers, 1995, p. 10).

New ideas come into being all the time. Why some ideas and not others gain traction and flourish can be mysterious. Researchers of diffusion theory have recognized that there are common elements of ideas that have successfully diffused into the society where they are based. Prior to choosing to adopt an innovation, careful consideration needs to be given to the five attributes of innovations:

1. Relative advantage – the degree that an innovation is perceived as better than what it replaces.
2. Compatibility - The degree that an innovation is perceived as being consistent with existing values, past experiences, and needs of potential adopters.
3. Complexity – The degree that an innovation is perceived as difficult to understand and use.
4. Trialability – The degree that an innovation may be experimented with on a limited basis.
5. Observability – The degree to which the results of an innovation are visible to others. (Rogers, 1995, p. 15).

Once an idea has been adopted by thought leaders – those people who are influential to others and who typically have a wide base of connections and are considered reliable by their peers – the innovation spreads more readily. "The dependence on the experience of near peers suggests that the heart of the diffusion process consists of the modeling and imitation by potential adopters of their network partners who have adopted previously. So diffusion is a very social process." (Rogers, 1995, p. 18). There are categories for those who spread innovations: the innovators themselves, though they might not be the people who spread the innovation far and wide; early adopters; early majority; late majority; and laggards (Rogers, 1995).

Not surprisingly, the more complex an innovation is to potential adopters, the slower the rate of diffusion. The earliest adopters will have more limited access to trialability and observability, where later adopters and laggards will have more examples from which to better understand the innovation. It is also important for anyone intending to adopt an innovation to remember that there are intended and unintended consequences in any diffusion process, some more direct, desirable, and anticipated than others (Rogers, 1995).

Typical diffusion-innovation trajectories (or stages) start with the knowledge of an innovation. The innovation-decision process is an information-seeking and information-processing activity in which an individual obtains information to decrease uncertainty about the innovation. The decision maker will need to be persuaded that the innovation is worth pursuing – that it will benefit them or their organization in some way. They may see the innovation in action or hear good things from a thought leader they respect. Ultimately, they will expend resources to implement the innovation. Finally, they will receive confirmation that the innovation is an effective or ineffective innovation for them. Some innovations are adopted rapidly, particularly if the innovations are compatible with an individual's values, and if there are other adopters nearby (Rogers, 1995).

Variations on innovations are not uncommon, nor is the discontinuation of innovations due to lack of resources, lack of knowledge of the original innovation, or the inability to generalize the result of a trial to full-scale use (Rogers, 1995, p. 183). That is an important piece of understanding this research, because the innovations studied here have been adapted to fit the facilities under study.

Residents are participants in innovative practices at their facility but may not have any input into the choice or implementation of innovations. Individuals in diffusion theory are described as either change agents or potential adopters of an innovative practice. Consequently, diffusion research does not articulate the role of a residential care facility resident – the consumer – in the adopting organization. When roles are not articulated, they may not be studied.

Diffusion theory helps identify innovations and understand how they are spread and adopted. To understand the influence of an innovation on the residents, other theories need to be employed. "Changes over time are creating a mismatch or 'structural lag' in which the vast majority of people are growing older more effectually but societal institutions and practices are slow in accommodating their expanded potentials" (Bandura 2000, p. 208). Using self-efficacy theory to probe for responses to the innovation clarifies how the innovations affect residents and may help uncover deeper insights on the effectiveness the innovation has in meeting intended goals.

Self-efficacy theory

The fundamental tenet of the theory of self-efficacy is that over time a person has used mastery and vicarious experiences, plus experiencing reinforcing verbal encouragement, to develop their abilities. This gives them self-confidence to manage their life in a way that supports their understanding of who they are. To truly encourage healthy behavior, self-efficacy needs to be recognized and supported. Economist Amartya Sen in his 2001 book *Development as Freedom* notes that "Understanding the agency role is thus central to recognizing people as responsible persons: not only are we well or ill, but also we act or refuse to act, and can choose to act one way rather than another" (p. 190)

Self-efficacy is acquired as individuals learn to master skills – though a combination of having skills modeled for them, practice, and positive feedback from respected "teachers". Individuals who acquire one set of skills are more likely to have confidence in their ability to master new skills. Agency takes this all a step further. "The power to originate actions for given purposes is the key feature of personal agency…beliefs of personal efficacy constitute the key factor of human agency" (Bandura 2000, p.3). In other words, your belief in yourself gives you the personal resources to act for given purposes. Not everyone who has self-efficacy also practices agency because not everyone wants to originate actions for given purposes. A master stonemason may not want to rewrite the rules of stonemasonry, but might just want to build stone walls.

Self-efficacy does not diminish with age, although it may be practiced differently. "By weighting heavily the domains of functioning at which they excel and minimizing those they consider of lesser import, people can preserve their sense of efficacy amidst a decline of functioning in their advanced years" (Bandura 2000, p. 210). Self-efficacy theory helps fill in the gaps that diffusion theory cannot in understanding the lived experience of elders related to food and food services innovations in residential-care facilities.

Health-behavior theories comprise a suite of models focusing on human responses to behavioral interventions designed to improve health outcomes. These theories help determine which path health education and health promotion programs should take when designing interventions to behaviors. (Hayden, 2014).

What is common throughout health-behavior theories is that each seeks to explain and predict intrapersonal, or individual, behavior. Essentially, they ask what factors – such as attitudes, beliefs, motivations, past experiences – does an individual bring to the table and how do those

factors influence behaviors related to health? Bandura (1997) notes that "causal factors other

than perceived effort, task difficulty, and luck are also important in people's judgement of their

capabilities" (p. 85) and that "weighing such factors as effort, task difficulty, and circumstances

is not a matter of attributions shaping efficacy beliefs but of using efficacy-relevant information

to appraise one's personal efficacies" (p. 84). The internal dialog (or calculation), formed over

the life of the resident, is their personal knowledge of what they bring to bear to achieve

whatever action they are choosing.

Elders moving to assisted-living facilities and nursing homes carry with them all the health

behaviors and habits they acquired in their lifetimes, which will influence their attitudes and

behavior towards the care they receive. Typical facilities use a medical model of care. In such

models, some residents remain in control of their lives, or family members may have control. In

many cases a doctor or family member controls the medications, alcohol use and diet of residents

in the nursing home.

> "All too often, however, people surrender control to intermediaries in areas over
> which they do have some direct influence. They choose not to exercise direct
> control because they have not developed the means to do so, they believe others
> can do it better, or they do not want to saddle themselves with the onerous
> responsibilities that personal control entails. Part of the price of proxy control is a
> vulnerable security that rests on the competence, power, and favors of others".
> (Bandura, 1997, p. 17)

Supporting people's belief in themselves through positive social and verbal persuasion is a

powerful factor for an individual. (Hayden, 2014). "We can imagine what would happen *if* we

were to act in a certain way and can therefore consider alternative actions, which is a way of

describing agency" (Burr, 2003, p. 1194). When people contemplate potential success or failure

of their proposed endeavor, they are using the fundamental components of self-efficacy. In this

study, as shown in Table 1, self-efficacy is used to better understand how residents respond to

innovations introduced into their home, particularly related to food and food services.

Table 1 Matrix of Innovation Theory themes and their influence on Self-efficacy theory with current and upcoming populations with examples of coded resident statements

	Relief from Boredom, Loneliness and Helplessness	Imparting hospitality, respect, dignity and acceptance	Changing demographics
Employee Training N=35	But, in the end we're getting slack because they can't give you the care they should give you. And that's the way I can express it.	Yeah. It just seems to me automatic that you would cut somebody's... And cut them in small pieces knowing they can't chew big pieces. But if they cut them they cut them in chunks. And he's one of the ones that only has 6 or 7 teeth. I can chew a chunk if I have to, I may have to chew a while but…but he can't and he won't, he'll leave it on his plate.	We have two very different populations here. It's the kids coming out today and their work ethic, or lack of work ethic. The Millennials are just a really, really hard group. There just a hard group. They lack compassion, they lack motivation.
Agency N=37	At this stage I don't feel like trying something I've never tried before. I shouldn't be eating out there, but Harriet and I been sneaking it out. (laughter). You can never get a group of people, especially like we have here, to satisfy so forget it. Alright.	I think, as a whole it's a wonderful place. I love it here. I really do. There's just a few things and I know I brought a lot of it on myself by opening my mouth and complaining and getting into arguments with different ones. I have talked to somebody, social worker about it, but it all comes back to bite me in the butt. I was told she would not be transferred off this floor, that I could go to the 4th floor if I wanted to. (Laughter). How about that?	It's like, good god. when the latchkey kids come into, who knows what the environment will look like at that point. But you have to really…it will get tailored based on what they're eating habits and preferences are.
Caring for Others	And one day, she was giving Lilly a hard time. She picked on	The woman closest to her pats her arm and eventually, when her meal	

	Relief from Boredom, Loneliness and Helplessness	**Imparting hospitality, respect, dignity and acceptance**	**Changing demographics**
N=36	that Lilly like nobody's business. And one day she was picking on her and she's very rough with her, I went to see [the floor manager] and I said to her, she's being very mean and very rough with Lilly. I says, that's not fair. I say's Lilly doesn't, half of the time, she doesn't know what she is doing. I says, and she's giving her [Lilly]such a hard time and they put her on a schedule to go to the bathroom.	doesn't come soon enough, flags an aide who assures her the older woman's meal is on the way.	
Support for Self-efficacy **N=46**	While I was visiting Chantalle, the aide taking her lunch order was patient and attentive to her usual habits. Chantalle said there was a purple mug she liked to use for soup and that Carter would know it. When the aide came back, it turned out the mug was pink and the aide had searched for it and found it.	The kitchen help is very friendly . I think when they come up and bring food and you ask them for something like bananas. They are very accommodating. They generally run right back up with something if they have it. I think they want to do a good job too.	
Lack of support for Self-efficacy **N=22**	One woman asked an aid for tea and the aid said "say please". Aides commenting on Chantalle, who is a big woman, that she does not need a snack	It doesn't make any difference to what they do. They write it all down but nothing changes. We found it just doesn't make any difference.	

	Relief from Boredom, Loneliness and Helplessness	**Imparting hospitality, respect, dignity and acceptance**	**Changing demographics**
	but that she would eat everything if they "let" her. "she has no filter around food".		
Plate waste **N= 18**	The other thing is, they serve too much. Instead of letting us ask for seconds, they serve too much. And when you have to watch what you eat, you're gonna eat, if you like something, you are going to eat a hell of a lot. I mean I have cut myself down.	Less quantity. Here they give us so much food. It's really a shame. You can't help wonder where all the excess food goes. There's a lot of, most of the people up there, most of the women complain about the food quantity, they look at and it almost kinds of turns them off, because they look at it and say I can't eat all that. They think they are supposed to eat it all. Of course, ….just eat what you can, don't worry about it. But then there is all that extra food. They should maybe think about smaller quantities for us older people. And you can ask for smaller quantities, but the smaller quantities are still good sized quantities.	They are just used to a greater variety of flavors. And more choice. They are used to that. The meal, like ordering, when they go to a lot of hospitals, you just call in and order your meal. Room service. That is going to be a big shift,

Albert Bandura (1989) defines the core of self-efficacy: "central and pervasive are people's beliefs about their capabilities to exercise control over events that affect their lives" (p. 1175). This "exercise of personal agency is achieved through reflective and regulative thought, the skills at ones' command, and other tools of self influence that affect choice and support selected courses of actions". (p. 1182).

How is it possible to understand the individual self-efficacy and agency of residents in residential care facilities? A further description of agency is clarified by Bandura's interdependent causal structure, or "triadic reciprocal causation" (Fig. 4) that includes: behavior, the internal personal factors in the form of cognitive, affective, and biological events, and the external environment – all operating as interacting determinants that influence one another bi-directionally (1997). These causal factors help frame an understanding of the agentic actions of an individual.
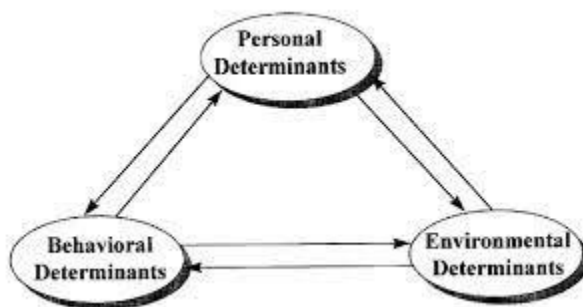

Fig. 4 Triadic reciprocal causation

Agency and self-efficacy are often used interchangeably, but they are different. A belief in self-efficacy, as noted above, is the key factor of human agency, which takes a step further to "originate actions". This research explores the influence of the innovations on the "free exercise of individual initiative (agency) in planning and managing their own lives" as called for in the OAA, particularly related to food and food services. This again hearkens back to satisfaction-with-life surveys that have found the domain of "control" to be an important part of a satisfied person's life (Ball et al., 2000; Mallers et al., 2014). Additionally, the environmental determinants will be explored; As elders move from their home to a residential-care facility, they need to adapt to a new community and redefine what community and sense of place means to them.

American economist and philosopher Martha Nussbaum, in her 2011 book *Creating Capabilities,* notes that "there is a huge moral difference between a policy that promotes health and one that promotes health capabilities – the latter, not the former, honors the person's lifestyle choices" (p. 26). By using diffusion theory, it is possible, over the 50-plus years since the OAA was signed, to see how the broad general objectives it contains have been manifested and how they have been diffused. Are we, as a country, "assisting our older people to secure equal opportunity to the full and free enjoyment of freedom, independence and the free exercise of individual initiative in planning and managing their own lives" or supporting their "health, honor and dignity" as articulated in the OAA?

Diffusion theory is used to better understand how those questions are being answered through the exploration of innovative programs and services supportive of the rights enshrined in the OAA, specifically those related to food and food services. Aristotle's' idea……"is that the job of government is to make all citizens capable of leading a flourishing life in accordance with their choices" (Nussbaum p. 128).

Securing equal opportunity to the full and free enjoyment of freedom, independence and the free exercise of individual initiative in planning and managing their own lives is one thing but taking advantage of that opportunity to *exercise* individual initiative requires more than access. The innovations represent changes brought by agential care givers, not by those who are being cared for. Instead of focusing on those change agents, resident self-efficacy and agency are explored to understand how the innovations bear on the lived experience of the elders-in-residence.

Nussbaum (2011) notes that "If people are well-nourished but not empowered to exercise practical reason and planning with regard to their health and nutrition, the situation is not fully

commensurate with human dignity: they are being taken care of in the way we take care of infants ". This reflects back on the OAA's objective six, "retirement in health, honor, dignity – after years of contribution to our economy". She further states that "even in the area of nutrition, where we might initially think satisfaction is all we want, we can see that a policy that just doles out food to people rather than giving them choice in matters of nutrition is insufficiently respectful of their freedom" (p. 56).

The innovations studied here were designed to address a variety of factors related to elder-care facility food and food services. Those factors include several universal concerns: Malnutrition is a common occurrence in nursing homes; residents complain about the quality of food, the dining experience, and other related food and food-service components; and food waste is an expensive and ongoing element in long-term care facilities (Bonnel, 1993; Evans, Crogan, Shultz, 2003; Meijers, Halfens, Wilson & Schols, 2012). The innovations are explored through direct observations, interviews of elder-care facility residents who are affected by the innovations, and document analysis.

Sense of Place

"Sense of Place: the particular experience of a person in a particular setting (feeling stimulated, excited, joyous, expansive, and so forth)." (Steele, 1981).

In *What are old people for* (2004), gerontologist Dr. William Thomas writes "Modern society has invested hundreds of billions of dollars and decades of effort in the creation and operations of placeless environments for the "frail elderly" (p. 204). He goes on to say that "while the intention of these organizations is clearly different from that of penitentiaries, they share a

common, rigid division of people into the guardians and the guarded, the therapists and the sick, the staff and the residents". (p. 205)

Moving into a residential-care facility has a variety of impacts on new residents and their sense of place. In addition to becoming a member of a whole new community, there is also a change in access to the former community that may compound feelings of loss (Cutchin, Owen & Chang, 2003).

This lack of a sense of place, the loss of habitus, submerges the elder and fails to honor the accumulated lifetime understanding of the world around them. Pierre Bourdieu used habitus to address the sociological problem of agency and structure: the habitus is shaped by structural position and generates action, thus when people act and demonstrate agency they simultaneously reflect and reproduce social structure (https://en.wikipedia.org). In an exploration of *Becoming "at home" in Assisted living residences,* Cutchin et al. (2003) note that "if an older adult is moving to assisted living, he or she needs to reintegrate the self (expressed here in the concept of place attachment as a form of identity) with a new combination of places (the residence and the community)" (p. s242).

Sidenvall (1999) explores the ethics of institutionalized culture surrounding meals that may subsume individual preferences and customs, leading to a "loss of habitus" (p. 320). She describes habitus as "something valuable that enables an individual to manage in established social contexts" such as shared meals (p. 322). The lack of attention to the individual life experiences, history, personality, opinions and preferences of a resident, compounded by institutional customs and practices, lead to "a loss of identity and hope" associated with low food intake and the possibility of malnutrition (p. 326). The research describes the need of a more

reflective culture to consider the ethical dilemma of caregivers who are confronted with the potentially opposing forces of managing mealtimes in a shared dining room and catering to the actual wishes and needs of the residents. Do the innovations support resident community and sense of place?

Although each person brings individual preferences to the table, by living in the same culture and the same county, Claude Fischler (1998) in *Food, Self and Identity* notes that "Food and cuisine are a quite central component of the sense of collective belonging" (p. 280) and that "(I)t is clear therefore that culinary systems play a part in giving a meaning to man and the universe, by situating them in relation to each other in an overall continuity and contiguity" (p. 281). In this, he is talking about food as a common denominator that joins people who eat similar foods prepared in a common way.

American poet and philosopher Wendell Berry (1995) reminds us:

> "If we can accept our world's real limits and the responsibilities that protect our authentic rights, if we can unite affection and fidelity, if we can keep instinct and light together, then (as our tradition teaches) we may hope to transcend our limits, so that our life may grow in generosity, love, grace, and beauty without end"
> (p.84)

Critical social analysis of gerontology can be used to positively view change processes related to the concepts of care in long-term care facilities. "Caring for elders requires creating conditions that allow each to engage her human potential by participating in world-construction, in the ongoing reconstitution of self and society in everyday life. ….to be the one-caring AND the cared-for is a need of all human agents and actors" (Dannefer, Stein, Siders, & Patterson, 2008, p. 106). This is another facet describing self-efficacy.

Hansen and Kuvin (2015) take the cultural significance of food and sense of place a step further in the use of traditional foods in dementia care and favorable response from residents. They found that "traditional foods created a feeling of belonging and joy" (p. 866). In their research three central subthemes were common. They were: awakening of memories and joy, improved appetite and food and reminiscence. Drawing comfort from familiar smells and tastes may be an overlooked part of establishing a sense of place for these elders.

"The biopsychosocial conception of aging highlights the adaptive capacities of older adults and their potential to enhance their level of functioning" (Bandura 2000, p. 198). Elders in residential care facilities carry with them all they have learned in their long lives. These decades of experience can be tapped to better understand the influence of innovations in their lives. This is critical because, though these elders live in "facilities" they are, in fact, "home". Engaging residents in assessing innovations can also deepen their connection – sense of place and community – to their new home.

Community

Community is a complicated concept. The Merriam-Webster on-line dictionary lists community as:

> 1. A unified body of individuals: such as:
>   a. The people with common interests living in a particular area
>   b. A group of people with a common characteristic or interests living together within a larger community.

In the era after World War 2, family groupings became more nuclear and fewer extended families lived under one roof. Postwar prosperity brought the widespread ability of Americans to be independent agents of their fate. Some of them did take care of family members, but they

themselves are relieved to not be a burden on their children. Public policies and programs such as Social Security, Medicare and Medicaid and the Older Americans Act have allowed them to live out their lives without needing to be taken in by family members.

This independence carries costs for them as they age. They need help once they can't independently manage illnesses or are unable to safely perform their Activities of Daily Living (ADLs), such as dressing, bathing and eating. If they move into a nursing home, they remain independent of their family as long as they remain cognizant, yet become dependent on a system of care over which they have little control. There are many rules and regulations related to Social Security, Medicare and Medicaid monies as well as state and federal rules which govern all aspects of care received in nursing homes.

A person moving into residential care is obliged to begin again. They must develop new relationships and navigate new environments. They must figure out where they are in the scheme of the new location. If they are to make a successful transition from their former life to their new life, they need to engage in their surroundings and determine how to acquire support for their goals. This activity towards acquiring community in their new home is strongly influenced by their self-efficacy, their belief in their own ability to successfully adapt to new experiences.

In *The Great Turning* (2011), David Korten notes:

> The distinctive human capacity for reflection and intentional choice carries a corresponding moral responsibility to care for one another and the planet. Indeed, our deepest desire is to live in loving relationships with one another. The hunger for loving families and communities is a powerful, but latent, unifying force… dedicated to creating societies that support every person in actualizing his or her highest potential (p. 18).

The loss of the ability to cook or prepare meals, the lack of access to kitchen facilities, the inability to be a "gift giver" of food are all important losses for any cook who moves into a residential care facility (Sidenvall, Nydahl & Fjellstrom, 2000). The feeling of fellowship, of participation in the world around them, is lost.

Food has other memory and meaning for elders – as a special part of celebrations (Yen, 1995), as a way to invoke memories (Hanssen & Kuven, 2015), or as a demonstration of being an integral part of the household (Costa & Jongen, 2010). Hanson and Kuvens' (2015) study notes that for those elders with memory loss, familiar smells and tastes can evoke positive reactions and higher intake of food. Sidenvall et al. (2000) found that it is not only the act of cooking that is important. The planning, preparation using fresh ingredients, serving at an attractive table, and sharing enjoyment of the meal combines to create a joyful gift. That gift anchors the giver's place in their community. Without it, they are set adrift.

Nursing homes are unintentional communities of people who often do not know each other and are mostly of a similar age. Residents hesitate to engage in building friendships for a variety of reasons, and there are few opportunities for intergenerational contact. Berry, in his book *A Turn of the Crank* (1995), writes, "There must be no institutionalized child care and homes for the aged", one of 17 tenets he has a for a better world.

His thoughts on institutions leads to questions. Why aren't there day cares inside of homes for the aged? Why aren't there more mixed-age and mixed-care opportunities? Excellent care can be given in "homes for the aged", but in our current practices, society does not seem to value the people who live there, or the people who care for our children or aged, so the levels of care are uneven. Who would be responsible for orphans, for elders who have no children or family?

Where there are homes for the aged, it is possible to afford opportunities to bring the wider world into the lives of those in care?

Those residents who can privately pay for their care have advantages, such as the ability to hire additional caregivers, eat a wider variety of foods from outside the facility, enjoy better access to the outside world and retain the ability to remove themselves from an untenable situation. They have more choices related to their community. Residents lacking those kinds of resources are more severely constrained in their access to the outside world, including their former community.

New medicines, new technology, clean water, clean air, clean food systems, and vaccinations have all increased life expectancy. One consequence is that there are a lot more very old people and they need care that they do not want – or do not have – from family. For some, that means someone to clean their house for them or having Meals on Wheels deliver lunch. For some, that means residential care – leaving their homes and moving into nursing homes – their final port of call.

In his book *Community and the Politics of Place*, Daniel Kemmis notes that "Republicanism was an intensive brand of politics; it was, heart and soul, a politics of engagement. It depended first upon people being deeply engaged with one another, and second upon citizens being directly and profoundly engaged with working out the solutions to public problems, by formulating and enacting the "common good" (p. 12). This foundation of American political thinking offers an opportunity to reflect on whether we, as a society, are currently engaged in political conversations that matter to some of our most vulnerable citizens. Formulating and enacting the

"common good" might include research into whether innovative food and food services improve the lives of institutionalized elders.

Medical models of care have shaped nursing-home care for decades. "Today's hospitals are the intensive care units of the past; nursing homes are yesterday's hospitals; assisted-living facilities are changing into nursing homes and home and community-based care are the future nursing homes". (Bernstein & Munoz, 2012, p.1269). Average life expectancy was nine years less in 1960 than it is now (World Bank, 2018) and the range of treatable conditions was much smaller. Nursing was what people who went to nursing homes needed. Yet the new aged need more than just medical care in nursing homes. They also need community.

Ethical Care

Diffusion theory gives a good framework for understanding how and why the innovations in this research are of interest to nursing home administrators. Self-efficacy theory offers a way to understand how the elders in residential care perceive and interact with the innovations. Situating those two theories in a perspective of what ethical care is – particularly without a clear definition of person-centered care – can help understand the research conclusions.

Gastman (1998) describes nursing as a profession with ethical and value-laden elements. He explores an ethical appraisal of meal services in residential-care facilities. His work examines "criteria that can be used to assess the dignity of mealtime care" (p. 235), however the resident perceives it. The basic tenet is that "caregivers must do their utmost to assure the maximal physical, social, psychological, moral and spiritual comfort of the resident" (p. 235). These dimensions work together to provide good mealtime care, grounded in an ethical framework, and

"conceived as moral practice" (p. 236). "Attention given to the quality of these daily caring duties can profoundly improve the resident's well-being" (p. 236).

There are similar terms used for variations in personal connections to food. Food agency, "is determined by an individual's acquired capacity to actively employ a broad range of learned cognitive and technical actions related to meal preparation" (Wolfson et al., in publication). Research is currently underway at the University of Vermont (UVM) and Drexel University to identify and understand how food agency influences individual actions related to food and eating when they are able to care for themselves. Food "agency" is different than food "voice".

Wylie and Nebauer (2009) explore "food voice" and the ethics of care in their discussion of chemosensory loss in elders. They suggest that facility managers and nurses routinely eat with the residents to assess the tastiness of the food and the general dining environment. If they find it tasty and residents are not eating well, it may be that resident abilities have become limited. This Australian study suggests that ethical nursing practices includes a "need for nurses to up-date their clinical knowledge, assessment skills and practice" related to chemosensory dysfunction and preventing under-nutrition (p. 27). In this way, they would have an up-to-date understanding of contemporary practices and could provide better care. Stonerook, Wolf, Bartlett and George (1999) and Hedman et al. (2015) research also recommends ongoing education and certifications of food service managers to be current in their nutrition knowledge as well as cultivating skills to serve residents better.

Listening to the food voice of elders is an ethical approach to good meal care. Mahadevan et al. (2013) more clearly define food voice as "how the participants of the study experienced their eating occasions as it relates to their perceived health and well-being" (p. 154). In part, the

residents wanted social experiences that were comfortable and safe. This approach complements the personal attention implicit in care arising from an ethical perspective and helps to define person-centered care.

<div align="center">**<u>Food waste</u>**</div>

As noted earlier, many of the current elders in residential-care facilities were raised during the Depression. Their lives were influenced by their experiences, or those of their peers, with food rationing and public campaigns by the federal government urging residents to not be wasteful. If they raised their own food, they employed food-storage techniques to get the most out of their labor and resources. Their current perspective on and reactions to food waste is colored by these early experiences. Understanding how elders, particularly elders who experienced the Depression, feel about plate waste helps better understand their approach to food and food services.

Huang and Shanklin (2008) developed a structural model to explore the reasons for plate waste. What they found was a relationship between physical constraints (poor dentition, dysphasia, etc.) and perceived service and food quality, and customer satisfaction and actual food consumption. Those with fewer constraints and those who perceived better service and better food reported greater satisfaction and generated less plate waste.

Providing food is not the same as getting people to eat. When meals are not eaten, there are a variety of associated costs related to both economics and health, and which few research reports quantify. Bannerman et al. (2015) found that elderly hospital patients in different Scottish hospitals were provided with varying amounts of food, even though there are national standards.

In all cases, patients ate an average of just 75% of the foods they were given. Grieger and Nowson (2007) saw plate waste upwards of 21%.

Australian research by Iuliano, Olden and Woods (2013) note that 75% of institutionalized elderly are malnourished or at risk of malnourishment and that the cost of that malnourishment in elder care is estimated at 10,000 € per resident. In current dollars, that totals around $11,000 per resident in the United States. They note that, on average, residents had five chronic medical conditions and were on nine long-term medications.

The costs they cite include supplements that could be replaced by a better diet, such as increasing high-fiber foods to reduce constipation, increasing vegetable and dairy intake to add heart-healthy potassium and calcium, or adding vitamins and micro nutrients to help avoid immune-system compromise. Spending money on food that is preferred – and therefore eaten – by the residents allows managers to anticipate costs, rather than juggling the unexpected spending of a health crisis brought on by malnourishment.

Meijers, Halfens, Wilson and Schols (2012) delved even more deeply into the costs associated with malnutrition in Dutch nursing homes. Essentially, they found that it is more cost-effective to keep a healthy person healthy than to restore the health of a malnourished person. In euros, regular nutritional care costs roughly is 5,329 per year, including food – but more than 10,000 per malnourished person, not including food.

The Johns, Edwards and Hartwell (2013) study compares the costs and quality of meals in a hospital and prison complex in the United Kingdom. The prison supplemented its food budget of 1.80£/per day per prisoner with food from prison gardens and farms. They were able to use the "free" labor of the prisoners and those costs are not reflected. The hospital meal costs were about

2.20£/per day per person. Together, these costs translated to between $2.25-2.73/per day. Not surprisingly, the researchers note that food provision is "under severe budgetary constraints" (p. 49). They further note that "nutritional intake is incidental to clinical concerns and is therefore approached as an afterthought" (p. 49), which seems to be reflected in the daily meal expenses.

There have been a variety of reports that explore alternative strategies for improving intake of food, through the lens of plate waste. An estimated 28 million euros in food-waste costs in British hospitals in the year 2000 comes from Williams and Walton (2011) research. While this cannot be translated into exact costs for residential-care facilities, it does show the scope of the concern. Their research also suggests a host of strategies that are applicable for any residential-care facility to reduce waste and improve nutritional outcomes.

Villarroel, Sangra, Massaguer and Codina, (2012) converted food waste into kilocalories, which helps to better understand the nutritional losses rather than just weight or volume of waste. Hartwell, Johns and Edwards (2016) explored replacing paper menus with e-menus, essentially an on-line menu, to reduce plate waste and increase satisfaction in hospitals. This practice might work well with the technologically savvy, such as baby boomers who are now entering their 70s. Whether it would be currently practical for residential-care facilities was not explored.

Regardless of the many years since the 1930s, wasting food is still seen by many of the oldest elders as morally wrong. They react to food waste as a failing either of themselves or of the facility, a waste of their monetary resources, and as an indication that changes could be made at their facility to better accommodate their own needs and those of their community. Perspectives on food waste may be very different for the next generation of elders, but for current elders, food waste holds meaning that carries a moral dimension. Understanding this perspective is an

essential part of understanding elders' responses to current food and food services experiences and related innovations.

Identifying innovations in food and food services in residential care homes using diffusion theory and exploring the experience of the elders with the innovation using self-efficacy theory situates this research in a way that can be furthered by future researchers. The research analysis uses a description of ethical care as a proxy for person-centered care. The analysis also references how community and sense of place influence the self-efficacy and agency of elders in a residential care setting. Perspectives on food waste may be very different for the next generation of elders, but for current elders, food waste holds meaning that carries a moral dimension. Understanding this perspective is essential to understanding elders' responses to current food and food services experiences and related innovations.

CHAPTER IV

Methods

Naturalistic inquiry asks for the basis of an assertion and for evidence in favor of the assertion as a means of establishing reliable methodological guidelines. The inquiry "must account for history and detail rather than permanence and generality" (Lincoln and Guba, 1985). To that end, this research used ethnographic practices of participant observation, focused interviews and document research – historical and current – to answer the research questions. Understanding research methods is the critical link between what the researcher uncovers and whether the emerging understanding is reliable and truthful.

With one exception, a literature search did not turn up residential-care facility food and food-services innovation research in the greater northeastern part of the United States. There is much more research around this topic in Great Britain, Australia, Canada and in the mid-western and western American states. The exception was Green House Model home research. Originally launched in New York State, Green House Model homes are more common in the Northeast than in other parts of the country.

Using the Green House Project web site, three Green House Model homes within 100 miles of the research office were identified. The name of each facility director was gained either through a web search or phone call. An introductory letter was sent to each facility asking for an interview with the director. One week after the letters were sent, a phone call was made to the directors asking for an interview. Two facility directors responded and there were subsequent visits to see each facility and meet the directors. After tours and discussions, the Green House that was a renovation of a previously "traditional" nursing home agreed to be a research site.

Observing a facility as it converted to the Green House model ideals was an opportunity to observe diffusion theory, with a twist, in practice.

To find another site that is a "traditional" nursing home with a food and food-services innovation, seven residential care facilities for elders within 25 miles of the research office were identified through the Medicare.gov nursing home finder tool. Preference was given to facilities that had a five-star rating from CMS. The five-star rating was used as a metric to find facilities that had met Medicare standards well, narrowing the choices to those facilities that might have the capacity to adopt innovations. Again, an introductory letter was sent to each executive director and a week later a phone call was made to the director requesting an interview. Five facilities responded to the letter-phone call combination leading to interviews with the executive directors and also, where possible, with executive chefs and cooks. After those interviews, for-profit chain-owned facilities were excluded from the study because local leaders indicated that they had limited flexibility from corporate leadership to explore innovative practices.

These visits thinned the choices to one government-owned facility with a similar number of residents to the Green House model home, and who also identified an innovative food and food services practice. A second visit with the facility director led to an agreement as a research site. Keeping the resident bed count relatively constant between cases means that staffing, food budgets and food services in general are likely to share similarities which helps limit variables that could influence the impact of an innovative practice.

Each of these facilities had food and food-service practices that could be considered positively deviant. Positive deviance is the identification and study of successful initiatives within a community, group or organization that uses tools available to all while achieving successful

positive solutions to common problems. The deviant practices under study were different at each facility and had, prior to this research, achieved varying levels of diffusion into the wider nursing-home community.

> "(T)o bridge this gap between what we know and what we do, between research and practice, we suggest leveraging the naturally-occurring positive deviance to both identify best practices in ways that are robust, credible, and to promote widespread uptake of innovations in health care organizations" (Bradley et al., 2009).

The most-cited example of positive deviance was work done in Vietnam by researchers Monica and Jerry Sternin. The Sternins noticed that some of the children in the village they were assigned to study were better nourished than others. Eventually, the research team identified families who were using commonly available edible plants and animals to supplement their children's diets – improving their health. By working with these "positively deviant" families, the Sternins were able to help diffuse this knowledge to the rest of the community, sharply reducing childhood malnutrition through means that all members of the community could readily access (https://www.youtube.com/watch?v=nqVrjym1z0g). More currently, the Bill and Melinda Gates Foundation is highlighting cases of positive deviance in its blog "Impatient Optimists" (https://www.impatientoptimists.org).

Bradley et al. (2009) discuss four steps in a positive-deviance approach. The first step is to identify "positive deviants", step two is to study the organization in depth using qualitative methods to generate hypothesis. The third step is to test the hypotheses statistically through quantitative research. The final step is to disseminate information on the "positively deviant" practice. This description seems to borrow heavily from diffusion theory practices.

Their positive deviance research discussed not only the "practices and processes present in top-performing organizations, but also the context in which they are implemented" (Bradley et al. 2009, p. 5). This approach dovetails with diffusion research; "best practices are largely viewed as providing relative advantage, being compatible with current practice, generating observable improvements and suggests the dominant mechanism for successful spread is interpersonal influence through professional and social networks as well as links to opinion leaders" (Bradley et al. 2009, p. 6). The critical difference between any innovation and a positively deviant innovation is that positive deviance uses resources common to all.

Positive deviance can be used to identify successful innovations but does not have the mechanisms diffusion theory has to identify and support the diffusion process. Searching for innovative practices that are positively deviant by definition makes them accessible to any similar facility. The high costs associated with nursing-home care and the limited money available to homes relying on Medicaid funding highlights the need for accessible innovations. Inexpensive innovations that can be shown to be successful are also likely to diffuse more broadly and more quickly than innovations requiring capital investment or large infusions of money. Partnering positively deviant innovations with diffusion theory provides a platform to understand whether or how these innovations are successful and a pathway to understand the spread of the innovation and how it has been communicated over time.

Once the facilities agreed to be a research site, Institutional Review Board (IRB) approval for human subject research was gained. IRB rules require a letter of permission from each facility director, samples of questions to be used in interviews, and examples of informed consent and recruiting materials, which all must be approved in advance of any on-site research. Interview questions for staff and residents were reviewed in advance by the director of the University

research service for clarity and to assure that they were geared toward the research questions, goals and objectives and tested at an unrelated . Per protocol, consent documents, as well as paperwork related to the IRB processes and protocols, will be kept for three years from the end of the study.

Once the research was approved another meeting with each executive director was scheduled to talk about expectations for both the researcher and the facility. The director of the Green House model under study noted that all residents sign a waiver upon admittance with the understanding that they may be included in research by the Green House Project organization or others. Many Green House models have been research sites (Thomas, 2004). The second, government-run, facility has never been a research site.

Each facility's director suggested that the most logical pairing was to schedule research visits with the activities department, which manages paperwork, protocols, training, and guidelines for volunteer activities. Researchers working in each facility would be expected to follow, at a minimum, the same basic standards as volunteers. In the Green House model, training required taking a daylong class on facility practices and understanding Alzheimer's disease, a background check, and blood work to prove an absence of tuberculosis. In the government-managed facility, there was no training per se but a written application, references and a background check were required. In addition, a daylong class was voluntarily taken on the innovative program, Kind Dining.

Participant observation was used in this study, rather than just observation. In both case studies, observing from the sidelines generated questions from staff and residents and interrupted the normal flow of activities. Consequently, this researcher asked to participate in day-to-day events

of the activities department. By participating in daily activities, the researcher became part of the background. This improved the authenticity of the observations by moving staff (and residents) from their "best" behavior to everyday behavior.

The field-study focus was specific to food and food-services activities and interactions at each facility. Dining-room activities including meal preparation, set up and break down of meals, meals in process, snack times and special food related events, were observed and recorded. In addition, data for each facility, including information about how the current food and food-service models were developed, was gathered from documents, electronic sources, historical archives, and interviews with staff and managers. The use of two contrasting sites instead of a focus on one, plus the replication of the same research format in each facility, was designed to observe the differences and similarities between them to answer the research questions and propositions (Table 2). In the end it was the differences, rather than similarities, that provided the most compelling information.

Key Themes	Green House Employee	%	Green House Resident	%	Green House Observation	Kind dining Employee	%	Kind Dining Resident	%	Kind Dining Observation
	R=3	%	R=7	%	R=22	R=2	%	R=9	%	R=25
Employee training	3	100%	3	42%	49	2	50%	2	22%	22
Support for self-efficacy	3	100%	4	57%	16	2	100%	6	66%	57
Lack of support for self-efficacy	2	66%	0	0%	12	0	0%	3	33%	11
Caring for others	2	66%	3	42%	19	0	0%	4	44%	26
Plate waste	2	66%	2	28%	6	2	100%	3	33%	5
Agency	3	100%	2	28%	21	2	100%	7	77%	15

Table 2 Key themes with number and percentage of resident, employee and observation frequency

Facilities were visited weekly or biweekly, depending on location, for seven months. Biweekly, consecutive-day visits roughly between 9 a.m. and 6 p.m. at the Green House model were employed to take advantage of the distances traveled and to use the time available most constructively. The government-managed facility visits were shorter but more frequent and were scheduled at different times of day. In each facility, a regular presence seemed to initiate a level of confidence from the staff who asked for help in serving meals when facilities were short-staffed, and residents became comfortable enough to ask for help in getting drinks and snacks. This level of interaction broke barriers in that staff and resident comments about meals and meal service, and interactions of residents with staff as well as interactions between staff and between residents, were often unguarded.

Sixteen different elders were interviewed as were five staff members from the kitchen and nutrition departments. The resident interviews were designed to address research questions aimed at understanding how food-related facility innovations were perceived by residents. Staff member interviews were designed to understand the facilities' approach to meeting the food preferences of current residents and the preferences of younger residents in short-term rehabilitation stays. Staff interviews were also used to understand day-to-day workloads including assessing and implementing changes to current elders' diets, assessments of new residents, food costs, purchasing decisions, food-related staff training and education, dining-room protocols, menu planning, religious protocols, waste management, following related state and federal rules and regulations, as well as meal preparation and serving.

The demographic characteristics were primarily people over age 65, who lived in the facility for three months or longer and were considered permanent residents, who spoke English, who ate meals that were not ground or pureed and who could answer two cognitively related questions such as "Who is the current President of the United States" and "Is there a grocery store nearby and how would I get there?". Interviewees were not provided with any incentive or compensation for their participation, other than thank-you notes.

The elders in these nursing homes are predominantly in their 80s and 90s. The average age of interviewees was 80 years old, with the two youngest at 65 and the oldest two at 95 and 96 years old. The younger residents have mobility, illness or disease concerns that limit their ability to care for themselves. At each facility, most of the elders who have the highest capabilities are housed on the same floor. Other floors are for more serious illnesses and for those needing memory care. Observations were therefore limited to the floor with the highest capabilities, in each case serving roughly 50 people – although all residents participating in facilitywide events were under observation on those occasions. Most of the residents who ate in the dining room were fed a normal diet. At the end of the observations period residents were recruited for interviews. Staff interviews were initiated in person and through emails and scheduled through phone calls and email exchanges during the month following the end of the observation period.

Once people agreed to participate, informed consent was reviewed with each interviewee. Interviewees were free to end their participation at any time. To maintain confidentiality, each participant was assigned a pseudonym and identifying information was obfuscated, such as the town they were from or a previous home they had lived in. All interviews were recorded and transcribed by the researcher; every person agreed to be recorded. Original recordings are in a secure, locked, location and will be deleted when the research is complete.

Floor managers were asked for suggestions on the best places to post signs and put up boxes for residents to use to apply to be interviewed. The managers at each facility recommended that instead of using boxes, the managers would post the recruitment flier in the dining rooms and personal requests could be made at the beginning of lunch, when most residents would be in attendance. In addition, floor managers recommended potential volunteers, which generated most of the initial interviews. During the observation period, various elders had asked about the research project. This piqued their curiosity and their interest in being interviewed and many signed up at the lunchtime solicitation period. Those initial interviewees spoke about their interview experience with their peers and that lead to snowball sampling of additional elders (Rogers, 1995).

To try to reach as many perspectives as possible, quieter residents who might have been unwilling to volunteer in a group setting but who had made comments about the food and food services during the observations were sought out and asked to become an interviewee. While this sampling design was intended to reduce sampling bias, there remains some inherent bias as those residents who have difficulty speaking, who regularly ate in their room, or who are on a diet other than "normal" were not represented. There is also almost no racial diversity as the majority of residents appear to be Caucasian. In addition, some interviewees indicated that they thought staff were "doing their best" which may have muted resident comments in sympathy for the staff. Sampling continued until a wide variety of ages was represented as well as a proportional sample of genders and no new information was being generated about the meals and mealtime experience at each facility.

Interviews were conducted in locations that were both secure for residents and private enough to not be overheard, in resident bedrooms with the door open, and in residential suites and

conference rooms. Facility-specific requirements regarding conduct with residents were followed. Interruptions by nursing staff and visitors halted interviews until they could again be private unless the interviewee wanted to continue.

There is always the possibility of risk in human subject research. Questions about either the past or present may upset elders for a variety of reasons. There were a few elders who were particularly moved by their conversations about the past but, when asked if they would like to end the interview, preferred to continue. Every state in the Northeast, except New York, has mandated-reporting laws on the abuse and neglect of incapacitated adults. I did not see any evidence of abuse, although there were circumstances when different training could have provided a more pleasant resolution and, in one instance, a floor manager was made aware of the actions of an aide who seemed overly frustrated with a resident.

Employees may also face risk when participating in research. Real or imagined, there is a possibility that there may be retaliation by supervisors, particularly if a supervisor believes that an employee spoke in less-than-glowing terms about the facility, other employees, supervisors, or facility or personnel practices. No employees indicated any concern that speaking on record would jeopardize their job. Risks to employees were minimized by careful selection of questions.

An investigation of different facilities as individual case studies was employed to understand the integration of innovative interventions intended to improve the mealtime experience of residents and their level of self-reported happiness or unhappiness in their food-related life. Each facility's food-related actions can be seen as positively deviant cases. The case-study format was used in this research for a variety of reasons. There are multiple variables that affect institutional food

and food services for elders and any one, at any time, might influence the outcome of a single research project. This research is an empirical inquiry that investigates the research questions and objectives related to meals and meal services, in depth and in context. Using a case-study format to examine these facilities and all their interventions allowed for a 360-degree view of their food and food services.

> Case study reporting mode is preferred because it is more adapted to a description of the multitude of realities encountered at any given site; because it is adaptable to demonstrating the investigator's interaction with the site and consequent biases that may result (reflexive reporting); because it provides the basis for both individual "naturalistic generalizations" and transferability to other sites (thick description); because it is suited to demonstrating the variety of mutually shaping influences present; and because it can picture the value positions of investigator, substantive theories, methodological paradigm, and local contextual value. (Lincoln & Guba, 1985, p. 42)

The case-study format allows the different histories, perspectives, and methods of implementation related to innovations at each site to be explored. The study employs a multiple-case design with embedded units of analysis, in the form of residents and staff. The research sites were in different states in the Northeast and have different service delivery styles. Financing of care has similarities and differences. Each offers a different approach to resident care, but each appears to be engaged in seeking and providing food and food service beyond the mere provision of food. Each reflects a different philosophical underpinning, from providing care to the most indigent, separated from the rest of the community by historical legacy, to an experimental redesign of "traditional" care.

None of the facilities requested anonymity in the research report. However, as much as possible, details about locations and names have been omitted, and as noted before, pseudonyms were developed for interviewees. These facilities are in the greater Northeast and have a capacity of

approximately 150 residents. One is a private not-for-profit facility and accepts Medicaid and Medicare patients, one is a government-owned facility where all beds are dually eligible for both Medicare and Medicaid. Both also provide short-term rehabilitation services funded through Medicare. The Green House model has an in-house food service and the government-managed facility uses a third-party food service. In both cases the dieticians are part time or under contract, regardless of their employer.

Interviews with elders were semi structured, with guidance questions to assure that each interview was roughly similar. The questions are in Appendix A. Interviews with staff were semi structured to address specific research aims and were informed by the research questions and propositions, as well as by the participant observations. Those questions can be found in Appendix B. Continuous data analysis during the observation period allowed for focused attention in subsequent visits and informed the interviews.

Transcripts were prepared by the researcher to assure confidentiality. Interviews are not pooled across the facilities; rather they are used to interpret the success of interventions at the given facility. Each facility generated a case study, culminating in a cross-case comparison and conclusions and the development of policy suggestions.

Triangulating is an important element of case study research (Yin, 2014). Interviewing facility personnel from the food services, in addition to elders, give different perspectives on the health and satisfaction of the residents related to food in each facility. In addition, document research on the history and context of the innovative practices and facilities offer another perspective from which to view the impact of the innovations. This convergence of evidence strengthens the construct validity of the case study and helps assure the accuracy of the findings. To further

support validity, member-checking has been performed with a subset of the original interviewees from each facility (Creswell, 2014).

Data has been analyzed and coded with NVivo 12 Plus software which was used, in part, to assist in the search for themes, phrases and words. Through the process, meaningful patterns, insights, and concepts were identified and analyzed, based on the original questions and propositions. A cross-case synthesis was used to aggregate finding across the two studies to do a meta-analysis of the data.
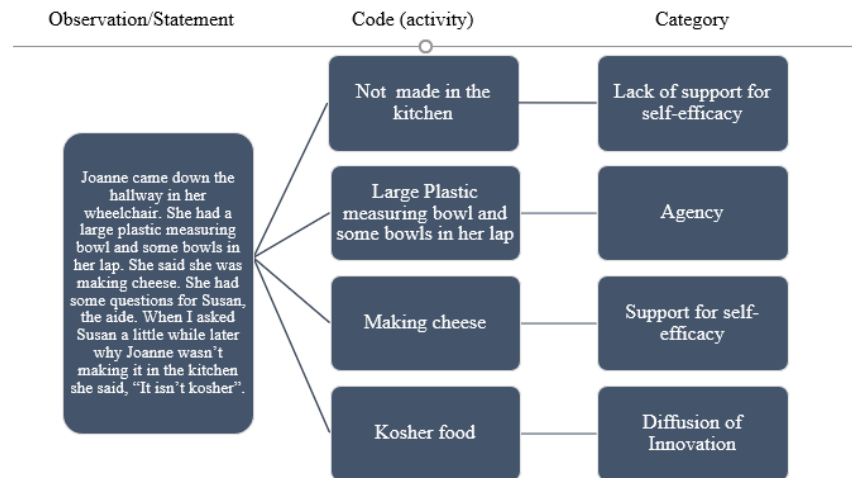

Fig. 5 Example of coding process

Codes were developed inductively (Fig. 5) and then divided into categories based in part on the questions and propositions themselves (Charmaz, 2005). Elders were asked about their gardens and farms growing up and throughout their lives. The aim of the questions was to put the elder in mind of their whole food life, not just their experiences in the facility. Initial coding was broad based to allow themes to emerge. Parent nodes were identified first. Further analysis of the data

allowed many of the categories to be subsumed by the parent nodes into child nodes,
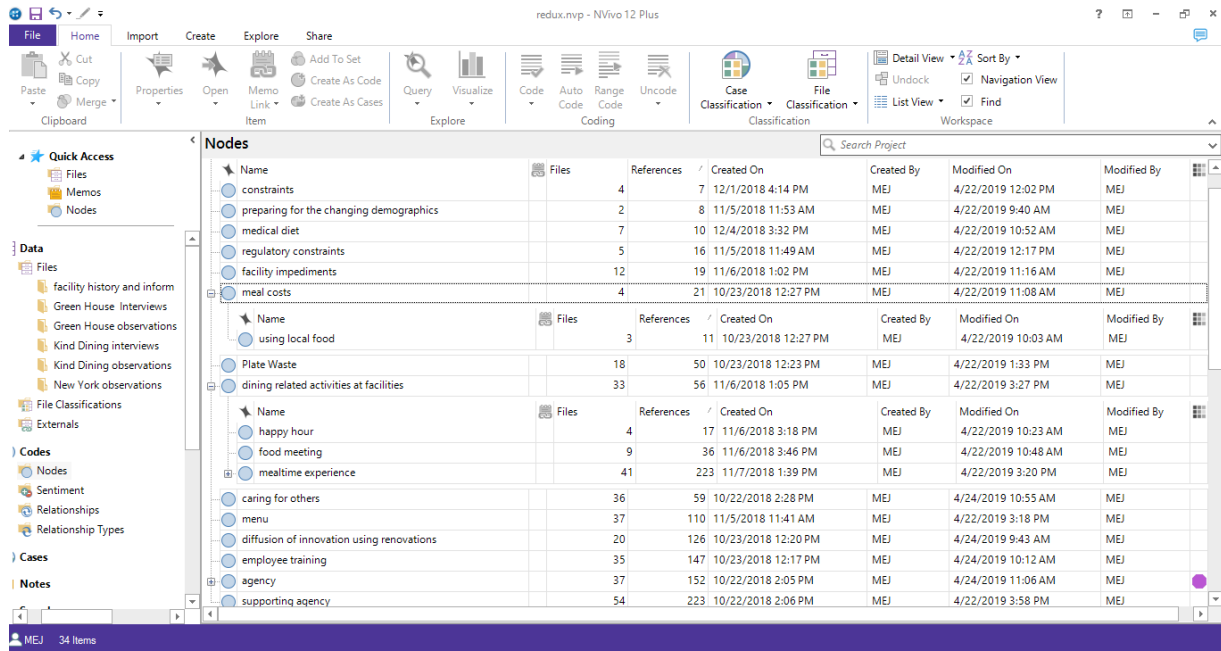
amalgamating similar themes (Fig. 6).

Fig. 6 Identifying child codes using NVivo software

NVivo software has a variety of functions that can be useful in sorting and understanding the

information. Eventually the various nodes were organized into the research goal categories.

Emerging from that was an understanding that although the parent/child nodes had clear

connections, sorting them into the research goals meant disassembling the nodes, figuratively

speaking. So, for example, while agency and safety were combined because much of the "safety"

coding related to residents feeling safer in the institution than at home, it was the only "agency"

node under "barriers and opportunities related to the innovation" for the conversation on safety

related to resident participation in meal preparation. Looking for anomalies and connections

deepened the research process.

A very useful function is the query function. It is easy to see in each node which material is coded multiple times but it is a sidebar that does not put the information into perspective. In this query (Fig. 7), viewing the intersections of coding between two nodes, and their child nodes, revealed interesting patterns warranting further review.
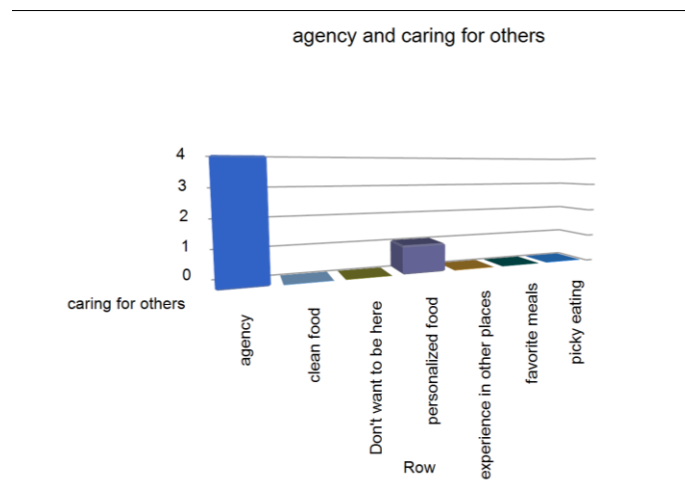

Fig. 7 Query comparing agency and caring for others

In the above graph, it is easy to see that caring for others and agency have clear intersections in the data. What was even more interesting was that personalized foods and caring for others also had a connection. These intersections helped to view and understand the data from a variety of perspectives.

The thematic coding was checked via an inter-code agreement process with two colleagues, one with a master's degree in counselling and another currently working on her master's in counselling who is also a research analyst at a nearby University Hospital (Creswell, 2014). They were asked to use four codes in their analysis – self-efficacy/agency, employee training, caring for others and food waste. They were assigned one interview and one observation from each location. Initial agreement reached only 33% which seemed very low. In discussion the

disparities came largely from a lack of clarity on the part of the researcher in defining employee training as the coders did not initially highlight examples where they thought training was lacking. In addition, examples of self-efficacy/agency from resident experiences prior to their nursing home experiences were not coded by one researcher. After review and discussion, inter-coder agreement reached 86%.

Using photographs to encourage reflection in elder interviewees was of interest in this research. Photo-elicitation projects typically ask individuals to take photographs or use pictures they find as representations of the research topic. Harper (2002) notes that photo elicitations should "be regarded as a postmodern dialogue based on the authority of the subject rather than the researcher" (p. 15). Using photos can be a way to start a conversation, search for common understanding and trigger the memory for details. In these cases, the residents were not interested in looking at photos except their own framed photos and photo albums. In some instances, their diminution of sight prohibited the use of photo elicitation. However, where possible, elders were asked to share their own scrapbooks, photo albums, and pictures with the researcher. Pictures of family were used to encourage the interviewees to talk about foods eaten across their lifetime, the attendant social roles related to meals, and their food agency. The generic scrapbook developed for the purpose, with pictures of people eating and various foods, homemade and from restaurants, including pictures of common kitchen items from the 1940s to today, was not used.

There are many rival theories for why elder residents like or dislike food and food services in care facilities (Yin, 2014). Those theories were well in mind during this research. There is no doubt that physical concerns such as chewing and swallowing issues influence any person's enjoyment of their meal; other innovations or practices might be influencing the outcomes of the

innovations of interest as well. Those rival theories – different for each facility – are discussed in each of the case studies.

The research may have larger policy implications for promoting best care in American facilities. The rapid aging of the current populace and development of new continuing-care and assisted-living retirement facilities highlight a need for innovations designed to reduce negative aspects of what has become a "traditional" care model. Those negative aspects include illnesses associated with designated elder care facilities – such as pressure sores and malnutrition – plus the boredom, loneliness, and helplessness noted by Dr. Thomas (2004). In addition, innovative practices that can help manage the ever-increasing costs associated with residential care homes will continue to gain importance as the next generation of elders ages in. This research uses the methods detailed here to examine the organizations in-depth using qualitative methods to generate hypothesis about the influences of specific innovative practices, through two case studies presented here.

CHAPTER V

KIND DINING CASE STUDY

<u>Introduction</u>

Nursing homes with high percentages of indigent residents depend on Medicaid funding to pay

the bills. The Older Americans Act was passed in 1965 as part of the "Great Society" reforms of

Lyndon B. Johnson's presidency. In that same year, Medicare and Medicaid, the health insurance

programs passed over by President Franklin D. Roosevelt when Social Security Insurance was

introduced, were also signed into law (Califano, 2015). These insurance programs for the poor,

disabled, and elderly were controversial in part because many legislators saw no way to predict

the costs for these programs – which would be funded by taxpayers (Woods, 2016). Johnson

hoped that, with Medicare and Medicaid to help support them, the combination of old age,

poverty and illness wouldn't send old folks "over the hill to the poorhouse" (Updegrove, 2012, p.

162).

The Older Americans Act laid out a plan to fund community-based elder-related programs, such

as Meals on Wheels and senior centers. Although the fundamental principles and objectives of

the OAA covered all elders, financing of elders in care homes is instead managed through

Medicare and Medicaid legislation. Medicare is an insurance program for any American over the

age of 65 who has contributed through payroll deductions. Medicare is similar to other medical

insurance programs – essentially managing the health care of elders, negotiating fees for services

with approved providers and managing payment for services. Medicaid is used for medical costs

of indigent and disabled Americans including nursing home care and personal services. The

Centers for Medicare and Medicaid Services (CMS) pays out Medicaid money to state governments as grants using a formula based on state expenditures (Figure 2). State governments then dole out money to nursing homes and other state programs for those residents who qualify. When food costs more or heating fuel gets more expensive there are few avenues available to get more money for the facilities; they must work with what they have.

There are a couple of mechanisms residents use to pay what they can for a Medicaid-approved bed (and attendant services) in a nursing home. These mechanisms vary by state, but typically this means: Any income beyond a certain limit is paid to the nursing home; a resident's long-term care insurance is used to pay for care; or a resident's Social Security income is garnished (minus the state-determined maximum spending money allowed of $50-$100 per month).

The nursing home in this study, like many others, offers a rehabilitation wing. Higher reimbursement rates for Medicare-approved services help bridge that gap between actual costs and the limited income streams for the facility. Medicaid reimbursement rates have typically been lower than Medicare reimbursement rates – 66% lower in 2008 (McGinnis, 2012). The facility in this research is a government-run facility and, in this case, local taxpayers cover the difference between the contributions from residents and CMS and the actual costs of the facility. Because this nursing home is obliged to take local indigent elders, there are few opportunities to have higher paying private-pay patients, leaving the facility on the lower end of the income-generating scale.

Despite that, in regional readers choice polls, this facility ranks second only to the most expensive assisted-living home in the region; it showed up in the 2018 US News and World

Report story on nursing homes as a recommended nursing home and has an award-winning director. How can a frugally funded, crowded, 40-year-old facility garner such good reviews?

Decentralized diffusion systems "come from local experimentation by nonexpert users. Local units decide which innovations should diffuse through horizontal networks, allowing a high degree of re-invention" (Rogers, 1995, p. 370). In this case, the local "unit" is an administrator who is willing and able to be an early adopter of an innovative program that requires little in the way of capital investment yet might help achieve the goal of person-centered care for her nursing home's residents. The frequency distribution of how an innovation diffuses (Fig. 8) is below:
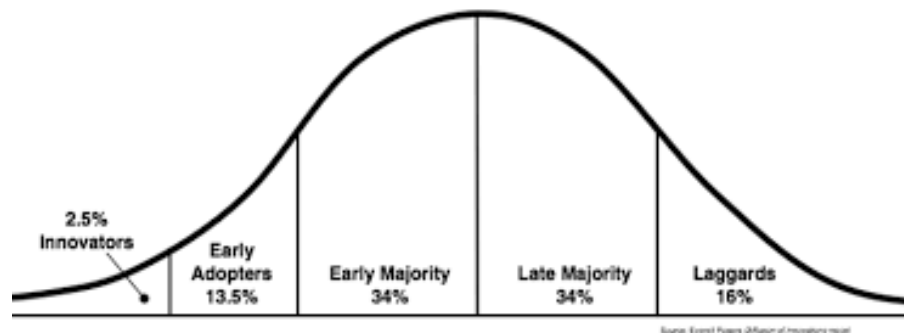

Fig. 8 Rogers, 1995, p.262

Early adopters often serve as role models for other members of their social system. They are respected by their peers and may be sought out for their opinions. Perhaps unwilling to be on the "bleeding edge" of change, they are willing to accept some risk for actions they perceive as judicious. They are usually well connected within their local community, which makes them ideally placed to diffuse ideas to their interpersonal networks. (Rogers, 1995).

The nursing home in this research has an administrator who was comfortable becoming an early adopter of a hospitality program she felt might improve the living conditions of her residents. This administrator has many of the hallmarks of an early adopter: she is well connected to her peers within the local region and she is willing to tolerate some uncertainty about outcomes but can't afford to be too risky. The innovative program adopted at this facility is intended to improve food services in residential-care facilities, but the lessons about hospitality speak directly to overall person-centered care.

Kind Dining® was developed by dietician Cindy Heilman as part of her graduate research project towards a master's degree in nutrition and food management. Among the lessons of the Kind Dining program is the idea that a lack of staff trained in hospitality contributes to both resident and staff unhappiness at meals, which can end up costing money. Unhappiness can lead to resident and staff dissatisfaction, which can mean higher resident and staff turnover, which is expensive. In addition, there is the possibility that a poor mealtime experience leads to more food wasted, yet another expense (Johns, Edwards & Hartwell, 2013).

Heilman worked in restaurants, nursing homes and assisted-living facilities, and as a health-care specialist for a large food distribution company before founding the Kind Dining program, which was designed to investigate the influence of staff on the residents' dining experience. The form and intended meaning for the program's central idea is that educating and training servers and staff would return significant mutual benefits for residents, servers and providers. Functionally, "The foundation of Kind Dining training is rooted in teaching relational principles around authentic hospitality and treating others with acceptance, respect and dignity. These principles apply to any culture change model and size of organization that serve meals"

(http://www.higherstandards.org). Both the intent and the language in this training program reflects the objectives of the OAA.

Kind Dining was developed in collaboration with expert staff and with resource support from three prominent Continuing Care Communities in Oregon beginning in 2007 (http://www.higherstandards.org). Heilman speaks regularly at conferences and her CV lists her participation in national dietician related organizations. There are connections between Higher Standards, LLC, which is the name of the organization that publishes the Kind Dining program, and the 2011 New Dining Practice Standards publication of the Pioneer Network.

The Pioneer Network is a not-for-profit organization with the goal of "changing the culture of aging". It was founded in 1997 by a group of nursing-home administrators, and one original member was Dr. William Thomas of the Green House model (http://www.pioneernetwork.net). It is not altogether surprising that the Green House model and the Kind Dining program have a link through the Pioneer Network, as this elder-care culture-change organization has been holding conferences and regularly speaking at elder-care related events since its inception.

There appears to be no published research on the Kind Dining program. There is anecdotal information on the Kind Dining website about numbers of workers trained, and reviews of both the training and the resulting changes from a variety of facilities. There is an opportunity for further research on whether the stated goals of the program are being attained in practice, and whether Kind Dining exerts any influence on "person-centered" care metrics. This case study will begin an exploration of how relevant objectives of the Older Americans Act are being diffused through the inexpensive-to-implement Kind Dining program in a government-funded

elder-care facility with limited funds, and how the diffusion of an innovation related to these objectives are perceived by the elders who live there.

Background

This four-story nursing home was built in the 1970s. The facility is the successor of the local almshouses and is obligated to take the most indigent elderly residents of the county. There is a two-story assisted-living wing in the front of the nursing home, built in 1999. See Appendix C for a building floor plan.

The ground floor of the nursing home and the assisted-living wing house their respective reception desks and waiting areas plus offices, a conference room, the rehabilitation/therapy services rooms, storage and other maintenance support space. The ground floor is partly built into a hill, so entrance from the back of the building and the employee parking lot is into the first floor. The first floor includes the kitchens and attendant services, a hair salon, a few offices, the staff dining room, laundry rooms, and a repair and servicing room for wheelchairs, walkers and other adaptive equipment. There is also a long room with two moveable dividers used for meetings and activities, and a large suite of rooms used by the activities staff, which includes a full kitchen. There is a small library of books, movies and puzzles in a room with large windows that has a small fairy garden with live miniature plants and whimsical ceramic creatures, along with a sink and counter, making it a good room for small meetings or family get-togethers.

The first and second floors have a solarium hallway that looks onto a large patio, accessible from the first floor. The patio has a pavilion where tables and chairs can be set up for meals or activities, or where people can be outside but sheltered from sun or rain. A wide concrete apron extends to the right from the solarium doors on the first floor around to the back of the building,

where there is a rocking swing that seats four people, a children's jungle gym, a few picnic tables, a low stone wall and access to the employee parking lot. On each side of the pavilion there are paved walkways and an additional paved path that extends from the doorway to the left, with all three paths connecting and leading to a screened gazebo that looks over farmland and forests.

There is a mix of mature deciduous trees and smaller flowering trees in the patio area, bordered by a forested edge that slopes down towards a river. There are small grassy areas around the walkways and a profusion of 2' x 4' raised garden beds that are tended by residents, with support from activities staff. Until recently, when he died, there was a long-term resident who cared for a multitude of raised beds and large pots of tomatoes and peppers he started from seed each year. This facility is not within walking distance of stores, libraries, restaurants and does not have a sidewalk to the main road.

Both the nursing home and the assisted-living wing can be accessed from the visitor parking lot, but each has its own entrance, with a reception desk and small sitting area. In the assisted-living wing, there is a small conference room on the immediate left off the entrance and access to the support functions of the building from a door to the left of the elevator. An elevator and a stairwell take visitors to the first and second floors. When the elevator opens, a long hallway to the left leads to the assisted-living apartments. To the immediate right is an office which, on the second floor, also includes the mail boxes, and more or less straight ahead is the solarium hallway leading to the nursing-home section. On the first floor, the small meeting room and the activities rooms line the right-hand side, while on the left side are floor-to-ceiling windows that create the corridor solarium. At the end of this corridor is the entrance to the patio on the left and a shorter hallway on the right, which leads to offices and to the functions listed above.

On the second floor the long solarium corridor looks down onto the patio and over the trees and hills of the surrounding area. On each floor those corridors have a pair of comfortable seats and a mix of live and fake plants. On the second floor, the hallway accessed from the solarium leads to a wing of resident rooms in the nursing home.

The three upper floors of the nursing home can be thought of as a large letter H within a box. The horizontal line of the H is a central nursing station with elevators and two small sitting areas on one side and the dining/activities room on the other side. On each floor, the vertical parts of the H are the corridors with bedrooms and bathrooms on the outside-facing walls. The inward-facing walls have similar functions on each floor – linen and other storage rooms, a large tub room, some nursing-related offices, plus stairwells.

Every bedroom has two residents, with each bathroom servicing two bedrooms, one from either side. These bedrooms are roughly 12'wide by 20' long and it is a tight squeeze, especially for residents in wheelchairs. Each resident has a small built-in closet and room for a single bed, a bureau and one or two small side tables, depending on the size of the bureau. Some people contrive to fit a reclining or rocking chair in the space as well. The beds are separated by a curtain. Many residents have their own TV, usually on the recommended TV stand. There are no refrigerators in any room and any food kept in the rooms must be shelf stable. There is one large window at the far end of each room looking out over the front or rear parking lots. This is a very rural area, so the entire complex is surrounded by trees.

The second floor of the nursing home houses elders who can still manage many of the Activities of Daily Living (ADLs) and who are cognitively alert. The third floor is split between the Therapeutic Living Center (TLC) area, which is a locked section for those with advanced

dementia or behavioral issues, and the rehabilitation wing. The fourth floor is a mix of still-able residents and those who are the most ill or incapable. At the current time, it has a census of 120 residents, although it has beds for 150.

On each floor, there is a dining room that doubles as an activities room. These rooms have a large-screen TV, a mix of round, square and rectangular dining tables depending on the floor and functions on the floor. Each floor has a small food pantry, a household-sized industrial refrigerator, and drink dispensers plus the attendant supplies of cups, creamers, sugar, etc. Each floor also has a small ice-cream freezer stocked with single-serve ice creams. At any time, residents are free to use the drink dispensers, which have juice, soda and water, the coffee and hot water urns, plus the ice-cream freezer. The exception is in the TLC behavioral unit which has stricter parameters for independent resident activities. The foyer area near the elevator on each floor has a set of shelves with real house plants and a bird cage with live birds. There are seasonally appropriate displays on the wall across from the elevators and large calendars listing monthly activities.

Across from the elevators are a row of comfortable faux leather chairs and recliners in almost constant use by the residents. Residents can almost always be found there as it is where most of the "action" happens; this space is at the intersection of most activities on any of the floors. There are additional comfortable faux leather chairs in front of the nurses' station and along the dining room wall. In a facility of shared bedrooms and limited common space these chairs also see almost constant use. There are usually residents sitting in wheelchairs or the padded chairs around the nurses' station during the day. Some are there because they are fall risks, and many are there because it offers more space and entertainment than being in their rooms. A few

residents walk the hallways daily, partly for exercise and partly for entertainment. In the warmer months, residents visit the patio and the outside walkways regularly, often on their own.

This facility is about to get an upgrade. There will be more single rooms – although one resident commented that she liked having a roommate as it made her feel safe – and more private bathrooms. There will be additional common spaces on each floor and somewhat differently equipped dining rooms which should allow staff to make a sandwich or a grilled cheese without having to call the kitchen.

The assisted-living wing, as noted before, is a two-story, rectangular wing of 20 efficiency apartments attached to the nursing home. There are five apartments on each side of a central corridor with views either of the patio or of the front parking lot and distant hills. Looking into an apartment from the doorway shows a bathroom on one side and a very large closet on the other. This short, wide, entry corridor ends in the middle of the long side of the main room. Altogether the apartments are about 500 square feet. These apartments have a kitchenette with a small fridge, dish sink and drainboard plus a small counter and a microwave, with cupboards above and below. There are no stoves or ovens. There is enough room in each apartment for a sitting area or dining table and chairs, a bed, television, book shelves and side tables. The closet has plenty of room for bureaus, a clothing rack or rod and some storage. One woman does her craft projects in this space. At the end of the hallway on each floor is a small sitting area with corner windows looking out over the grounds; there are a few comfortable chairs, houseplants, and a table where a jigsaw puzzle might be set up until it is completed.

The assisted-living wing is intended for low- or moderate-income individuals. They are mostly private pay, although there is some CMS funding through the "home and community-based care

program". This program partly supports, for example, two current residents who are in their 50s and are physically disabled. There is a schedule of limited nursing and personal care services offered as part of the monthly fees. More intensive nursing or related therapy services for assisted-living residents are paid for privately, through insurance, or through Medicare.

The assisted-living wing has its own dining rooms which are located on the solarium corridors on each floor, overlooking the patio. Meals are brought to the dining room on wheeled steel carts. These dining rooms are set up like a home kitchen. There is a refrigerator, cooktop and oven, wash sink, upper and lower cupboards and a long table that can seat 10 residents at a time. There is a small table in each dining room that always has snacks, and a whiteboard displaying the day, date and daily activities. The tables always have condiments such as salt, pepper and sweeteners. Residents keep some preferred foods and condiments, such as a personal supply of real maple syrup, in this refrigerator.

All meals for the whole facility are prepared in the production kitchen. The nursing-home meals are taken up to each floor in a steam table. At mealtimes a kitchen aide exits the elevator pushing a steam table and towing a wheeled 4-shelf stainless steel cart that has the breads, desserts, plastic tops and bottoms used to keep plates of food warm or cold, and other miscellaneous needs for each meal. They also bring up wheeled stainless-steel carriers for plates and bowls.

Because the dining room is also the activities room for each floor of the nursing home, where exercise, trivia, crafts and similar events take place, the tables and chairs are often rearranged. The activities staff tries very hard to work around meal schedules, putting the room back into the dining configuration after each event. There are usually tablecloths on the tables; real china and silverware are used.

Each floor is somewhat different. This study focuses on the activities of the second floor, where the dining room has five round tables that seat as many as six people and a long row of rectangular tables down the center of the room. The round tables are variously used for those who need assistance in eating – almost all are placed at one table – or for residents who want to sit together as a small group or who prefer not to sit at the long table. When there is a full census there are 50 people on each floor, although not everyone comes to the dining room to eat.

Usually there is the daily menu on a tri-fold card in the middle of each table. There is also salt and pepper and a paper-napkin holder in the middle of each table. Tablecloths are used for the whole day so they are often stained by the time supper is served. Some tablecloths straight from the laundry also have stains, indicating a dearth of new cloths. An hour or so before dinner (the noontime meal) and supper, a nursing or ward aide will come around with individual meal tickets, asking each resident what they would like to eat for the impending meal. Nursing aides also put tablecloths (as needed), silverware and clothing protectors on the tables before the meal.

In this facility, at this time, almost every resident appears to be Caucasian. There is one woman who was originally from Cuba. Most of the daytime staff are also Caucasian. Residents and staff generally speak English as their primary language. The staff and resident racial composition fairly accurately mimics the regional statistics. Staff wear name tags, but they are hard to read unless the reader is very close, and often the tags are clipped to a side pocket or on a lanyard.

This building has air conditioning in the dining rooms and there are a few room air conditioners, primarily in the assisted-living wing. These buildings currently lack electrical capacity for everyone to have air conditioning in their rooms. There is not a central chiller unit for the facility as a whole.

A clipboard at the visitor-volunteer-vendor sign-in station shows the number of nurses and various aide classifications scheduled on each shift of each day. On average, right now, there are 17 LNAs, two to four RNs and four LPNs on each of the two day shifts. Night shifts from 11 p.m. – 7 a.m. are more lightly staffed.

There is a robust activities department with a certified activities director. The staff is assigned two to each floor for weekly daytime activities, with lighter schedules on weekends. Staff schedules are staggered, and a few have a later shift to be able to help with evening activities – mostly musical events. These activity aides do crafts, games, cooking events, special meals on the floors and in the common rooms on the first floor, music events and outings. They help residents get to music, chapel, or other events on the first floor or patio; care for the birds on each floor and Johnny Cash, the cat who lives in the activity rooms; put together individualized Christmas bags for each resident; celebrate birthdays and do weekly one-on-one visits. Before Lily the cat died, they took care of her litter box on the second floor. They carefully track which residents come to what events and who has been visited by the staff in the weekly one-to-one visits. Several of the activity aides are also LNAs. The activities director also supervises the volunteer contingent. At last count, there were 70 volunteer name tags on the board, including two for dogs that visit regularly.

There are also environmental-services workers assigned to each floor, or partial floors, kitchen aides, speech and occupational therapists, social workers and maintenance workers who come and go on each floor. There is a person who repairs adaptive equipment. Most of the day-shift workers are women, except the maintenance crew.

There is a severe lack of LNAs in the region, which is why there are only 120 residents right now. The facility is unable to hire enough trained workers to have a full house. The executive director has organized a training program for LNAs to expand the pipeline of qualified workers. While the training is specifically for potential workers for this facility, the program is also available to anyone who would like the training. The fees to take the training vary depending on whether those enrolled agree to work here once they are licensed, or if they plan to work elsewhere (Keene Sentinel, January 8, 2019). The executive director is also part of a regional group of residential-care-home directors who regularly meet to discuss problems of common interest, and staffing is an ongoing concern. There are several colleges in the area that offer nurse-training programs, but no local programs currently train workers in the lower-skilled and lower-paying LNA jobs.

Monthly resident council meetings, attended by residents and the activities director, are off-limits to visitors and most staff. This is supposed to be an opportunity for residents to make specific complaints without fear of reprisal. At least twice, however, a social worker has spoken to a resident about a complaint aired at a resident council meeting while the resident was with a group of other residents and staff, leaving no doubt about who made which complaint.

There are quarterly food committee meetings, which until 2018 were held monthly. The dietician noted that many of the same issues were coming up in the resident council meetings, so the food meetings seemed duplicative. They did not want to eliminate the food meetings, but they reduced the number to quarterly meetings. There is an ombudsman who visits occasionally, and all residents are encouraged to attend her meeting when she is on site. The ombudsman program, which exists in every state per the OAA, is staffed mostly by trained volunteers whose job is to

advocate for elders in residential-care facilities. The ombudsman program is administered by the Administration on Aging.

At this facility, as in every CMS approved facility, residents are assessed on their activities of daily living (ADLs) when they arrive. This includes the ability to eat independently. Residents are monitored to see if they can eat a regular diet or need a mechanically ground or pureed diet. Self-determination is assessed – residents might be under a doctor's orders, they may have a family member who has been authorized by the resident to make their care decisions or they may have full control over their decision-making. This includes what foods they can eat and whether they can imbibe alcohol.

There is a document, updated daily, that is checked whenever food and drink are served here. This document gives current information to the caregivers about which diet – regular, modified or pureed – should be served and information as to whether residents have self-determination in their choices of food and drink. There are residents who are free to choose what they like, including what they will drink at the monthly happy-hour social. Others have doctor or family orders that limit or preclude alcohol use. At every observed activity related to food – and at all meals – the dietetic and activities staff have been scrupulous in checking each resident's diet type and their self-determination status.

During a happy hour last summer one resident ordered a Manhattan but was instead given a semi-representative mocktail due to his doctor's order. He drank what he was served but he also commented that it didn't taste like any Manhattan he had ever had. When I saw his obituary a few months later I wondered at the doctor who said no to alcohol for a man in his 90s. The question of quality versus quantity of life is an ongoing debate in medical care related to elders.

The main meals of the day do not feel rushed. Residents are not hurried to finish their meals. The

cleaning staff waits until most residents have left the room before coming in to clean. Tables are

cleared as residents finish their meals, but tablecloths are not stripped until everyone has left the

table. Tablecloths and clothing protectors are put into small walker-sized rolling laundry carts.

Staff are reasonably careful when putting the used dishes into the dish caddy to keep noise to a

minimum. There is food waste that seems to mostly be attributed to too-large portions although

residents identified other reasons for food waste. When one ward aide asked a resident what she

would like to eat, she asked for small amounts of everything and the dietician commented that

some residents have standing orders for small portions. Joan, one of the residents, commented:

> Here they give us so much food. It's really a shame. You can't help
> wonder where all the excess food goes. I don't know what they do with the
> extra food. There's a lot of, most of the people up there, most of the women
> complain about the food quantity, they look at and it almost kinds of turns
> them off, because they look at it and say I can't eat all that. They think they
> are supposed to eat it all. Of course, …. just eat what you can, don't worry
> about it. But then there is all that extra food. They should maybe think
> about smaller quantities for us older people.

Probably the biggest driver for the food services here is cost. At a facility with limited income

and limited access to additional income, costs are carefully managed. In interviews, several

residents commented that they could see the wasted food and wondered if reducing waste would

allow the facility to afford, for example, better cuts of meat. In typical budgets, waste

management costs and kitchen costs are separate line items that don't influence each other, so

wasted food is not accounted for in the meal costs. Residents who mentioned food waste were

concerned about what the waste represents. They have suggestions on ways to make cheap meat

tastier and more tender and ways that waste could be avoided in the dining room. Resident

Hyacinth commented:

It would be a lot better if they cooked what they needed for the day and sliced them [meats] right and people would eat a lot more of that and then, instead they try it and they can't eat it, so it gets thrown in the garbage. If they cook it, slice it correctly into thin slices, it would break up and even if they overcooked it, it wouldn't be too bad to eat, you know, it would be tender enough so that it could be eaten.

Despite crowded conditions, the very tight budget, the lack of air conditioning and the age of the facility, the executive director has recently been honored as an excellent administrator by a peer organization, and the facility received very good marks (no deficiencies) from the most recent CMS audit. It is considered the second-favorite elderly care facility in the county, behind only the most expensive private-pay assisted-living facility, according to local surveys. One of the likely reasons for that is its use of the Kind Dining program.

All staff, from environmental-service workers to nurses, are required to attend Kind Dining trainings, which are offered on an occasional basis and are led by the executive director. The training is a full-day exploration of hospitality, focused on dining services and the role that every member of the staff has in providing a dining experience that is as good as possible within the constraints of the facility. The nine modules of the training are: Making a House a Home, Feel the Change a-Comin', Making It Personal, What You Bring to the Table, Setting the Meal, The Symphony of Service, If I Only Had a Heart, Emotion Control, Don't Touch That, and Polishing Service.

The overall theme is "old-fashioned hospitality", and the Kind Dining concept came from the idea that caregivers are not necessarily "trained in the knowledge, skills and attitudes" needed to impart that hospitality (http://www.higherstandards.org). The nine modules of the training program explore the overall experience of dining. Starting from the psychology of dining, the

training discusses the physical setting, the interactions between caregivers and residents, food service safety, and the attitude the staff brings to the meals – both toward the food and toward the elders. The words dignity, appreciate, dependent, choice, listen, ethical, communication, kindness, courtesy, empathy and hygiene are used to illustrate the concepts of the training, language like that found in the OAA objectives. A difficult-to-practice but important tenet of Kind Dining is that everyone, except the residents, are guests. Hyacinth notes "The kitchen help is very friendly. I think when they come up and bring food and you ask them for something like bananas, they are very accommodating. They generally run right back up with something if they have it. I think they want to do a good job too".

The Kind Dining program tenets can be seen in practice in other ways. Non-food staff and visitors are discouraged from using the elevator from the kitchen during specifically noted meal times, posted at each floor next to the elevator. This allows the kitchen staff the opportunity to get the food to the floors without delay. This helps staff keep the temperature and texture of food at its peak and serve meals on time.

Because meal choices are made by residents between each meal time, the staff can provide good service and generate less waste. Special requests on a regular or occasional basis are accommodated within facility parameters. Plates, bowls, glasses and flatware are usually handled properly, as per the training. Dishes are cleared promptly before another dish is put down and staff wait for the majority of residents to be finished with their meal before clearing tablecloths. Staff express familiarity with the diet and preferences of at least a selection of the residents although they ask about preferences at each meal.

As the meal tickets have already been filled out by the time the steam tables arrive, meals can be quickly plated and served. With recent upgrades, the "Three Squares" electronic ticketing system now includes information such as food preferences, special requests, standing orders, likes, dislikes, and allergies for each resident at each meal. By making what needs to be sent up on each steam table more obvious to kitchen staff, the right foods arrive on the right floors in a timely fashion. One woman, for example, likes to have sliced red onions, sliced tomatoes and a few pickles every night with her evening meal. When those aren't put on the steam table, someone has to call down to the kitchen and have them sent up. The staff hopes the updated ticketing system will improve such problems.

The executive chef noted that whole unused pans of food left over from a meal are served in the staff dining room at the next meal which, by default, gives the staff a chance to experience the food the elders are eating. One kitchen aide noted that, after hiring, all kitchen staff must try samples of the pureed and ground food to learn how it tastes. In addition, cooks do a visual check of how much of each meal returns to the kitchen and make notes in the ticketing system about the returns.

During the day of what is billed as "customer service training" the Kind Dining workbook is used as a guide. Several of the staff commented during one training that the executive director was tough but fair, which they respected. By clearly advertising her approach with jangling keys and audibly clicking dress shoes, the director gives fair warning to employees that she is nearby – an interesting approach to employee management.

The complete title of the workbook is *Kind Dining - Bringing Warmth to the Table*. The focus is on encouraging the staff to understand their influence on the dining experience of the elders –

and further, the importance of the dining experience for the residents. The training manual notes that "A strong community creates a sense of belonging". This is intended to highlight the importance of dining together as an example of the concepts of community and sense of place. The manual also states that good dining experiences increase overall satisfaction with the facility, since some residents spend more than 60% of their awake time around meals. (Higher Standards, 2008, p.7).

This training included activities designed to help understand the experience of an elder. One activity was to bind together fingers and then try to open a ready-to-eat pudding cup, to simulate what it might be like for someone with limited dexterity. At a recent monthly "dining experience" one of the 94-year-old women present, Anne, spent at least a minute removing the top from a butter packet. She was offered, and refused, help. The training activity was a good example of what the dining experience is like for elders and it encouraged the staff to look for obstacles to a good dining experience. The training also included feeding each other – another worthwhile example of life as an elder with limited mobility and a limited ability to perform the activities of daily living. It is possible to forget that although some people need to be fed by hand they should still be afforded respect as fully-grown adults.

Hyacinth is originally from Minnesota. Her family owned and operated several neighborhood grocery stores. When she was 18 years old, she met and married a serviceman who brought her back to New England to live.

> HYACINTH: My dad was the butcher. I lived in Minnesota where the Hormel plant is. So we had very fresh meat. He'd get a side of beef and butcher the whole side and make fresh hamburger and beautiful steaks. So …they'd gone through the Depression and everything. I was very fortunate as far as food growing up. Then I got married and a whole different story. My husband lived off the land and they ate dandelion greens, fiddle ferns, woodchuck.

M: That's a big change.

HYACINTH: Snapping turtles, deer, venison, and that was very difficult for me.

M: In what way.

HYACINTH: The change from fresh unprocessed meat to wild meat. Woodchuck, they ate a lot of woodchuck.

M: How does woodchuck taste? What does it taste like?

HYACINTH: Dark meat on chicken. But, it isn't bad. But they'd have to soak it overnight in salt water. So my grandparents… my grandmother and my mother were excellent cooks and loved to bake and my grandmother had these six children, my mother and dad had three and everything was freshly cooked and baked and every Sunday was a big roast beef, ham, baked ham, baked chicken, and not, which I feel is a problem today, they didn't cook with a lot of spices and a lot of herbs and I think you ruin the flavor of a lot of food, especially if you don't like a lot of the spices. And especially beef, I don't think there is anything better than having a little salt and pepper, period. But, so a lot of old-fashioned cooking [is plain].

They baked their bread, cinnamon rolls, everything. And when I got married, we never bought bread. I made our bread every week, and cinnamon rolls. One year my husband's mother and I did 2,000 quarts of sauerkraut. They had 2 acres of gardens and we canned everything. So a lot of, very little frozen foods even, mostly canned. Lots of canned tomato sauce, tomatoes, and all the vegetables canned. So then when we were married we decided, I had three boys, so everybody ate quite a bit, so I made good hearty meals and we decided to, we generally got the best and got less. And once in a while had venison, when I couldn't pass it up for my husband any longer, I'd throw a venison roast in the oven. They made jams and jellies and everything. Potatoes and onion, everything. They raised chickens, got ice off the Connecticut River for the ice house.

It was quite a change for me. Cause I started working in the grocery store when I was twelve. I never did any gardening or anything. I worked from the time I was 12 until I got married. When I got here, I didn't work, I was out in the gardens all the time. Which I didn't enjoy, I didn't like gardening. I loved the cooking and baking part.

M: Did you like the canning part?

HYACINTH: Yes, I did.

M: Did you have fruit trees?

HYACINTH: I don't remember having a lot of…they got apples every fall, but they had neighbors that had different trees and blueberries, blackberries, and

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strawberries. So the neighbors all gave stuff to each other for jams and jellies and
everything.

The "six dimensions of whole care" discussed in the training include: personhood and know the person. Because there are no extant indications of the background of any resident, few people who work at the facility know the history of their residents. A half-dozen times during the observation period, longtime staff expressed surprise when casual conversation brought up knowledge and skills possessed by the people they have taken care of for years.

The remaining dimensions of whole care include choice, relationship, comfort and support. Many of the same concepts are articulated in the Older American Act objectives as well as the more recent CMS emphasis on person-centered care. One piece of the training included the following quote: "to avoid criticism, do nothing, say nothing, be nothing" (Higher Ground, 2008, p. 24). This part of the training was emphasized by the executive director, who clearly told the staff that it is okay to say and do something if, as employees, they see substandard care.

The LEARN model – Listen, Empathize, Ask questions, Restate and (implement) New behavior – is geared towards overall employee behaviors and the attitude staff bring to the job every day. Examples of cooperative, organized, flexible, smart and ethical personal characteristics are enumerated as good general practices, in addition to being good practices during meal times. There is also a section on teamwork principles. The heart of Kind Dining is communication, including a focus on differences that can be subtle – between what is actually said and the inferred subtext of words, ways of speaking and body language. A worker who is thinking "I don't want to be here," might be conveying "I don't like you," to a resident. The workbook has sections intended for participants to make personal assessments of their strongest characteristics

and develop a plan for improvement that includes goal-setting. It asks each staff member to consider how their team can help them reach personal goals.

The training includes specific instructions on setting a table properly, noting where cutlery, glasses and napkins should be set. The workbook encourages the use of a checklist and asks what obstacles are encountered and what staff members liked or disliked about setting up for a meal. Ideally the checklist includes the whole dining experience: Are tables or chairs wobbly and in need of repair; is the room clean; is there enough space between tables; is any music appropriate in style and volume? For workers preparing server stations, the workbook suggests having backup supplies, bus and linen carts nearby, and prepped foods such as salads and desserts ready. These detail-oriented steps by staffers move toward a general goal that benefits residents: "Attractive tables create the overall atmosphere and shape a diner's first impressions of a meal" (Higher Standards, 2008, p. 40). Aides learn that, if they're in the room when the meal is served, they set the tone for the meal.

The training recommends that all staff involved in the meal should know the menu ingredients of each meal. At this facility, menu ingredient lists are at the nursing stations, on the steam tables and in the employee dining room. Menus are put on each table at the beginning of the day, listing all three daily meals as well as substitutions that are always available.

Sharon grew up without a lot of money, but she has fond memories of a garden and fruit trees, a cow that provided milk and butter, and of her dad butchering and curing a pig every year. She remembers picking wild berries and canning fruits and vegetables with her mother.

> SHARON: Well we had a lot of vegetables. Of course, when we had the meat, we had the meat to go with it. We had a lot of chicken and dumplings. Mamma raised her own chickens. We had our own chickens and eggs. We were country people,

I'm telling you. I reflect back now, we had everything we needed. Mamma and Daddy provided all that. We didn't have very many sweets. Mamma would make cookies occasionally. Because back in those days we had rations, coupon rations.

M: Of course, during the end of World War 2.

SHARON: Yes, you'd get a coupon ration book for the number of people in your family. For a certain duration before they issued others. You had to make do with what you got.

M: That was for flour and sugar?

SHARON: Yes, all the staples. But we had plenty. We didn't have the best of everything. But we had, and it reflected later in life. I mean, all of us grew up healthy. Of course I'd like to have some black eyed peas cooked with bacon, I'd like to have some lima beans cooked with ham and onions. I like my onions cooked, not raw. But of course it's just a cultural difference from the north to the south and I realize that. And it's healthier for me to eat what they serve me. I don't have to like it. I do have to eat it.

Avoid engaging residents in conversations about how bad the food or food services might be, the executive director asked during Kind Dining training; instead, offer alternative foods, talk positively to residents about the meal, suggest that residents participate in the food or resident council meetings and, for example, offer to help them if they want to go further than just complaining in the moment. In an interview, one resident commented: "I did complain yesterday, and I've never complained before". "Wendy helped me".

The Kind Dining program is very specific in how a meal should be timed. Beverages should be served within the first three minutes, the first course within 10 minutes and the main course within 20 minutes. Dessert is served when the main course is finished. A whole section details how to take meal orders as in a restaurant – though here, orders are taken in advance. In this facility, as noted before, some residents have standing orders for smaller portions or for particular foods they like to eat.

Sharon is diabetic and has gained weight in her year at the facility. She was already heavy when she arrived, and the gain is a source of angst for her. Every day, she alternates between broiled fish and broiled chicken for dinner and supper, along with a vegetable and starch. She grew up in Louisiana where vegetables are cooked in lard, not water. "My suggestion would be about vegetables. Of course, down south we cook 'em with the bacon and the onions. Cut the squash up, and the zucchini or whatever and kind of sauté it and smother it down until it's soft. We don't cook it in the water and serve it in bowls of water like they do up here. Yuck, yuck. You know. Oh, God".

The staff has become accustomed to her meal choices and the chef, through the kitchen aide, regularly asks whether her meals are cooked to her liking – all person-centered actions that support the resident.

At each meal, a nursing aide works in tandem with a kitchen aide to sort tickets, making sure the "extras" or special requests are met so there is no delay getting plates from steam table to diner. It is up to the aides to keep an eye open for resident needs. Here, residents will usually put up a hand to get an aide's attention. While the Kind Dining program offers training about all aspects of the meal, the on-the-ground experience sometimes differs. At times, a resident would put up a hand to ask for something, but the aide would walk right by. Aides would often face the steam table to chat with fellow workers while waiting for plates to serve, paying little attention to the room full of people behind them.

The training goes in to some detail about actually serving a person, including a section on proper busing techniques – and suggestions on motivating residents to eat, which ends with the question

"Have I done all I can to encourage this resident to eat?" Kind Dining also suggests corrective

questions staff might ask themselves to improve dining-service procedures.

Sherri learned how to cook at the boarding school she attended. She says "Cooking wasn't my

cup of tea. I never cared for cooking. I got a lot of meals over the years. But cooking wasn't my

cup of tea. I'd rather be sewing or something like that". She continued:

> SHERRI: I never liked cooking period (laughs). I got a lot of meals and I ran a restaurant for nine years, but I still didn't care…Everyone told you what they wanted there. That was easy. But when you have to plan your own meals, that's different.
>
> M: What did you do? Did you – were you the overall manager?
>
> SHERRI: Oh yeah. I was of course the manager and cook too, head cook. Hamburgers and hot dogs and we served chicken, three-piece chicken and we served shrimp and steaks and salads and, we didn't serve too many vegetables, salad and french fries, you know, with it.
>
> M: You did that for eight years?
>
> SHERRI: Nine years I guess it was. We served homemade bread, all the time. My daughter made it. I don't think we ever served more than once or twice we served regular bread. We had homemade bread all the time for sandwiches or to go with your meal. Of course, that went over good. And donuts. I made donuts and pies. I like to make pies. I love to make pies. And I used to like to make donuts. Yeah. I have to tell you. I stayed open til,.. I wasn't open in the winter time. I stayed open until after deer season. Of course during deer season, I was the only restaurant open early in the morning for the deer hunter, you know. 5 o'clock in the morning I'd be open. I would have a crowd. It was only a small place. I would have a crowd in the morning. I had them go into my house and sit in my dining room table or the kitchen table, cause I didn't have room in the dining room. But this one time, I think there was one piece of pumpkin pie eaten out of it. Someone wanted to buy the rest of the pie. I sold it to him. And then I found it later it was put in somebody's bed at a camp. I bet there was some swearing at that. (laughs heartily)
>
> M: What gave you the idea to open the restaurant in the first place?
>
> SHERRI: Well, my husband….my husband wanted to farm. I didn't want anything to do with a farm or an animal. But anyway. We farmed, so you know who got most of the work, the kids and I. Like I told them at the book reading the other day. Finally, I said, either those GD cows go, or I go. I don't know where I'm going but

(laughs) … Well, the cows went. So, then he wanted me … he didn't want me to go and work out, driving the car, going somewhere. He wanted me home still, so we, so they decided to run a restaurant.

Clearly this is a woman who knows something about hospitality.

Kind Dining further emphasizes courtesy and friendliness, making conversation, paying attention to body language, attending to needs and wants, and practicing empathy – again all related to hospitality. Making conversation is an art that needs practice. This training acknowledges that not everyone is skilled in conversational arts and gives a variety of suggestions for starting conversations with residents or helping to facilitate conversations between residents. It also suggests a bevy of polite, courteous ways to end or bow out of a conversation.

One module delves into emotion control -- managing the wide gamut of resident emotions, including grief and anger, and suggests ways to deal with those emotions along with ways to apologize and ways of self-care for staff. Staff are reminded not to take resident emotions personally and to use the LEARN (Listen, Empathize, Ask, Restate and New Behavior) model. The training talks not only about residents but also about the impact on caregivers of caring for elders.

The handbook stresses that hospitality in a nursing home is also about caring for residents in ways that protect the freedom and dignity of elders and encourages "whole care". One statistic cited in the workbook notes that "older adults have the highest suicide rate – more than 50% higher than young people or the nation as a whole" (Higher Standards, 2008, p. 15) – hence the reminder for active listening.

The section on food safety covers the basic ServSafe rules, including how hazards like food poisoning and germs (like salmonella and E. coli) are introduced, managing "at-risk" foods, basic sanitation rules and time-and-temperature standards. The final section encourages staff to have a holistic view of the dining experience: to work as a team, to understand the management perspective, to view the experience from residents' perspective, and to better understand co-workers' strengths and weaknesses.

The appendices include suggestions of positive language useful for greeting residents and serving them, courteous words and actions, as well as reminders to avoid discussing personal issues in public and to respect the privacy of residents.

While excellent for the bottom line, expenses of $1.41 per person per meal does not support much experimentation. In addition, a centralized kitchen limits what can be offered to residents. Kitchens such as this are designed for batch, or production, cooking. They are not set up like restaurant kitchens where the elements of a meal are organized to get a meal plated and to the customer efficiently. Here, the kitchen is designed to get food efficiently into a steam table and to the floor for plating and serving. As a consequence, batch kitchens are not very flexible – they can't put out 150 individual meals a night, as a busy restaurant might do. Between the style of the kitchen and the very low cost per meal, choices and quality are limited.

> HYACINTH: Yeah. And then they'll say, if you don't like the food, have your family bring things in for you. But most of us feel we are paying for our food here and we don't want to put the added expense on our family to also bring food in, because it's so expensive. And my son doesn't want to do it and I don't want them doing it. We're only allowed $70 a month from the government. It doesn't leave a lot of money for personal items and food. I don't think it's right. A lot of people say, well you brought your kids all up and did for them. When you get to our ages, I think what all of us feel, we don't want to be dependent on our kids. We've taken care of our lives. We did what we did for them, because that's what we thought our

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life was and what we wanted. But kids today a lot of them are working two or three jobs trying to keep going and I know, most of them that I know, if they can help, they certainly do. But it's just, I know it's very different with the institutional food so I try. And you know they just say, don't run down the food and don't run down anything, but I don't say that we're running things down, we are trying to let them know what our concerns are and trying to give them ideas on how maybe still they can efficiently make some changes.

Kind Dining focuses on hospitality and this facility uses practices that support hospitality, such as asking residents an hour before mealtime what they would like to eat. This way, residents' choices are more likely to be honored even if choices are limited. Kitchen staff has time to add items to the cart, adjust the amounts of each of the main course meals, and reduce waste. During observations, it was typical to see staff checking with residents about the next meal.

An aide, with her hair piled high on her head, wearing scrubs and about 35 years old, sits down next to Joan. She asks each person at the table what they want for supper (dinner is the noontime meal here). The options are sweet sausage soup or broccoli-and-beef stir-fry with brown rice, roll, and tropical fruit for dessert. This meal also always has baked chicken or fish, various sandwiches and grilled cheese available. The aide asks what they want. Louise says she doesn't know and that she doesn't eat much. Joan reluctantly agrees to the beef stir-fry but says she wants fresh fruit, not canned fruit. The aide writes it all down on the sheets, which I can now see are individual order sheets, about the size of a large grocery store receipt. The aide also asks what each person wants to drink. Joan orders ginger ale and tea with honey, which Louise says sounds good and also orders. Anne asks for coffee. The man at the end also wants coffee.

Asking well in advance, sitting down to be on the same level as the residents and highlighting the options available was an example of the aide supporting the agency of the residents within the parameters available to her. This reflects the Kind Dining training.

Residents who have mobility often appear early in the dining room. Those who need help are

brought in from 30 minutes before the meal up to the time of serving. It is uncommon for a

resident to be brought in late. Residents largely choose where they want to sit and there is a

regular shuffling of seats. Here many of the residents like to sit at the long center table, which

seats about 20 people. Meal tickets are ready for the kitchen staff when they arrive on the floor.

> The meal slips were sorted in some way by the senior aide and placed on top of the
> steam table for Linda to use. Linda plated each request, with the aides adding fruit
> from lidded cups on the side of the steam table. Each cup lid was marked with the
> item name. One person had gluten free bread, which one aide said the resident
> preferred toasted. A couple of times an aide would ask a question and if Linda did
> not know the answer she would ask them to call the kitchen. She would not commit,
> at one point, to whether a resident was capable of eating something I did not catch,
> asking the aide to find out for sure.

The people who need help eating typically are seated all at one table. This allows one aide to

feed two people.

> Residents started arriving in the dining room at 4 p.m. It was a steady stream until
> 4:45. The aides started getting drinks for people at 4:45 and everyone was served by
> 5:05. Aides finished putting together room trays and those were delivered before
> 5:15. One of the aides burned the hot dog roll that contained a hot dog for a tray
> resident. When she was queried by another, she said that the resident liked it that
> way. I didn't hear anyone asking for substitutions. Almost all the residents ate all of
> their meal tonight. There were five aides helping with supper. Three residents ate in
> the foyer. One eats there regularly, one sometimes eats in the dining room and the
> other needs feeding help and I don't remember seeing her in the dining room
> before. There was one new resident at the meal tonight.

> One of the aides commented to the other aides that there was lemonade again in the
> dispenser. Aides were cordial and friendly with each other and with Linda (the
> kitchen aide). They did not ask why I was there. Linda did ask and I told her I was
> observing. She remembered meeting me before and that it had not been a good day
> that time. There was conversation at the long table and at the round table with Bob
> and Pixie. I did not observe any interactions at the other tables. There were

tablecloths that looked like they had been there all day, with paper place mats, bibs and silver set before dinner.

Sharon had been sitting at one end of the long table since she arrived a year ago. Two months ago, she decided to move to a round table. She is a gregarious person and seems to naturally attract people to her, although she sometimes has the opposite effect of rubbing fellow residents "the wrong way". When 96-year-old Louise moved here last spring after two falls and weight loss worried her family, Sharon befriended her. Louise lived alone for many years and is a quiet, funny person who is overwhelmed – and not altogether pleased – to be in a nursing home. When she arrived, she tucked under Sharon's wing and stayed. When Sharon sat at the long table, she had Louise on one side and Merry on the other side. Merry is a force to contend with. One day I was wearing a tee shirt with a heart in the center. She saw me, looked at my shirt and told me, loudly and in no uncertain terms, that "Just because you are wearing a heart does not mean you are a nice person". She has a reputation on the floor for making mean statements. Eventually Sharon felt she was in a tough spot; between Merry's constant negative outlook and Louise's neediness her meals were becoming an uncomfortable situation. She told the staff that she was going to move to a new table. She took Louise with her when she moved, but now she sits with a couple of people she has become friendly with and who all talk together. Staff accommodated her move, which did not appear to have any negative secondary consequences.

> And I just, it just clicked in me and I said I can't do this anymore. And that's when I moved back to the table with Bobbie and then they moved Fred back there. Now Fred is sharp as a tack. He's a real sweet, sweet guy. I like him. Of course there are limitations of the you know, conversation and disability (blindness). He knows a lot about of stuff about things I don't know about. Like ball games and stuff like that. But he and Bobbie converse a lot. They know a lot of people and she knew him [before] you know, so that works out real well. And that's what they wanted

somebody that would be able to talk with him about subjects that he knew about,
And that's good and it works out real well with him.

The next set of menus introduces a new innovation that will have a five-week rotation to see if that lessens the complaints about meal variety. The current spring-summer and fall-winter menus rotate every four weeks and get boring, according to the residents. Residents who rarely leave the facility commented in their interviews that they crave foods from their previous food lives that they never expect to eat again. The Kind Dining program does not address concerns such as variety in the menu or understanding the prior life of an individual resident and their food histories. Kind Dining shapes the dining experience for residents but is agnostic as to the food itself.

Residents bring a variety of agentic methods to managing their surroundings and holding on to their personal integrity. Sherri is a quieter example of how some people approach their nursing-home experience: "Just keep still. I lived in a dormitory enough, or I was brought up to eat what was in front of you. Shut your mouth. (Laughs) That's my theory".

Methods

This facility was chosen after a series of visits to facilities local to the researcher, as detailed in the overall methods section of this work. Convenience sampling was used determine the initial contact list and evolved into a selection after learning about the Kind Dining program and the facility's focus on food and food services. Before observations were started, the researcher had an interview with the executive director, who encouraged a connection with the activities staff both to be vetted before working in the facility and to understand facility practices. In practice, becoming a volunteer made it easier to be accepted by the staff and residents. The activities

director has all volunteers (this has never been a research site) fill out an application, a background-check form, and give three references. All the references were called. During a half-hour meeting with the activity director on the first day of research, our discussion focused on the expectations of volunteers and any visitors to the building, as well as information related to helping with events. The activities director also stressed a no-touching policy unless the resident initiates contact. In addition to the background and reference checks, attendance at a daylong training in the Kind Dining program was encouraged; it was free except for a small fee for the booklet.

Over a seven-month period weekly visits, mostly between the hours of 9 a.m. and 6:30 p.m., were made to observe and record activities related to food and food services in this government-owned elder-care facility. Residents were observed at meals, at activities, and at times in between meals. Observations were recorded after each day and analyzed using NVivo 12 Plus software. In addition, nine interviews with residents and two interviews with food-service personnel – the executive chef and the head dietician – were conducted after observations had concluded. Those interviews were recorded on a digital recorder, transcribed by this author, and analyzed using the NVivo software.

Observation practices varied with the time of day. In a place where there are few common spaces there is no good place to sit and observe – moving throughout the space gives a much more holistic view of the day-to-day activities and interactions. Time between meals was spent helping activities staff with events. Typically, that meant assisting with craft projects, serving at special meals or the monthly happy hour, helping with resident cooking projects or wheeling residents who cannot locomote on their own to music or other events. Once the staff and elders were

comfortable with my presence, requests would be made to go up and down the hallways knocking on doors and encouraging residents to participate in the varied events or to help a resident in some way.

When residents, staff and volunteers asked about me, I answered that I was a researcher interested in food and food services here, and a volunteer in the activities department. Some residents asked more specific questions, but most staff and residents were satisfied with that answer. They could see my name tag and knew I was affiliated with the activities department. Most questions came during meal observations as unfamiliar staff wondered why a volunteer was sitting adjacent to the steam table during the meal.

Residents were observed at least once during each of the daily meal times, during snack times, at activities related to food, such as during the monthly happy hour, and at specialty meals. Regular meals were observed, as noted above, from a vantage point near the steam table, where the whole room could be seen. If that corner of the room was too busy, one of the corner round tables would often have empty seats that could be used. This location was somewhat less desirable as there were usually residents at each table and they enjoyed talking, which was a distraction to observations.

There were a few occasions when staff would ask if I would bring a meal to a resident in their room. This was a good opportunity to understand the meal experience for room-bound residents or those residents who choose to eat alone. Generally, the staff encouraged residents to eat in the common dining room, but there did not appear to be any restrictions on receiving a tray meal. In addition to some residents who eat in their rooms, there is at least one woman who chooses to eat in the foyer area near the elevators. She routinely sits in a chair there and has a wheeled

table/shelf she can move in front of her when she eats. She is an outgoing and funny person but said she prefers to eat there alone rather than the dining room.

Activities that required little help, such as karaoke and trivia, allowed for unfettered observations. Nurses and aides would come and go from the dining room (the only large common space on each floor) during events, getting drinks for themselves and residents and bringing medicines and snacks for residents. In addition, therapy and social workers would come and go, sometimes collecting residents for appointments, joining in the event if they had time and inclination or following up with residents on various matters. These were opportunities to see how snack times were managed and to view the different care practices as residents were given medications. It is also possible to see the nursing station from the dining rooms and to observe staff as they worked.

Volunteers are welcome to eat in the staff dining room if they are working during a meal. There is also always cereal, bread and milk available. Meal times are staggered with those of the resident meal hours so staff helping with a meal do not miss out on the meal. This was a chance to observe employees during their breaks and to sample food being served to residents, plus a well-stocked salad bar. Generally, staff eats whatever is being served to the residents.

To recruit interviewees, this researcher developed a poster asking for volunteers, which was approved by the IRB. The poster gave residents a brief description of the project and encouraged them to put their names in a nearby box. Senior staff were asked about good locations to hang the poster and put the box. They recommended that instead of using a box, they would hang the poster on the dining room doors, invite me to give a brief description of the project and ask directly for volunteers at dinner (noontime) meals. Over a period of two days, the dinner meals

were attended and requests made for volunteers. Many people were interested. In addition, staff recommended residents who they thought would be good to interview. After initial interviews, those residents spoke with their peers and snowball sampling resulted in additional interviews. During the many observation periods, residents had become familiar with my face, which was also on the poster, and many were comfortable approaching me to schedule an interview.

Resident interviews were designed to address research questions aimed at understanding how food-related facility innovations were perceived by residents. Interviews with residents were held either in their rooms or in one of the first-floor common rooms. Interruptions by staff, residents or visitors halted interviews until privacy could be re-established. These interviews were semi-structured, with questions asked in roughly the same order and based on the propositions of the study. The interviews with elders started with questions about their childhoods – specifically whether they had had a garden growing up, whether they helped in the gardens and what crops were grown. Next-tier questions asked who had taught them to cook – if they had been taught how to cook – including whether they had learned to preserve foods grown in the garden. The final questions were about their experience at the facility. The questions had been tested at an unrelated assisted-living facility in March and April of 2018 and reviewed by the director of the University survey center. Test interviews showed that starting with questions related to the full span of their lives led residents to be more mindful of their overall food experience as they answered later questions about food and food services in their current residence. The questions are in Appendix A.

Staff interviews were used to understand day-to-day workloads including assessing and implementing changes to current elders' diets, assessments of new residents, food costs,

purchasing decisions, food-related staff training and education, dining room protocols, menu planning, religious protocols, waste management, managing state and federal rules and regulations, as well as meal preparation and serving. The questions are in Appendix B.

Two secondary coders reviewed the data coding. Eventually, after clarifying discussions, consensus of 85% was reached on coding. Member-checking was performed with three resident interviewees from the facility. They read the case study reports and were in agreement about the overall conclusions. Both actions were designed to increase the reliability of the data. In addition, results were triangulated from a combination of semi-structured interviews, participant observations and document analysis, which improved the validity of the results.

Most of the elders who live here were born just before or during the Great Depression and many of them remember Victory Gardens and food rationing. One resident remembered that she was shielded from the Depression because her father "ran his farm well" and they did not lack for anything. Encouraging residents to think about their lifelong experiences with food provided nuance and shape to their current attitudes and perspectives about the food and food services at this facility. NVivo 12 Plus software offers an easy-to-use program to help code observations and interviews. Exploring common themes and using pattern-matching helped better explicate the influence of the innovation on the facility's ability to provide satisfactory mealtime experiences for its residents and meeting its regulatory responsibilities of providing person-centered care.

<u>**Analysis and Findings**</u>

There is a constellation of innovative practices here that make it difficult to tease out the influence of the Kind Dining program. A well-managed, well-staffed, engaged and active

activities department offer at least two events every day, including weekends. Birds and plants live on each floor and a cat welcomes visitors in the activity rooms. Furry mechanical cats comfort the most memory-impaired residents by purring and moving like a sleepy cat, which seems very real to the residents. In season, the facility runs an active gardening program.

Individual residents looking for additional diversion find accommodation in a variety of ways – delivering daily newspapers, helping put together flower arrangements for the whole facility from locally donated flowers, planting vegetables and flowers in raised beds and large pots, washing flower vases in preparation for new flowers or coloring intricate patterns at a station set up in the activities area.

All these activities and arrangements give meaning and structure to the daily life of residents, and support both person-centered care and the objectives of the OAA. "By affecting [a] level of involvement in activities, a sense of personal efficacy contributes to the maintenance of cognitive functioning over the adult life span. Structural changes that expand the roles and opportunities available for older people would make it easier for them to pursue fulfilling, productive activities over their entire lifetime (Bandura 1997, p. 208). These activities also obscure the influence each innovation has on residents' satisfaction with their care at the facility.

There are differing reports on whether not-for-profit status influences willingness to be innovative (Castle, 2001; Grabowski, Elliot, Leitzell, Cohen & Zimmerman, 2014). This facility bucks trends seen in other research about who are early adopters of innovations; It is not part of a chain, is currently facing difficulties finding qualified staff and has limited private-pay residents. What this facility does have is a longtime executive director who is willing to take risks, who is

well connected to her peer network, and who has autonomy in managing her facility (Castle, 2001; Grabowski et al, 2014). In diffusion research these components describe an early adopter.

Overall, the intent of the innovative Kind Dining program dovetails with the objectives of the OAA. The maintenance of honor and dignity, the full and free enjoyment of the best possible physical and mental health, and the free exercise of individual initiative in planning and managing their own lives are all OAA goals supported by Kind Dining training. The OAA objectives also helped frame the observation and interview data. This framing led to broad categories of coding, which evolved into narrower coding that could be used to understand the influence the innovation has on care, from the resident perspective. The additional influence of the research questions and objectives also bounded the code categories. Table 3 shows the codes that were most relevant with those boundaries.

Key Themes	Kind dining	Kind Dining total number of references	Number of files per theme	Number of references per theme
	Files	References	Combined	Combined
Employee training	11	27	35	148
Support for self-efficacy	29	129	46	186
Lack of support for self-efficacy	12	24	22	39
Caring for others	19	31	36	59
Plate waste	10	26	18	50
Agency	17	67	37	152

Table 3 Key themes and number of references and files for the Kind Dining innovation

Research by Sheir, Khodyakov, Cohen, Zimmerman, and Saliba (2014) is an assessment of studies about culture change. They note that "nursing home culture change remains an evolving field" (p. S6). They also note that, though there is "clear face validity", there is not enough

information for providers to choose interventions that have proven, positive outcomes. This research is no exception. The facility has no way of knowing which, if any, of the culture change interventions in current practice here are effective. There is anecdotal evidence; there are awards for both facility and director. Until now, there has been no research at this facility. Nevertheless, the research does show emergent domains related to the impact of the Kind Dining innovation on the elders which could be turned into an analytic framework worth exploring further with quantitative research of a larger sample size. Those domains include supporting self-efficacy, lack of support for self-efficacy, agency, employee training – encompassing the mealtime experience, and personalized foods – plate waste, and caring for others. Those codes were then restructured under the research objectives (Fig. 9) which not only gave a different perspective on the individual codes, but also helped to see where previously grouped codes changed with the different perspective.

Fig. 9 Coding based on research propositions

The features of this innovation are classic: Kind Dining is relatively uncomplicated and inexpensive to adopt; it is compatible with the mission of the facility; it is simple, easy to trial and easy to observe. In addition, the features of the adopting organization are also classic: There is an internal champion; this facility regularly takes in interns and, as such, is a learning organization; and the structure supports the adoption of this innovation. (Bradley et al, 2009).

The sheer variety of innovations supported by this facility gives it many of the hallmarks of practicing positive deviance. Its funding is similar to not-for-profit facilities serving the most indigent elders and its demographics reflect the surrounding area. It doesn't have access to anything other local facilities lack, yet it gets a five-star rating from the Medicare.gov 5-star nursing-home comparison data set and, as noted before, shows up well in local reader polls and other national polls. Its residents are not only happy with their care, some even call it their "spa".

The first two steps in diffusion research of identifying – in this case a positively deviant – nursing home and conducting qualitative research have been taken. The following steps of testing the hypotheses generated by the qualitative research in larger, representative samples of organizations and then disseminating the information will not be completed in this research project and offer opportunity for further research. Those final steps relate to a fuller understanding of what role this innovation plays in the overall diffusion theory picture: alignment with the external environment such as regulators, and a dissemination strategy (Bradley et al, 2009). The presumption of diffusion research into positively deviant innovations is that the seeds for success are within the organization itself and exploration may find that these seeds are transferable to like facilities where there is interest in change.

The concepts of hospitality, respect, choice, courtesy and friendliness – all supporting resident agency and person-centered care – are practiced in the various activities offered at the facility, albeit imperfectly. The Kind Dining program reinforces those concepts. By using those concepts to set the tone of the most important activity of each day – eating – the overall approach to staff-resident interactions is established. In addition, understanding how residents use their agency in their new community to advocate for preferences related to food and food services is also a piece of providing person-centered care. "The prolongation of life underscores the need to alter social attitudes and institutional practices in ways that are conductive to healthy, productive aging" (Bandura, 1997, p. 198).

Residents are served meals they have ordered in a timely, courteous and efficient manner, for the most part. The dining room is organized to be comfortable for the residents, with tables large enough to avoid physical contact. Tables also vary, as noted earlier, with one long rectangular table surrounded by smaller round tables, allowing residents options for seating and companions. There is enough space around each table for wheelchairs and walkers to navigate comfortably. In both the Resident Council and the Food Council meetings, residents can comment on the food and food services and make suggestions and requests. There are also comment boxes outside of each dining room.

The mealtime experience seemed to be strongly influenced by the tenets of the Kind Dining program. Food arrives on time and is served at the right temperature. Residents are free to sit where they like. One of the nursing aides sorts meal tickets as the kitchen aide is setting up the steam table at each meal, while also putting together the odds and ends that each resident needs – such as toasting bread or rolls and adding syrup or other condiments. The staff uses a chart, updated daily, that gives the type of diet, restrictions and preferences of each resident. The

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kitchen staff member who plates each meal refers to the chart before giving the plate to an aide for serving. Another staff person puts together trays for those residents who are not eating in the dining room, adding the main part of the meal once the dining room patrons have been served. If there is enough staff, the tray meal tickets are interspersed with the dining room meal tickets and carried immediately to the resident. One or two staff members sit at the table where residents need help eating. Remaining staff serve the meals as they are plated.

The meals do not feel rushed. Staff do not pile plates around each resident, instead waiting for the salad or soup to be finished before serving the main meal. No one else has to wait for one resident to finish their salad, for example, before being served their meal. Plates and cups appear to be held and served properly. Residents put their hand up if they need assistance or if they feel their neighbor needs assistance. Residents who are late to the meal are accommodated without complaint and many mobile residents leave as soon as they finish their meal.

Plates and tables are cleared as parts of the meal are completed and once residents indicate they are finished. Cleaning staff typically wait until most of the residents are done with their meal before sweeping and mopping. Clothing protectors and napkins are collected in small rolling laundry carts at each meal, although tablecloths stay on the tables for the day. The steam table is packed up once all plates and trays have been served. The kitchen aide and the lead nursing aide talk about anyone who was not at the meal to determine if any residents will need to be fed later – due to medical or other appointments. The kitchen will send up a meal if necessary. Personalized foods are, within reason, accommodated and are theoretically managed through the Square Meal computer program. When all goes well, special requests arrive on the floor with the rest of the meal and are routinely distributed. When the program has a glitch, that meal is delayed for that resident until kitchen staff can respond.

Overall, the effect of the Kind Dining program on the residents is positive, but there are employee actions that indicate the need for ongoing training. Busy or careless staff might assume drink choices, for example, based on past experience and serve something different than what the resident requested for that meal. Residents who were seated first may wait for their meal the longest for no discernable reason. Sometimes a resident or a staff member might be having a bad day and show it during the meal.

Other areas of concern were also evident. Staff who touch their hair or face before taking a plate of food are not practicing good serving hygiene. Rarely are both the television and music playing at once but sometimes the aides play music loudly and not to the taste of the residents. Lights are bright fluorescent and it feels more like a cafeteria than a dining room. Some of the tablecloths are stained and unappealing even when they are clean. Glitches occur and individual meals are delayed while the kitchen sends up the necessary food.

Residents themselves also strongly influence the dining experience. Some residents and their habits and practices lead to potential problems, such as a female resident who might not want to sit at the same table as a man in a sleeveless T-shirt, or residents who eat their food noisily or cough while they eat. Supporting each individual resident – person-centered care – is tricky to accomplish in an involuntary community with a wide variety of backgrounds, habits and expectations. There is a balancing act between differing perspectives that must be maintained by everyone for there to be relative harmony. "Indeed, the combined findings suggest a bidirectional relationship between efficacy belief and social support: A strong sense of social efficacy facilitates development of socially supportive relationships, and social support, in turn, enhances perceived efficiency" (Bandura, 1997, p. 206).

Many of the residents who were interviewed have participated in food meetings and resident

meetings and have made food and food-services suggestions through the suggestion box. They

have spoken with the dietician and the nursing staff. They have used their self-efficacy to

identify concerns related to their care and agency to seek changes. They are stymied by

employee training and the limited financial resources of the facility. They are perfectly lucid in

their concerns and frustrated that what they see as simple changes are ignored. They know it

could be better – meat that isn't overcooked, vegetables that are served separately or drained

better, smaller servings – but they are willing to go only so far to push for changes.

One interviewee had me shut off the recorder whenever someone interrupted our interview

because she is concerned about retaliation from staff. Whether or not there is retaliation the fear,

for example, of having to wait to go to the bathroom or always getting the last meal or other

small indignities are enough for residents to be wary of complaining too much.

Many of these same residents also exhibit a strong caring for others. They see either people who

do not advocate for themselves or they see situations where another resident is not getting good

care.

> M: and I've noticed you advocating for other residents too. What would
> you change to make their lives better, if you could around the food
> particularly, or food services.
>
> SHARON: Well, of course, their ability to relate their own needs would
> really be the biggest determining factor and if they can't be kindly enough
> to select their own meals, then somebody has got to do it for them unless
> it's prearranged by the family. I would like this, this, this for this person.

Mostly this caring for others tends to be seen in making sure that another resident is included in

events or eats their meal. Caring may just be a comforting presence or admiring a new hat or a

lovely flower bed. Sharon enjoys talking with almost everyone and she has been an advocate for her more sickly roommates. Through her agency, she has developed strong relationships with her roommates and even some of their children. However, in just over a year two of her roommates have died and she looks forward to having her own room. Not only for the privacy, but also because it is hard to experience so much death and loss of friendship. Caring for others is a complicated endeavor in elderly residential care homes.

Food waste was a topic that was frequently raised in interviews. For some the concern was that portions were too large, sometimes it was that the food was so poorly cooked – usually overdone – that no one ate it. There is a certain loss of morality that comes in to play for these residents when they leave food on their plate. They see food waste as money down the drain, money that could buy better cuts of meat. As Hyacinth commented about the choice she and her husband made: "We bought less, but better". These people lived through at least part of the Great Depression. Ration books, gardens, gleaning and farming were a part of almost everyone's childhood. No one really raised the specter of childhood hunger but one interviewee has kept, for example, from the once-a-month visit to the grocery store with the ration book to purchase staples like sugar and flour, the memory of a perfect apple eaten on the trip home.

Discussion

The study of adopters of innovations in nursing homes and how residents perceive the effects of an innovation is limited. In addition, each facility has its own characteristics that make generalizing results difficult. Leadership style, ownership type, staff characteristics and facility

limitations all influence the introduction and implementation of innovations at residential care homes and determine their opportunity for success.

Observations and interviews focused on food and food services make it possible to understand how Kind Dining innovation is diffusing several of the objectives of the Older Americans Act which align with ethical care understood as person-centered care. However, there are so many variables in play at this facility that ascribing attributes to just the one innovation risks missing the influence of other mitigating variables. By coding the materials based on the Older Americans Act objectives and the research questions, some clarity on the influence of Kind Dining emerge. Using the query function, it was possible to look at how "employee training" and "supporting agency/lack of support for agency" overlapped (Fig. 10). By looking at those specific overlaps, the influence of the Kind Dining program on the resident experience are easier to identify.
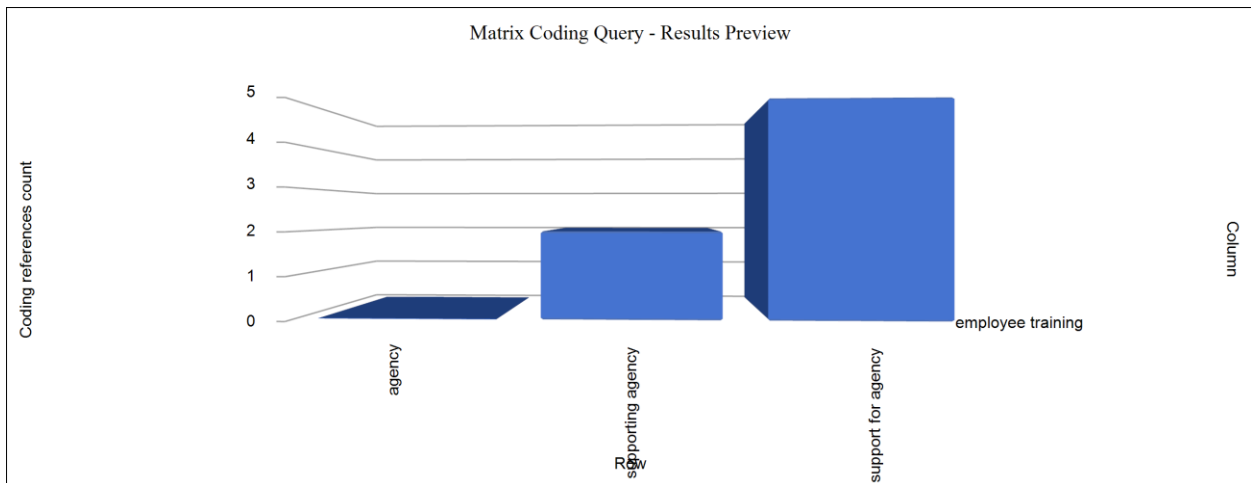

Fig. 10 Comparison between employee training and support/lack of support for self-efficacy and agency

The overall focus of Kind Dining toward hospitality lends gravitas to any activity that supports a positive environment. That there are so many variables speaks to leadership being open to innovation and accepting of change. The importance of good leadership is highlighted when instead of ignoring or glossing over problems, new ideas are tried.

At this facility, every staff member knows and understands the executive director's expectations and goals related to resident care. She leads Kind Dining training and emphasizes that she expects her staff to practice the concepts articulated in the training. Staff are familiar with their residents and responsive to resident needs generally, the staff turnover on day shifts during the research period was limited – the day aides and nurses were consistently the same people.

In interviews, several residents commented that they were concerned about the consequences of speaking up – of using their agency – concerning the food or about the staff. Sharon believes that her complaints about how some of her tablemates have been treated by individual staff has resulted in her getting served last at most meals, regardless of when she sits down. This is a small community and she is unlikely to move to another facility so her concerns are not unfounded. It isn't that she will be obviously neglected or mistreated – she has agency and will readily speak up about obvious abuse. The small indignities, discussed earlier, are where staff could show their unhappiness about complaints. When you need help going to the bathroom, you are less likely to want to irritate the people who will be helping you. Regardless of the reality that this is "home" for the residents, they rely completely on staff to manage each day.

There are repercussions from low funding of nursing homes, particularly those homes with high percentages of elderly indigent residents. The combination of a poorly funded facility and low wages influences the care of residents. Getting and retaining good staff is more difficult if they

can move to another job with better pay and benefits or even a similarly paying job that doesn't require washing a person who has died or cleaning up after a resident with norovirus. In this facility, overcrowding and lack of funds for improvements affect both residents and staff. Residents are aware of the low pay. They simultaneously feel bad for the staff and still want to get the services they feel they are paying for, and that they need. Staff members who feel undervalued with each paycheck are more likely to do the minimum work required, have more stress over bills or the need for a second job. Whether or not they can leave that stress and angst behind during their shifts likely varies every day. When it can't be left behind, the residents may be affected.

 "I don't bother" saying anything because "nothing changes" was heard several times during interviews. The dietician, the executive chef and the executive director do in fact concern themselves with resident complaints. The problem may be that they don't have enough skills to effect changes that might improve the situations. Where this and other facilities lack, seems to come back to training.

This gap in the communication between residents and kitchen staff highlight that lack of training. Complaints are seen as just that, complaints. They are not always seen as an opportunity for improvement. Various interviewees have owned restaurants and managed large kitchens – one man had been the baker on a Navy ship supporting 2,000 crew members – and they showed a keen appreciation for the complexities of a production kitchen. The residents are assets that are not well deployed – are not valued for the "years of service" as articulated in the OAA.

Alton joined the U.S Navy in 1944 at age 18. He ended up in "cooks and bakers" school and was a navy baker for six years before joining the U.S. Air Force for 16 years. He grew up in a nearby

small town where his grandparents owned a "100-acre rock farm. Take 100 acres and you got

seven cattle and try to make a living out of it. It don't work very good. But it keeps you going".

He remembers both his mother and grandmother as good cooks, but he didn't learn to cook from

them. After a stint on a 2,000-person Navy aircraft carrier, he moved to a smaller ship:

> Let's put it into proper perspective. We'd bake very day. We'd make 40 loaves.
> This was on the ship. Then we made rolls for lunch and whatever, we had biscuits
> and all that kinds of stuff. We had to make 2 sheet cakes. There were 60 (slices) to a
> sheet. We had to make 10 pies or so. I can't remember now. We always baked
> cookies. Oh my god. We tried to keep ahead of the ice cream. There was nooooooo
> mixer. And I had to have it out of the galley by the time the cooks came in. There
> was about, I guess there were about 200 men on board then. There was another
> baker and myself. We made the bread, pies and cakes. Everything by hand.

After retiring from the service he moved back to his hometown area and became the cook at the

local hospital, eventually becoming the head cook at this very facility.

> M: so you were a cook here for quite a while?
>
> ALTON: A period of time
>
> M: So what do you think about the food now?
>
> ALTON: Don't ask me such things, because I have to answer the fact that I was a
> cook here. Plus, I can't squawk about any food I eat. But the food, in my opinion, is
> passable. Sometimes I eat it, sometimes I don't. That's because I have my own
> tastes. I can't say anything about it, because, you made it".
>
> This place was not what it is now what it was back them. This was an old folks
> home. That's what it was. You was destitute and didn't have anybody to take care
> of you. This is where you came. We had one lady here that had been here since she
> was a baby. She was in a wheelchair. She was pretty smart, she knew what was
> going on. Oh yeah.

He talks further about using the foods grown on site at what was then a large dairy, beef and

vegetable farm, including carrots, garlic, leeks, onions, potatoes, corn, spinach, cabbage, plus

meat from the cows (sent to a butcher and returned), milk (sent away to be pasteurized and

returned), plus eggs and meat from chickens.

> ALTON: We had whatever they had down there. We didn't get... We got some dried goods from the government. We had prunes all the time. We had cheese of one kind or another. Square blocks of, I can't tell you what kind of cheese it was now. And we had fruits of one kind or another that came in.
>
> M: Canned or fresh?
>
> ALTON: Both. Canned, fresh and dried. Apples came in always. We had a bunch of dried apples, we had pies. A couple of cans, we had apple pie, apple this, apple that. If they came in fresh we had fresh applesauce and one thing or another.
>
> M: It's a lot of work to do that.
>
> ALTON: Well we had a lot of work to do. But we did it. There were two of us
>
> M: Two of you in the kitchen to cook for 300 people?
>
> ALTON: Yeah.

He had helpers to wash the dishes, pots and pans, meals were planned ahead and the residents at

the time chose their meals the day before, rather than the hour before. When he was asked about

living here he commented:

> ALTON: I was over to Austin House (private assisted living) for 6 years before I came here. I lost my wife 8 years ago.
>
> M: You've lived here for almost …
>
> ALTON: Almost 2 years. I was 6 years over to Austin House, but I couldn't afford to stay there any longer. I like that place. You've got three chefs and all kinds of waitresses. You go in there and get a big ol' menu, order what you want, sit down, and enjoy it. Sit where you want, do what you want. Unless someone else has your seat then you have to go someplace else. Never had no arguments. We had pretty close to 150 people there.
>
> M: It's a nice facility. I have a friend who is living there.
>
> ALTON: It's a beautiful place. I was surprised this place stands up next to it. In the newspaper Austin House is number one, but this place is number two. I said, ah…
>
> M: This place is pretty good. It feels like it to me. I don't know. I don't live here.

ALTON: This place isn't bad, I'll tell you. Not bad at all.

Curiously, problems remaining after the implementation of this positively deviant innovation related to food and food services can also be solved, in part, by using resources at hand – the residents. As Bandura (1997) notes: "Because experienced judgement and wisdom do not lend themselves as easily to study as do the mechanics of cognitive processing, these facets of cognitive functioning that improve with age get neglected. The contributions that the elderly can make to the quality of life in a society receive little attention" (p. 199). With these kinds of life experiences, the residents have specific critiques based on years of practice: Slice the meat against the grain instead of serving it in chunks because too many residents have missing teeth; learn how to cook the meats so that they aren't dry; either add more spices or put spices on the tables for use by those residents who like them. Joan commented:

> I think probably they don't spice a lot because you don't know what people like, everybody likes something different. I think they should have, and I think I've asked for this in the meeting, more spices on the table. You know. Maybe put a jar of… I had a round table in my home with all sorts of different spices on it. And if I wanted something different I could just grab one.

Joan is in her late 80s and grew up in suburbia. She lost two husbands and was never able to have children. She worked her entire adult life. She came from a small family and, other than a rarely seen niece, she is the last of her line. All her grandparents died when she was very young. She had a brother and a nephew, but both have died. Joan doesn't remember having a garden as a child, but she grew herbs wherever she lived as an adult.

> I grew herbs and I grew some carrots out there. My little garden. Just a little plot outside my porch. Then they, this was at Ranchwood apartments, they put out plots for anybody who wanted one. So you could plant your own things if you wanted to.

My husband planted tomatoes, squash. I planted carrots in my garden, and spices and something else …. he planted some other things and it was, again, it was fresh food. Take it in, wash it. A little stewed tomatoes, we had a bunch of those. It was fun.

She retains memories from her lifelong love of cooking and the foods she enjoyed cooking. She enjoyed experimenting: "I could always go to the refrigerator and find something to make a meal out of. I like to do that. That's fun". When asked about her childhood experiences with gardening and cooking, she commented:

No, they never had a garden. We never lacked for anything. My mother was a terrible cook, Oh, she was a terrible cook. But she was a wonderful baker. She could make anything bake-able but she could not cook anything. You gave her a steak and it came out like a shoe. Really, it was awful. So I did that when I got older.

She talks about how much "cleaner" the food was when she was young. She is concerned about chemicals in foods and how it affects children, in particular. She commented that everything was fresh, with very few canned foods.

JOAN: We just ate good food and everything was fresh. And everything in the stores was fresh. There wasn't any gunk in it. Everything was fresh, the display, like the fresh food area in the stores today, but even that stuff has been touched up, what's on the market today, you know, has been sprayed."

M: And you miss that [freshness]?

JOAN: Oh yeah. Everything hadn't been rolling around. Like they say, it's fresh fish, it's not fresh. It's been rolled around in a truck for a couple of days before you get it in this neck of the woods. You have to live near the water to get it really fresh. Even there, you could get in a day. I lived in Reading, in Massachusetts and I had fresh food. It was fresh.

M: And you notice it?

JOAN: Oh yeah. You can tell the difference in a minute. The taste of it. Completely different. Completely different.

Because every resident is allowed to keep a certain amount of their social security, she could eat out occasionally if someone takes her. Otherwise, she eats every meal at the facility. She is a stark reminder that not everyone living in a nursing home has someone coming to take them out for special meals or support them in their later years. She must advocate for herself and the Kind Dining program, even practiced unevenly, does support her.

Most of these residents, like Joan, are in their late 80s or early 90s. For decades they cooked food for themselves, their families, in their restaurants or the kitchens they worked in. They have eaten out at countless restaurants. They have prepared food well and poorly, they have eaten good food and bad and they have years of experience that is going unrecognized. They aren't looking for wholesale changes. Overall the foods are acceptable, usually served at the right temperature and in a timely way. The specific complaints are tractable. As one resident commented: "But the baked chicken they send up as an alternative, is baked so dry, overbaked. And they say they have to do that because they're required by the health department to bake it to a hundred [degrees]. I said restaurants bake chicken and theirs doesn't come out dry and overbaked or they would never make any money".

One of the comments that came up over and over again in resident interviews is the presentation of the food. A universal complaint centered on food bleeding into other food --when water from vegetables mixes in with gravy or tomato sauce, or when rolls sit in tomato sauce. Besides being visually unappealing, it influences the texture and taste of the food and none of the interviewees could understand why their vegetables weren't in separate small bowls instead of on the plate, or why their roll wasn't on a bread plate. These are complaints that are addressed through the Kind Dining program – attention to details and taking the time to talk with the resident about the meal experience are included in the training but not in practice.

Again and again the primary complaints relate to staff training. This is a barrier to resident satisfaction with the food and food services. Food services at this nursing home are provided by a food-services company which employs, among others, an on-site executive chef and a dietician. The executive chef has been employed here almost her entire professional life, working her way up from ward aide to the top job. She has no formal training beyond on-the-job training received here and during a few years working at a different facility. The dietician was trained at a local college and interned here while working towards her master's degree. As the dietician is a part-time, 30-hour-a-week position, she also works part-time for other organizations as a dietician.

On-the-job training in restaurant kitchens is a standard way for a kitchen employee to learn the arts of cooking. Restaurant chefs who have worked their way up often disparage cooking schools, though cooking schools might offer training that could be useful for solving common but avoidable problems. At one dinner the kitchen aide had a few cheese sandwiches pre-made to be grilled. She commented at one point, after getting some help from one of the other aides, that it had never occurred to her to butter the bread on a hard surface, instead of on her hand and how much easier and neater it was. "The bread usually shreds." There are well-known highly touted culinary schools throughout the northeast that could be paired with to develop programs for improving the experience of residential care dining.

Hyacinth talked about how the meats are cooked: "….it gets cooked too much or something before it gets down to us. I don't know, it's just the pork and the chicken have a tendency to…like chicken fingers. I like them but, God, then you gotta get a steak knife to cut them. It shouldn't be like that".

Why, for example, is the meat always dry? Could it be that by the time the food arrives on the floor the latent heat in the meat has cooked it beyond done and into dryness? Why are the vegetables cooked in water? Could they be steamed instead? How can cheap cuts of meat be made tender and edible to someone with limited teeth or other dentition issues. Joan notices things "Yes, as I said, people have choppers. They can't eat a lot of this stuff. You watch and see what goes off the table at the end of the meal. A lot of leftover food. And some of it is for that reason. Not all of it, but some of it".

The residents deplore the waste of food, seeing it as a waste of money that could be used, for example, to buy better quality meat. Waste also represents the staff's lack of consciousness – food is left on the plate because it is too tough to eat, not because residents weren't hungry.

Josephina remembers her childhood very fondly. She grew up in Vermont on a small dairy farm that had fruit trees, chickens, an annual pig, and a large garden tended by her grandfather. She noted that:

> We didn't have a lot, but we always had plenty of food. It was all homemade. My mother only bought staples at the grocery store. Flour and sugar and stuff like that. We had basic meat and potatoes and vegetables. We didn't have Italian stuff and things like that, we, but we had very good meat and potatoes. My mother was a wonderful cook. she made three big meals a day. We had, for breakfast we had our choice of oatmeal, eggs, bacon, there was donuts at every breakfast. Muffins.

They canned produce, juiced tomatoes, stored vegetables in the basement "in four big bins", smoked meats, and made jam and other preserves. She talks about using every part of the annually butchered cow, including the hides, the tongue, and the brains for head cheese. She started cooking for her family when she was 11 and managed the cow herd during her 13th year while her father recovered from a heart attack. "That was just part of what we did". Her first

husband was of Italian heritage, so she learned to cook Italian food from her mother-in-law. She also spoke of her family hunting for deer, eating venison and selling the hides. She grew up in an era where everything was used but the squeal.

When she talks about food at this facility, she is speaking from a childhood where nothing was wasted, where her mother taught her – a self-described good cook – to cook at a young age. She continued to hone those skills until she moved here. She went to college after raising six children and then spent a decade or more training people as a peer-advocacy counselor. Her job was "going into people's homes and teaching them how to advocate for themselves and teaching them the different services that were available, how to advocate for [those services]". She brings a lot of experience to her critique of this facility.

> JOSEPHINA: We throw so much food away here that it's not funny. And I can't believe that if they didn't have so much waste, if they bought good food and limited it, we could have better food. There wouldn't be the waste. I don't think it would – to me it just makes sense that it wouldn't – cost so much. And the other thing is, so often they are young cooks. And I said to them, I used to blame the person cooking, because, I said, I would not send something to table without tasting it. And if it didn't taste good, I wouldn't send it to my table. And I said I don't see that happening here. We get things that taste horrible to eat.

> M: Because you think the chefs are inexperienced?

> JOSEPHINA: I don't blame them anymore. You can't hire people off the street that have not practiced cooking in a place like this. That's cooking for so many. It's not their fault. They don't have the experience to cook in a place like this. You can take cheap meats, but you have to know how to cook them. If you don't then you… Of course they come and they are too tough to chew. And we have people at our table who only have 6 or 7 teeth left. And they can't chew food like that.

Collectively, these comments speak both to the resident concerns about the money wasted through food waste and the waste of the resource itself – representing the time, energy and other

inputs required to grow, process, store and serve the food. This guilt over the food they waste affects their morality, not just their pocketbooks.

Supporting the agency of the residents presents challenges for the staff. One night one of the aides, clearly frustrated with a resident named Pepper, abandoned Pepper in the middle of the dining room when Pepper changed her mind about leaving the space. Pepper is capable of locomoting her wheelchair, albeit very slowly, but it was an ugly scene. Other staff intervened but every person in the room was aware of what had just happened.

One staff member enjoys hearing music during meals and tends to turn it up loud enough to be heard over the clink of plates and silverware. This forces the residents to talk louder or not talk at all and the choice of music is not to the liking of all residents. The vast age difference between most of the residents and the staff means that music, cultural references and hospitality expectations might be widely disparate. Supporting the agency of the elders would require the staff to know the cultural preferences of the residents in their care, which they may not have had any prior experience with. "Cultures age as do people. The changes that individuals undergo over their life course are extensively examined, but commensurate in-depth assessments of the changes that societies undergo over time are lacking" (Bandura, 1997, p. 201).Those cultural differences are an indication that the Kind Dining program may need to be repeated to reiterate the practices related to hospitality as the elders understand it; Hospitality means something different to each generation. Perhaps an additional module that speaks to the arc of social norms and cultural references during the lifetimes of the residents currently in care. Staff should have updated ServSafe training. There were several instances when hair, mouth or face was touched before serving a plate of food. The staff would often stand facing the steam table and talking with each other rather than keeping an eye on the dining room and the needs of the diners.

Residents have mechanisms to bring concerns forward. They do speak up about their concerns and the innovation of interest supports resident self-efficacy and agency. Yet there are still areas where person-centered care is practiced unevenly. One staff member might walk into a craft event with a cup of pills in applesauce and feed it to a resident without saying a thing. A different aide might greet the resident, tell her what is about to happen and then proceed. It is clear from seeing both of those things occur that, again, the Kind Dining training needs to be supplemented or renewed periodically – a continued focus on the meaning of person-centered care is necessary.

Residents may let go of some skill sets to focus on ones more important to them now. (Bandura, 1997). An example, unrelated to food, highlights the disconnect between caregivers and their understanding of the skill sets of elders. The most alert and responsive elders know the names of many of their caregivers, but it is a challenge to keep track of the changes over three shifts a day. Most often, name tags are in a place or turned in such a way that they can't be easily read. Aides will often ask the elders, "What is my name" and are then insulted when the resident cannot remember, or stops to think. The easy-to-use mechanism of a clearly typed large-font name tag would make that question superfluous and would be an aide de memoire for the residents as well. When residents are asked to name their caregiver, but cannot remember, their obvious embarrassment is painful to observe. Naming their caregiver is a tool that parents use to teach their children names. For elders with a lifetime of memories, and who may have partial memory loss, it may simply be that the resident is working to maintain other skills that supersede keeping track of their rotating caregivers. This practice seems disrespectful and pointless and it also goes against the Older Americans Act in not supporting a resident's honor and dignity. This is another area where training might help the care givers understand residents' abilities better and where a simple change in name tags might avoid the situation altogether. It is interesting that the workers

themselves don't always know each other. One night when Joan queried the aide about another staff member, the aide said, "I don't know anyone's name here. Just the names of the people on this floor that I work with".

Generally, it seems as if residents who spend the most time participating in offered activities, including the gardening program, and attending the resident and food council meetings have also developed the strongest sense of place and community. They are greeted by name and they know many names as they travel in the halls. Their habits, likes and dislikes are more generally known by other residents and staff. They are more alert about staff turnover and the health and well-being of their fellow residents. They advocate for those who can't. The Kind Dining program supports residents by reminding staff that residents should be treated with dignity and respect. The facility could be collaborating with these alert, efficacious, agentic elders to understand and improve the overall day to day experience of the residents. "But institutional practices still lag behind the capabilities of the elderly. Their skills and wealth of knowledge go untapped despite a critical social need for their contributions" (Bandura 1997, p. 209).

The residents know, if they care to know, everything that happens on their floor, and often the whole facility. They make connections with each other and with staff members. At one meal, the oldest resident in the facility was late to dinner after coming back from an appointment. The aides noticed her arrival. The woman [resident] closest to her patted her arm and eventually, when her meal didn't come soon enough, flagged an aide who assured her the older woman's meal was on the way. A sense of place and community are exemplified in residents who can be seen caring for others.

This unintentional community forms and reforms friendships and connections. Joan and Anne

spend much of their free time together, enjoying each other's company. They worry about each

other's health and sit together at meals and events. Sharon has taken Louise under her wing and

she supports and advocates for her. Although everybody seemed to struggle with Jim due to his

combative conversational style, he was nevertheless welcomed into craft or other activities with

good cheer. There are issues as well; Sharon and Joan just rub each other the wrong way.

> SHARON: The other day they had the music on real loud. She (Joan) was back
> there fiddling with the stereo. And I said, don't turn it up. She looked at me and said
> I will if I want to. It stopped me so bad, if I had been thinking I would have said,
> shut the front door. But I didn't think quick enough. (laughs)
>
> M: That would have been a good response.
>
> SHARON: It would. Lord have mercy. But you've got all kinds of personalities to
> deal with. Everybody ain't gonna click, you know.

They are polite to each other, but they will never be friends. With that said, however:

> Maude and Lucy (two activity aides) got into a conversation about what they were
> having for dinner that night. Joan started to say something and neither Lucy nor
> Maude paused in their conversation, although Maude was standing just behind her
> and Lucy was sitting next to her. Joan said, "No one is listening to me". Sharon,
> who was sitting on Joan's right, said "I'm listening to you". "Tell me again what
> you were trying to say".

This facility has an opportunity to learn from the next generation of elders – the baby boomers –

as they start using its rehabilitation services. These baby boomers could be mined for

information about their expectations of food and food services. The facility could use that

information to review current practices and decide how it might need to change as this large

cohort of elders, who had very different life experiences than the current elders, starts to enter the

elder-care system.

Conclusion

The Older Americans Act defines the federal approach to elder care: to "secure equal opportunity to the full and free enjoyment" of the "best possible health", "retirement in honor and dignity" and the "freedom, independence and the free exercise of individual initiative in planning and managing their own lives". For those elders who are also indigent, the Center for Medicare and Medicaid Services help provide the funding necessary to support the intent of the OAA.

Those metrics are not being met in entirety. At times, elders are treated as children; they generate frustration in – and retaliation from – their caregivers. Low meal expenditures limit what can be offered, leaving residents to find their own special meals or satisfy their yens elsewhere --or not at all. Current residents bring a variety of skills and experience with them when they move to a nursing home. Developing a way to appreciate the vast knowledge of these residents would be worth pursuing.

As positive deviance research has found, sometimes the answers are right there, if you look. Repeating Kind Dining training, and adding a cultural differences module, might be a good way to remind staff that this is the residents' home, where they deserve the most hospitable care possible. In addition, it would be worth pursuing some formal training for kitchen staff, particularly kitchen managers, on preparation techniques that address the concerns of the residents. There is certainly an opportunity now for cooking schools to develop a training focus on nursing-home cooking, as the nursing homes start to care for the baby boomers and try to meet their expectations.

The next generation of nursing-home residents are likely to have very different characteristics than this generation. They were not raised in the Depression. They have had access to foods from

around the world, access to fine-dining establishments and access to what they want to eat for most of their lives. They are used to food courts with a variety of options and are less likely to have grown up with a garden or home-preserved foods. They eat out a lot and they will expect service akin to what they get in restaurants (Cobe, 2018, Aug. 7).

The multitude of innovations in practice here would benefit from more research to clarify which actions support person-centered care for current residents, specifically whether the food and food services are providing satisfaction to the elders. The Kind Dining program shows some influence: The dining room is well organized to provide a comfortable space; dining services provide meals that are served correctly and promptly; residents are served what they ordered and special requests are honored where possible. When a meal is delivered to a floor, the nursing staff moves quickly to support the kitchen staff.

The impacts of having a busy and engaged activities staff with extensive programs, live animals and plants on every floor plus strong top leadership are likely exerting influence on the general environment. This still leaves questions about the overall results of Kind Dining. Further studies warrant taking the next steps of quantitative research of a larger sample of Kind Dining programs.

It is ironic that many caregivers are working in low-paying jobs, currently in the range of $23,000-$36,000 a year including overtime and bonuses, which determines their social security benefits – potentially leaving them in old age to become Medicaid recipients themselves (https://www.payscale.com). This area has not been explored in this research, but there are rich opportunities for further research, particularly on low-wage caregivers, on the impact on their health and the long-term economic challenges and consequences of low pay for challenging

work.

As Hyacinth noted, "I try not to say anything or run things down, but you know it's the rest of our life. We chose to live here, and I think all of us feel that we are just trying to finish up our lives as comfortably as we can."

CHAPTER VI

GREEN HOUSE MODEL CASE STUDY

<u>Introduction</u>

The Older Americans Act (OAA) was the original innovation in modern elder care. The ten objectives listed in the OAA lay out a national philosophy for supporting elders in old age. This approach includes the concept of respecting the inherent dignity of the individual in a democratic society and the objectives clarify the intent of the legislation.

The OAA, for the first time, defined and funded community-based programs to assist elders but didn't specify the approach to care provided in care homes. Care homes, largely a continuum from older models of sanitoriums and almshouses, are designed to act more like medical facilities with residential features – or as boarding houses – than as personal homes.

By the early 1990s, new models of elder care in care homes were being realized as alternatives to what had become typical care, in part to address a growing concern for more person-centered care. The Green House model, originally the Eden Alternative, is the focus here. The Eden Alternative Principles, precursor to the Green House model, closely reflect the intent of several of the original OAA objectives such as creating opportunities for meaningful work, maximizing decision-making authority in the hands of the elders, and ensuring that medical treatment sustains and improves health and happiness.

Thirty years went by after the OAA legislation was passed before the Eden Alternative Principles and practices were introduced. Yet they were, and still are, considered radical. Ten more years went by before the Centers for Medicare and Medicaid Services (CMS) showed movement

toward fully realizing the practice of person-centered care – and the intentions of the OAA – and only in 2017 did this concept finally acquire the powers of monetary incentives and legal action through CMS guidance and regulations related to nursing homes.

The latency highlighted here in the long delay between the OAA's passage and the application of innovative nursing-home care incorporating the objectives of the OAA perhaps reflects innovative practices that needed the right time and the right people to be created. Change agents are an important part of diffusing an innovation. Change agents are people who see a need for change, diagnose the problem, create an intent to change and translate the intent into change. They also need to be respected and well connected within their milieu and understand the challenges to change faced by their peers (Rogers, 1995). The facility under research here is part of a larger organization interested in adopting person-centered care practices.

The Green House model began, as noted above, as the Eden Alternative. Gerontologist Dr. William Thomas shared his innovative ideas around reforming elder-care homes through conferences, personal connections and by engaging with nursing homes willing to try something different. Starting in 1992, Dr. Thomas was able to diffuse the Eden Alternative principles and practices to enough facilities that research on the effectiveness of implementing the ten guiding principles of the Eden Alternative, as well as the training given to care workers, could be assessed to determine the efficacy of the interventions. Using typical nursing-home-related assessment metrics, the Eden Alternative homes had fewer behavioral issues, fewer bedsores, higher resident and family satisfaction and less staff turnover (Thomas, 2004).

Those early results showed the potential advantages of scaling up the Eden Alternative: to put those principles behind the design of nursing homes and not just include them as an afterthought.

These successes also attracted the support of funding sources such as the Robert Wood Johnson Foundation, and the diffusion of the Green House model was begun.

Currently there are approximately 260 Green Houses nationwide, in a country of 15,000 nursing homes (www.thegreenhouseproject.org). Of Green Houses in the greater Northeast, some hew close to the ideal while others modify it. As noted before, it is not unusual to see adaptations of an innovation in innovation research.

In a little more than 20 years, the Green House model has had a larger impact on nursing-home care than the number of actual Green Houses in existence would indicate. Green Houses and the extensive outreach and financing behind them have caught the attention of federal policymakers and agency decision-makers. CMS rulings published in November 2017 require person-centered care and care planning for all residents of nursing homes receiving money from CMS (Bowman, 2017). Currently six in 10 nursing-home residents are receiving Medicaid (https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/).

This new CMS ruling clarifies the rights residents have in directing and managing their own care. The 2017 rules change has the OAA objectives at its core – essentially, all decisions default to the resident (Bowman, 2017). Changes brought by the new rulings include a requirement that, in CMS approved facilities, someone from the food or nutrition-services department will be involved in the resident-care planning process. The words "person-centered care" have become ubiquitous in elder care and now have the teeth of regulations behind them.

The Green House in this study is a modification of the original idea. The first Green Houses struggled financially because of the small number of residents inherent in the design, the relatively large ratio of staff to residents, and infrastructure costs. Green House models have a

goal of changing the whole nursing-home system, so affordability is a key to widespread success.

Ultimately, the Robert Wood Johnson Foundation and other funders stepped up and supplied

some funding between 2002 and 2018, as part of their goals to "support programs to help

everyone in our nation have the opportunity to live healthier lives"(www.rwjf.org retrieved

December 2018).

> Since 2002, the Robert Wood Johnson Foundation has awarded $20 million,
> primarily to NCB Capital Impact, to develop, test, and evaluate The Green House
> model. In 2011, the Foundation made a new $10 million program investment to
> build on its existing support of Green Houses, with the goal of helping the model
> achieve greater reach and impact than its current presence of 146 homes across 24
> states.
>
> Specifically, the PRI lowers the cost of financing Green House projects that serve
> low-income individuals and low-income areas. NCB Capital Impact serves as
> administrator for the loan fund and seeks investors to leverage RWJF funding in
> any one project by a ratio of 4-to-1. The investment was part of RWJF's larger $100
> million "impact capital" commitment designed to help the Foundation and its
> grantees leverage funding from multiple sources and spread innovative solutions
> that improve health and health care for all Americans
> (http://blog.thegreenhouseproject.org, retrieved December 2018).

Are residents of Green Houses living the experience of the project's goal of vanquishing

boredom, loneliness and helplessness? More specific to this research is the influence of the

innovations on food and food services. By using the diffusion theory framework, the path of

innovations put into practice by the Green House model can be seen in the steady increase in

new Green Houses, and in regulatory and language changes within the overall nursing-home

industry that are moving closer to the objectives of the OAA. More research is being pursued on

all aspects of the Green House model, including on outcomes related to resident health,

employee morale and turnover, and costs. Current research has shown mixed results, and more

research is needed (Elliot et al., 2014). Research allows potential adopters to better understand

the relative advantages, compatibility, and complexity of changing to this new model before they

make the very large capital commitment of building a Green House or retrofitting their existing facility into a Green House. The modifications made to the Green House model in this case are significant. Understanding the influence of the modifications on the residents could provide useful information for future Green House model development.

Using diffusion theory to review the effectiveness of culture change within long-term care facilities has been limited. A meta-analysis of diffusion research related to culture-change in nursing homes notes that an empirical base that includes longitudinal data and baseline assessments, plus information on the performance of a variety of culture-change measurement tools, is very limited (Shier et al., 2014). That meta-analysis also noted that many culture-change efforts are not focused on a holistic quality of life and the well-being of residents. Diffusion theory is used to understand how the Green House model supports the objectives of the OAA. Self -efficacy theory is used to understand the lived experience of the model by the elders in residential care homes, particularly related to food and food services.

In the Green House model of innovative elder care, the form of the change – moving to a smaller house model with private rooms, kitchens, etc. – is readily seen. The intended meaning for the change – relief from loneliness, boredom and helplessness – is clear. Determining whether the function of the changes have come to fruition for the residents needs the close, constant observation of ethnographic research.

Background

The Green House model's focus on the individual resident is a big innovation for people used to typical residential-care facilities. In an ideal Green House model the buildings themselves are

designed to have no more than 10 residents per House, each featuring single bedrooms with private baths that open onto a shared living room and dining room combination. Pets and plants are encouraged. Meals are prepared in each House in residential-style kitchens – elders are encouraged to participate, as their abilities allow, in all aspects of the dining experience, including creating the menu and preparing the food. Meals would be eaten at communal tables and family style. The smell of food cooking is part of the concept of a home-like atmosphere envisioned by the Green House model.

This particular Green House model is a distinct modification of the original idea. As noted before, the Green House model was envisioned with 10 residents in each house, with common living spaces that includes a kitchen, intended to more closely resemble a home. The Green House in this study started as a typical long-term elder-care facility and was retrofitted to add the kitchens and attendant areas necessary to cook and clean up meals. This Green House is part of a larger complex of a long-term care retirement community that includes independent and assisted living apartments and a nursing home. There are nine wings, each with 16 people (again, the ideal is 10 people per "house") and each with its own kitchen.

A caregiver is called a Shahbaz, a "midwife for the elderly" (Thomas 2004) and is trained to do the usual LNA personal-care responsibilities as well as meal planning, preparation and serving. There are also elements of Green House training that encourage facilities to provide easy access to human and animal companionship, opportunities for elders to give and receive meaningful activities, to put maximum decision-making into the hands of elders and to encourage aides to see the whole person (Thomas, 2004). The job responsibilities are unusual for caregivers whose training as traditional aides does not typically include meal preparation or the philosophy behind the Eden Alternative care principles or the Green House model focus on food and food services.

Because there is an assisted-living facility attached to this Green House, there is also a centralized production kitchen which works in collaboration with the Green House kitchens. On each floor of the nursing home one of the kitchens is more complete than the others and it is where the bulk of the meals are prepared for the whole floor. By centralizing the cooking on each floor the facility can use one cook/chef per floor instead of one in each wing. Pans or pots of food are made in the center wing and then brought to the other two wings to be baked, simmered or reheated. This meets part of the goal – having the smell of cooking encourage residents' interest in food and eating. The goal of having the residents participate in meal preparations and meal planning has been more problematic. Lack of staff, limited staff training, and kosher practices means that until related issues can be resolved, the facility discourages residents from using the kitchens to prepare and serve food.

This is a kosher facility where specific food restrictions are adhered to; milk and meat meals are always separate. Jewish holidays are celebrated as well as the attendant foods. For example, no bread is served during Passover except for matzoh and other unleavened items such as Passover-friendly muffins. Kitchens are cleaned prior to Passover to remove any old leavened bread crumbs. Pork and shellfish are not served in any form.

This facility is located in a large metropolitan area located in the greater Northeastern United States. It is a continuing-care retirement community, in that there are apartments, assisted living, nursing care and adult day care. This is not a place where you pay a large up-front fee in addition to the monthly fees and are guaranteed care for life. However, if more intensive care is required, there is a practice of preference for those who are already residents of the complex moving into openings in the assisted-living and nursing-care residences on site as needed.

The complex is surrounded by woods and, largely, residential homes set in mature plantings. There are schools and small businesses in the immediate vicinity and larger strip malls and grocery stores within a few miles. This is adjacent to a busy urban area and although there are sidewalks at the facility, they end at the roadway. There are no stores, libraries, movie theaters, coffee shops, diners or delis within easy walking distance of the facility. See Appendix D for an overview of the facility layout.

The plantings at the facility are attractive; longtime residents comment on how the trees and other plantings have grown. The grounds are well maintained, with fresh mulch, minimal litter, clean entrances, screened dumpsters and a small bus-stop style smoking area that faces away from the parking lots during warm months, and well-maintained parking, walk- and driveways in the winter.

The overall facility presents a long block of buildings that vary in color depending on the type of housing. There are some differences in style between the apartments, which have more entrances and look more like condos, and the assisted-living and nursing-home sections, which are more monolithic four-story buildings with secure entrances.

The assisted-living and nursing-home sections share functions on the first floor. The assisted-living section has a primary entrance into a staffed lobby area. To the left is the main dining room, along with a smaller dining area used for residents who need more help. The kitchens and kitchen support rooms are off a long hallway that leads toward the nursing-home section. The executive chef and dietician's offices, plus dry storage of foodstuffs, linens and crockery, are also off this hallway.

To the right of the entrance is a hallway leading to a community room with a lectern and chairs that can be rearranged. There is also a small café-style room where programs are led by the activities department. There is a coffee-and-tea station, and a small sink and counter in this space. Bathrooms and support staff offices are nearby.

Throughout the assisted-living facility and nursing home, furnishings are upright padded chairs in common areas, with square four-person tables in the dining rooms and common rooms. Most of the flooring is wood laminate; walls are covered with paint, wallpaper or a combination of both; window treatments are all in muted colors; and ceilings are high. It looks very similar to mid-level hotel lobbies and conference centers. There are no strong odors, except during meal times when food can be smelled in many locations. Lighting consists of overhead fixtures in addition to natural lighting from large windows. Elevators are used to access the upstairs floors for residents, staff and visitors; key cards are needed to access stairways and some administrative hallways.

From the entrance to the assisted-living area, a visitor can turn left and walk down the long hallway past the kitchen-support areas. At the end of the hallway there is a left turn that fronts along an inner courtyard, which can be accessed by wide doors. The corridor makes a right turn, again fronting along the inner courtyard, which forms a square outdoor space. Along this corridor is a children's day care on the left. There are large windows to the corridor and the children can be seen playing, napping, eating and learning. The children's day care has its own entrance from the parking lot and often uses the inner courtyard, accessing it by crossing the corridor to a small entrance not typically used by the residents. Their play area is fenced off from the rest of the courtyard. The play area has a plastic "tree house" with a slide and ladder, places to sit and room to run around. The rest of the inner courtyard has comfortable padded chairs,

patio tables with umbrellas, and a few benches. Paved walkways go through plantings of trees and bushes.

Just beyond the child day-care section, the corridor opens into the "Great Room". On the left the wall curves towards a conference room used for training, private parties and meetings. That room has glass panels facing the Great Room, as well as tables and chairs, plus video capabilities for trainings. Beyond the conference room is a very large fish tank set in a partial wall. On the other side of the fish tank is a grand piano, sitting on the edge of a large space containing a few tables and chairs. The Great Room is used for entertainment and special programs. Along the right wall is a small seating area with a remembrance book for comments about residents who have died, then an open-fronted room with dining tables and chairs, and windows looking into the inner courtyard. Beyond that there is an open seating area and a café. Around the right corner is another door leading to the inner courtyard, and a set of bathrooms.

At the end of the Great Room furthest from the day care, a café counter curves along the front of a kitchen area where the bakery is located and where lunch is served every weekday. Many of the muffins, cookies and other similar items are baked in-house. There is a deli display case with a sign that says that there is no meat served there, but in fact meat is served there often. Tables in the Great Hall area have signs reminding everyone that only kosher food can be eaten there. The entire complex is kosher, except in private and specified places (including all resident rooms), so any food eaten in common areas must be kosher.

A free meal is served at noon for staff and visitors, which residents can also eat. This helps avoid the issue of non-kosher foods being brought into the facility; the activities coordinator commented that it helps impart a sense of community. Meals range from vegetable soup with

bread and iceberg lettuce salad to baked chicken casserole or spaghetti and sauce in cold weather, to seafood salad, fish cakes, rice or grain salads and three-bean salads in warmer weather, as well as occasional cake, jello or cookies. There is always some kind of juice in the afternoon. The café area has a place that serves tea, coffee, cocoa or water and, across from it, a place to doctor your drink and get condiments and napkins.

The nursing home front entrance is the furthest from the main road. A small fenced courtyard to the left of the entrance is where adult day care participants sit in good weather; there are some attractive plantings, comfortable chairs and a small gas grill. This entrance has a portico that shelters vehicles collecting or discharging people. To the right of the entrance is a porch, about 10 feet wide, that extends all the way around the front of the building until it reaches what is the front of the great hall. The porch has occasional groupings of comfortable outdoor chairs, and there are plantings between the porch and the sidewalks that edge the driveway.

Automatic doors at the nursing home entrance, and an air lock, help keep the warm/cool air in at appropriate times of year. These open into a lobby, where a receptionist sits behind a counter, with a sign-in sheet for visitors and vendors. To the left is the entrance to the adult-day-care section, as well as an entrance to an outpatient rehabilitation unit. Behind the receptionist's counter are several offices. To the right is a hallway where there are windows that look onto the porch. On the left are admissions offices, a bathroom and a hair salon. At the end of the hallway, a TV screen lists upcoming events and other information, such as weather or trivia.

From the TV screen, a right turn leads into the Great Hall, at the café end. To the left are three elevators, one of which opens on both sides, allowing access to back-of-house offices and storage spaces. A cart about 10' long by 4' wide displays jewelry and other items made by

residents to sell, sits at this end of the Great Hall. It is open irregular hours. Beyond the elevator bank is the café. Usually the center of the Great Hall contains lots of chairs, a few couches, and soft chairs, used for everything from musical entertainment to family gatherings. Religious ceremonies are held here and day-care children sometimes play in the space.

The second floor of the nursing home houses the activities department, a conference room and small kitchen. It is also the memory care floor. The third floor is the rehabilitation floor with a large room filled with exercise and other rehabilitation equipment in addition to the patient and patient-support rooms, and the fourth floor houses elders who are more independent and, usually, don't need memory care. At each floor the elevator opens onto a large foyer with a pair of chairs on either side of a small table set against a wall directly across from the elevator bank. Ahead and slightly to the left is the entrance to one wing, on the right the foyer takes a right that leads into another wing and to the left is a staffed window where residents check in and out if they leave the floor and where staff offices are located. To the left of the window is a corridor to the third wing.

The fourth floor of this nursing home is the primary focus of this case study. As on each floor of the nursing home, there are three wings, each with 16 residents, for a total of 48 residents per floor. A more typical Green House would have only 30 residents in the three wings. At the entrance to each wing is a kitchen. The center wing has the most complete kitchen and the largest room behind the kitchen used for both meal prep and for storage. In each wing a commercial dishwasher, as well as a small wash sink and a hand sink, are in the back room. Each wing also has a counter near the entrance with supplies to make coffee, tea and cocoa, as well as whole fruit and small 100-calorie cookies or snack packs. Condiments, creamers, drink thickeners, styrofoam cups and plastic silverware can be found there as well. On the other side of the counter

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is a small, complete kitchen with double ovens, a six-burner glass-topped stove, a commercial-style double-door refrigerator, microwave, a small sink, upper and lower cupboards and dispensers for juice, soda, water and ice. The cupboards carry two sets of dishes: one color for meat meals and one color for milk meals.

The kitchens front a dining space where there are four square tables for four, as well as upholstered dining chairs, most with wheels and arms. Beyond the dining area, there is a space big enough for a couch, which faces away from the kitchen, a coffee table (in some of the wings), plus one or two upholstered chairs, all facing a set of built-in shelves where there is a very large flat-screen TV. The shelves carry, variously, a few games, a few puzzles, a few books, a few magazines and a few ornamental vases or ceramic pieces. Mostly they are empty. Next to the TV is a small counter where a computer and a nominal nursing station are located. Deep windows at this end of each common room are used by the staff to sit, chat or place their work logs and charts when they aren't using them. Several recliners, each of which is used almost exclusively by a single resident, are on either end of the couch. Other residents use the couch or an upholstered, upright, chair. Overhead speakers near the TV and in the dining room area are rarely used for conveying information but will often have a radio station playing music. The televisions are typically on and it is common to have both the TV and the overhead radio on at the same time although each wing seems to have their own pattern of TV and radio use during meals.

From the entrance, the corridor is open on one side to the kitchen, dining and common area. The other side has doorways to bedrooms and each wing has a bathroom directly across from the dining room area. Once past the kitchen and common spaces, the corridors are "double loaded" with doors leading to rooms on both sides. The corridors curve so the end cannot be seen from

the beginning. These bedrooms are all single rooms with private baths, roughly 12'x12' in size, although the ones closest to the entrance are a bit smaller, about 10' x 12'. At the end of each corridor is a sitting area with some soft furniture and coffee tables, which is not designated as a kosher area. A doorway leads to stairs that is the "area of refuge" in an emergency. Random furniture is placed in these sitting areas as well, usually pushed into a corner.

Three bedroom entrances are located off of this sitting area and each of these bedrooms is a shared suite. The suite doorway opens into a common foyer with a bathroom to one side. There are tall doorways – but no doors – to the left and right. Curtains can be pulled across the entrance to each room. The two residents in these suites share a bathroom. Every bedroom has a window, some looking onto the parking lot, some into the interior courtyard and some to the woods surrounding the facility.

Floors are carpeted throughout the wings, except the bathrooms and the kitchen, which have wood laminate flooring. Walls are painted in light colors. All windows have blinds and the common-space windows are valanced. Resident names are on the walls outside of their rooms. Single rooms each have a deep windowsill where residents often display photographs. The shared suites have double windows that are flush with the wall.

Bedrooms typically have a single bed, a bureau, a closet with a clothing rod and shelving, and side tables next to the bed. A wheelchair is a bit awkward to negotiate in the space. One resident has her sewing machine set up on a narrow table top along one wall – a vestige of her previous life before her Parkinson's Disease became advanced. Another uses her long, low bureau as a makeshift kitchen counter to prepare various foods. Bedrooms might also contain an easy chair, a small refrigerator and a television. Most of the furniture is supplied by the residents, as is the

bedding, though some furniture comes from donations to remaining residents when other residents die.

Most rooms have walls displaying framed photographs of family members and a bulletin board to post activity schedules or calendars. Residents have a button they can use to get the aides' attention, which flashes a light outside of their room and notifies the phones carried by the on-duty staff. The phones alert the staff that someone needs them and gives them information about the source of the alert – including from the common bathroom near the dining room. Residents can also use their private phones to contact the front desk to get help if for some reason the call button does not summon someone.

During the first and second shifts, each wing is staffed with four aides in addition to two nurses for each floor. Each nurse is responsible alone for one wing and also shares a wing. A floor manager is on duty during the day and a cook is on each floor for lunch and dinner. Social workers, rehabilitation staff, activities staff, kitchen staff, dieticians, maintenance staff, and visitors come and go throughout the day. Family members can visit whenever they like, but they are encouraged to avoid very late nights and early mornings.

The facility was originally designed to have a central production kitchen, with dining rooms on each floor. The central kitchen produced and shipped the food to each wing of each floor in insulated boxes until mid-2017. The nursing home underwent renovations in 2016-17 to convert each floor and each wing to an urban Green House, focusing particularly on kitchen renovations to make them capable of producing three meals per day for the 16 residents in each wing.

Meals are planned for all dining rooms by the dietician, her assistant, and the executive chef. Resident input is limited to conversations at monthly food and resident council meetings, but

residents and families can – and do – request meetings with the food service staff and dieticians about the food and food services. Each floor has some leeway in how a meal is prepared. If chicken is the main dish for a meal, the cook may decide not to serve the scheduled barbecue chicken to 16 people who don't like barbecue chicken and instead serve a much-preferred teriyaki chicken. A main dish alternative is offered at every meal, but the hope of the executive chef and the cooks is that the main dish will be the most appealing item on the menu. Tailoring the food to the likes of the residents is a core tenet of the Green House model. In one exchange observed while a resident filled out her lunch ticket, she asked her tablemate, "Do they have green tea here?" Instead, she had iced coffee and said, "That was so good. I'll probably hate it by the end of summer, but it's wonderful now."

Food is "shopped" for in the central stores area of the facility. There is limited pantry space on each floor so cooks collect what they need from the central stores each day. Because this facility is a kosher facility, as stated before, all the food is kosher and diet is partly controlled by kosher holidays. Pork and shellfish are not served, and meals are either meat or dairy, but not both at once. Currently, according to the dietician, the assisted-living areas has a higher percentage of Jewish residents, where the nursing home has a higher percentage of gentiles. The dining areas, both public and resident-focused, are kosher, including any food that is brought in from outside. Residents and guests who want to eat non-kosher food can eat it in resident rooms and in the few common rooms and spaces. Sometimes the residents show frustration at the kosher limitations. One resident, in talking about the food her family brings for her laughed a little sheepishly and commented that "I found out a lot of it I can't – unless I eat in my room. I shouldn't be eating out there, but Harriet and I have been sneaking it out".

As noted in the introduction, residents are discouraged from working in the kitchen area on each floor – in fact there are signs requesting "staff only beyond this point". As a consequence, almost every resident has a refrigerator in their room for ready access to the foods they like to eat between meals, to replace meals they do not like, and for access to drinks not offered by the facility. One resident not only likes to cook, she produced a cookbook a few years back, when she was in her late 80s. She regularly "cooks" in her room, making items that need little or no actual cooking, such as dips and marinated cheese. Although not entirely happy about cooking in her bedroom, she will prep her foods in her room.

> JOANNE: If I could just fix even the stuff and let somebody else cook it. I need a table. I don't like using the bathroom. I go into the kitchen to wash my chicken and everything
>
> M: They are letting you do that?
>
> JOANNE: yes. They let me do it. I have chicken now I want to wash and get ready.
>
> M: They have someone who helps you?
>
> JOANNE: They help me any time. I have to be sure there is somebody free They help me though. They told me they'd give me an aide to help me. Sometimes, they are short. If two call in sick, they can't help me. But they are very good to try and help me. Yeah.

The dining room is also the common room, so activities at any of the tables must be completed or moved to accommodate meals. Because of the variety of wheelchairs and reclining wheelchair/beds, there are too many chairs in the space. Extra chairs cannot be stacked and are pushed under the window, blocking anyone from sitting near the windows and enjoying the view, as well as crowding the space. The four-person square tables are not very large, so residents must take care not to hit each other with their wheelchairs, or worse yet, hit the non-wheelchair person on the knee or foot.

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HARRY: Everybody else at my table – I'm gone and they are all still sitting and bullshitting. And at night they kill me. I gotta watch their legs, because they all have those braces on their legs (wheelchair feet) and I make them take them off. Sometimes I forget and when I sit down in the chair and put my legs in and I get BANG. Ya, know, I got new knees. My knees are steel. I look now, because I didn't before. Christ. So I have to be very careful with my knees

Clean linens are used for each meal and tables are set with tablecloths, clothing protectors, real dishes and flatware. At lunch and dinner, food is cooking, or heating in the oven or in a crockpot on the counter, and the dining area smells good.

Some days there are food-related special events. A celebration of national pizza day featured red-and-white-checked tablecloths on the tables and pizzas were delivered at noon as an option for those with no dietary restrictions. An accordion player arrived at the nursing home at 12:30 and played for 10 minutes in each wing. The intention of a celebration was there, but the staff didn't seem to be engaged in the meal as a celebration. The big TV was on in each wing. In one, an aide turned the TV off while the accordion played but the other two wings had a loud TV and a loud accordion player at the same time. It was weirdly discordant.

The aides, cleaners, kitchen staff, maintenance workers and nurses on the fourth floor are almost all Black or Hispanic. Some are native-born, but many speak with a strong accent or cadence from their country of birth. The local populations of working-age adults have shifted racially over time. This community drew Italian and Polish workers, who worked in war-related factories during World War 2, a heritage reflected in the facility's residents, many of whom have lived in the area their whole lives. Since then, this area has attracted an even more diverse work force. One town away the Black population is 10% of all residents, double that of the state as a whole, and the Hispanic community is more than three times bigger, percentage-wise, than the state as a

whole. Another local community is almost 50% Hispanic, and Spanish is the primary language spoken at home for 58% of the residents, according to regional census reports. Most of the aides, nurses, cleaners and kitchen personnel are female. Maintenance workers tend to be male. During weekdays on this floor in the past year, one aide, one kitchen staff, one social worker, and all the maintenance people were men. The rest were women.

While there seemed to be little extant racism between the residents and the staff, there were obvious language and cultural barriers. All but one of the residents on the floor appear to be Caucasian and most are native to the immediate communities. Residents talked of parents who had been immigrants and who spoke their native language at home, so there is a familiarity with other cultures. None of the interviewed residents spoke Spanish or were Hispanic themselves and no residents spoke in Spanish to the aides during the observations.

Name tags are worn by every staff member. Volunteers and visitors do not wear any identification. Name tags here use a much bigger type face for the last name and a small 30-point type for first names – making it hard to read unless the reader is very close. The tags are often worn clipped to a side pocket and some are on lanyards around the neck. They are almost always facing in towards the body, adding to the difficulty in reading them.

There was a curious disconnect around resident and staff names. Staff members know most of the residents' names, though they frequently call a resident "Mama" or "Papa". Residents often -- but not always -- know the names of their direct aide and the nurse but they often do not know the names of the other aides. This is partly because of high staff turnover and partly because the name tags are hard to read. Because residents struggle to name the caregivers, they can't ask directly for help, often just calling out "Miss!" to get someone's attention. The intent of the

Green House model, according to their web site and Dr. Thomas's books, is to create a home-like atmosphere. It is striking that residents do not know the names of the primary aides on their wing. Memory issues could apply, but the elders in this study have possession of their faculties.

Altogether, out of the 48 residents on the floor, even accounting for deaths throughout the year, there was an average of 10 men, and the rest were women. The ratio of men to women is typical of the overall elder statistics – women tend to live longer than men and that is reflected in these very old populations. Most of the residents on the fourth floor are in their late 80s and early 90s although there are two residents in their 60s and 70s who have disabilities. Over the eight months of the study, there always seemed to be two residents in each wing who were entirely dependent on caregivers. The majority of residents on this floor are able to play bingo or participate in other activities, have a conversation and eat independently.

Menus, here called tickets, look like grocery-store receipts; they are small, with small printing. They are placed at the usual seat of each resident at the start of each meal. Although there are no assigned seats, the most mobile residents seem to prefer to sit with certain other residents and aides place everyone else. Residents are expected to review the meal options and choose what they would like to eat. There are never pencils or pens given out to residents to use in marking their preferences. Residents share pens and pencils between them or wait until an aide comes by to help. This means that residents regularly don't choose their meal until the very last minute. That causes issues with the production of enough food and with food waste. The kitchen produces too much of both the main meal and the main alternative, or not enough of one meal and too much of another. Conversations with the floor cook and executive chef indicate that they recognize that changes need to be made and are exploring options for improvement.

Aides are responsible for serving and cleaning up the dining room after the meals. Each shift has a Shahbaz – a caregiver who has the additional responsibilities of plating meals and clearing the kitchen and dish room afterwards – and there is a cleaning person who sweeps up, does general tidying in common areas as well as cleaning bedrooms and bathrooms. Ideally each aide would be a Shahbaz -- more like a homemaker with some clinical responsibilities than a clinician with kitchen duties -- but here one aide per shift has that role.

This facility struggled over the past year to retain aides. Throughout the observation period there were employee-attendance issues. Direct observations and overheard conversations between staff members indicated that this was common. On many days, only two of the four aides would show up for their shift in a wing. Residents had stories of limited aides and no kitchen aides showing up over a weekend. That would put the onus on the remaining aides and the executive chef and his crew to fill in the blanks. This lack of staff shows up in meals that are rushed and in meals that are not as advertised.

Nursing and kitchen functions were usually staffed by the same people each week, but the direct-care aides showed steady turnover, with new faces during every visit. Staff would comment about working double shifts and having staff from other floors filling in. In addition, the "careers" page on the website showed signing bonuses and other incentives to entice new employees. Families with several members working at the facility are not uncommon. Residents commented about the effects of short-staffing on their care.

Problematic staffing bled into every area of the facility. Certain residents, who are actively discouraged from being in their room for a variety of reasons, end up in common areas for hours with no discernable distraction or engagement. They are often still sitting at their table when the

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next meal is served. As noted before, one couch and several recliners populate the common area of each wing, but the recliners are each devoted to a single resident who spend the whole day in front of the television and are moved only to eat and go to the bathroom. No live plants or animals are in any of the wings, though dogs come occasionally with visiting family members. The idea of having living plants and animal visits is another elemental Green House ideal – not focused on in this study but noted by their absence. Some residents spend more time than they want to in bed because they need more help than is available. Chantalle is an 89-year-old who is large enough to need both a hoist and two helpers to get in and out of bed. Because of that, she is often in bed until 2 pm.

Meals on the fourth floor are staggered between the wings which allows the floor cook or Shahbaz, to have a more orderly rollout of each meal. For example, breakfast starts at 8 a.m. in one wing, and then at 8:15 and 8:30, successively in the other two wings. Breakfast meals are cooked by the aide who is designated as the Shahbaz – unlike the other two meals, which are prepared by a cook.

Coming off the elevator just before a meal on any given day means appetizing aromas come from every wing. In the center wing each day, the cook makes first lunch and then supper. Baking, or heating foods in a crock pot, is done in the kitchen of each wing, carted there on a stainless steel trolley by the cook. The cook generally stays on the floor until the meals have been served and then either takes a break or goes home, depending on the time of day. The Shahbaz's responsibilities include plating the meals, checking tickets collected by aides and sorting them by table, and handing out meals to aides who bring them to the residents.

Noon and evening meals have a typical pattern. Aides get people from their chairs in front of the TV into the bathroom or into a chair to be brought to the table. A few people who are permanently in reclining chairs will be wheeled over from in front of the TV or from their rooms. On a Tuesday or Thursday, bingo would have ended at 3:30 in one wing and Chantalle will be holding court at the far table. Because, as noted above, she needs so much help getting up, she was likely cooped up in her room between last night at 8 p.m. and today at 2 p.m., where she has been bored and lonely. Her daily visitors are mostly nurses and aides, though a granddaughter visits regularly and a daughter from Virginia visits occasionally. Chantalle is from the area and there are people from her social organization who visit as well. Lynne, one of the other residents, has commented that Chantalle is "like a spider", knowing much of what happens in the building, despite being in her room most of most days. Chantalle is gregarious and talkative.

Lynne is in her mid-70s. She has Parkinson's Disease, which makes her body twist and move almost constantly. She uses a walker and, when she sits for meals, aides try to make sure her chair does not have wheels because her movements will make the chair roll around even as she tries to sit still. Lynne is originally from the Azores, islands off Portugal. She has a son and a daughter who live in the area and two grandchildren. She has commented that she could live with her son, but she does not want him to take care of her and prefers the safety of living here. She has occasional seizures and other complications from Parkinson's Disease.

M: What do you miss here? In this country and in this place?
LYNNE: Being in this place, what I miss is my freedom
M: In what way?
LYNNE: Not having a car to go to the store, to go, just out. …
M: You are happy enough?
LYNNE: yeah

M: It's not as important to you now?

LYNNE: It used to be at the beginning, but after a while you get used to it….

M: How long have you been here?

LYNNE: It's going to be five years in January

M: When you first moved here, what were your thoughts?

LYNNE: just the idea that you might never leave here. It was enough. I keep saying that to myself. No sense in feeling sorry for myself. Cause that's not going to help me.

M: No, No. You seem like you have a pretty good attitude.

LYNNE: I try. I think that's what keeps me insane

M: (laughing) It's good to be a little insane.

LYNNE: Yeah. I know.

Both Lynne and Chantalle enjoy each other's company and both have the same dry wit, though Lynne also has a devilish sarcastic streak that sometimes leaves aides unsure how to react when they can't tell if she is joking.

Carol eats with Lynne and Chantalle. She is hard of hearing, even with her hearing aids in, and uses a walker. She eats a regular diet but needs to have her drinks thickened. She typically carries thickener in her walker basket – an accessory everyone here with a permanent walker seems to have – and she is usually the table resident who has a pen or pencil useful for marking down meal preferences on the meal ticket. These women have all been at the same table for several years. Their previous tablemate died early last year and their new one is Suzanna. Suzanna would like to go home, though home would likely be in one of her children's homes, not the one she left when she moved here. Suzanna visited Europe several times and misses being able to travel. She has not come to grips with the idea that she will not be going home and her response to that thwarted desire is to direct a stream of swears and invective at anyone who

talks with her. Not constantly, but regularly. Suzanna's daughters, who used to visit daily, are now more infrequent visitors, although one is in at least weekly.

This table is the most likely to be conversational throughout a meal. Lynne will share half of her berry-flavored Ensure with Carol and make sure there is thickener to add to it. They all know that Suzanna is on a restricted-liquid diet and they make sure she does not drink too much – which she accepts with equanimity. Carol, Lynne and Chantalle know each other's food preferences intimately. On days that mandarin oranges are served, Lynne will comment that Carol should get a double portion, knowing full well that Carol dislikes mandarin oranges. They all enjoy the joke. Throughout the floor there is a strong sense of caring for each other:

> Clotilde: Sometimes they do – Like Harriet is a diabetic. I think she may take a pill or something. Once in a while they eliminate cake or pastry on her thing (menu) and other times they just give her anything.
>
> M: I guess you have to advocate for yourself somewhat.
>
> Clotilde: Really do. I feel bad for those who can't. I really do. There is a lady who sits with us, she's 98. The poor thing. She has trouble taking a spoon and moving it to her mouth. We're all through our whole meal and she's still on her soup. It's so sad. She sits there falling asleep. It's just so sad.

Lynne likes to share special treats and Chantalle will sometimes comment that she shares too much. Lynne's reaction is, essentially: What else is she going to do with whatever-it-is? Not that Chantalle doesn't share, but she is more inclined to parcel out her treats over time, making them last until the next allotment comes from her granddaughter. They share candy, fresh fruits and other food from family or friends. Caring for each other gives them pleasure.

At other tables, there is very little conversation. George recently joined the floor and he knew Harry when both lived in the greater community. They talk with each other, although the two

women at the table rarely contribute to the conversation. At one table, 96-year-old Lilly is

surrounded by two people in reclining wheelchairs who speak only with great difficulty. The

newest addition to her table, Sara, also in her 90s, routinely falls asleep while eating. Lily herself

is in a wheelchair, although she can walk with a walker. She is very hard of hearing but reads

lips well. The easiest conversations with her involve using a notepad, something the aides rarely

do. She tends to say very salty things and has a huge laugh. She had no children, but her niece

and a sister visit on occasion. She is observant about what is going on around her and has

commented that she had a happy life and is grateful for her experiences. Generally she is put into

a reclining chair after each meal, where she stays until the next meal. Usually she is asleep, but

she enjoys a conversation if someone sits nearby.

> M: Would you change anything about the food or food service?
>
> LILY: Can I tell you something? I don't give a damn.
>
> M: In what way?
>
> LILY: Any way. It isn't worth it. It isn't worth it. I won't say a lot of them… many of them don't know what good food is. As long as you fill their mouths. This is exactly how I feel. This is what I see. But, I'm content, honest to God. I am. Because I know that this a limited time we're all on the earth. I want to make the most of it.
>
> M: And you are?
>
> LILY: You bet your life. You come in here with me, boy, (does a boxing move) I'm gonna get the big gloves. BOOM, BOOM, BOOM, knock them out for good if it's a guy. And you know exactly what I mean. (Laughter) He'll be walking like this.

At the fourth table, Joanne sits with her sister Gloria. Donna and Gary are also there. The three

women are all in their 90s. Gary has an illness that puts him here, rather than old age. He gets

daily visits from his wife and other family members. While he can eat by himself, he must be

slow and deliberate. His wife often helps him eat, though aides rarely do. Sometimes there is

conversation, but Gary has great difficulty talking. Donna's left side does not work well and she is hard of hearing, but she was very caring when Gloria and Joanne's brother needed calming prior to his death in August. She spends her days doing word searches, watching true crime stories on TV, and is usually interested in bingo and any music events.

Each wing varies, but this tableau is typical of a mealtime experience. By choice, the most active, alert residents are seated together and those who need help eating are grouped at one table by the staff. In one wing, the men are seated at one table. No one could explain why – two could not talk and one did not want to be at the facility at all – so there was rarely any conversation between them. When asked, many residents will tell you that they don't form many friendships here. They feel lucky if they find one person they can spend time with but they are also cautious. These are very old people and death is common for them. Most have already experienced the deaths of husbands or wives, siblings, children and many of their friends. They take care not to invest too much into a friendship that might literally die at any time. "People also become more selective late in life in the social relationships they cultivate and maintain. They prefer established relationships that provide positive emotional experiences, but they are reluctant to devote the time and effort it takes to explore new ones that often entail some strains and other negative aspects during the acquaintance process" (Bandura, 1997, 211).

This facility has been operating as a Green House since March 2017. Some of the people lived there before it was either a Green House or kosher and they have a perspective on how the changes have affected them. Harry, a social person, enjoyed the happy hours in assisted living, remembering them as convivial events. He has his own happy hour in his room, but he doesn't have much of a chance to have a beer and a conversation:

M: I remember you saying to me one day that they don't do happy hour anymore.

HARRY: That was in the other building. They have happy hour over there. They used to have on a Friday or Saturday. They'd be, "What do you drink?". They used to make cocktails. But I always had a beer. I don't drink alcohol, beer is -- Now I drink plenty of beer, but it's the non-alcoholic beer, O'Doul's yeah, yeah, that's a good beer. It tastes good. The alcohol content in it, there's just enough to give it a -- just enough to keep it alive.

(opens the fridge and shows me his supply)

HARRY: They give me two a day. My daughter buys it, brings it and leaves it downstairs. And they bring it up. They give me two a day. Sometimes I only have one and I always have extra one in there. In case my brother comes. When he comes he wants a beer, so I give him a beer.

Chantalle will tell you that salt pork was the start of almost every meal she made: onions fried in salt pork, mushrooms fried in salt pork, chowder with salt pork. Lynne misses eating fava beans. They all miss eating the occasional lobster or prime rib. They miss the possibilities available in their earlier lives. As Chantalle commented: "I don't feel there's more than 10% that really want to be here. ... I have accepted that I'm here, but now I don't really want to be here. But for what, because I can't have what I want".

Methods

There are a number of Green House models in the greater Northeast of the United States. This is not altogether surprising as the founder, Dr. William Thomas, is based in Rochester, NY. Green House model food and food services are very unusual compared to typical nursing homes and are ripe for research on potentially positive changes related to resident outcomes (reductions in malnutrition, muscle wasting, etc.) that might be effective for other facilities. Green Houses were deliberately sought as research sites for this research because of their reputation as innovative facilities. After initial letters and follow-up phone calls and visits with three Green Houses, as

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detailed in the overall method section, this facility was chosen as a research site. Reasons included the recent adoption of Green House principles by the facility, including renovations that added kitchens to each wing in the nursing home, the Green House variations in practice here, and the facility predisposition for research. At this facility, all residents and staff sign waivers acknowledging that there might be research at the facility in which they may be involved.

Before doing research at the facility, this researcher met with the executive director, who approved the research and suggested working with the activities department. The activities director strongly recommended a two-day training – part of their standard new-employee training – which included information on Alzheimer's disease and practical information about the facility. A background check and a negative test for tuberculosis were both mandatory.

Activities was a logical department to connect with, as its staff go to all wings on all floors. At this facility the fourth floor houses the most alert and capable residents and was chosen as the focus of this study. Working with activities staff meant participating in games, music events, and other social activities. Events were never scheduled during meals, except special food events, so meals were easy to observe.

The dining room/living room area is the place where most of the activity on each wing is focused. As indicated, some residents are in their wheelchairs at a table during most of the day. Other residents are in their assigned recliners or sitting on the couch. There are few distractions, so some residents wander – one swipes fruit on his way through each wing and shares it with residents who spend most of the day in their room. During meal times, it was possible to sit in the living room area near the windows and observe the kitchen and dining room areas.

When residents, staff and volunteers asked about me, I answered that I was a researcher interested in food and food services here, and a volunteer in the activities department. Some residents asked more specific questions, but the majority of staff and residents were satisfied with that answer. They could see my name tag (which I brought to each visit as the facility does not have them for volunteers/researchers) and knew I was affiliated with the activities department.

Eventually staff and residents accepted the presence of a researcher on the floor and the researcher was incorporated into the routine. Residents sometimes asked for help in ordering meals; both staff and residents asked for help serving meals. Help would also be asked to bring residents to music events, hair appointments or just to sit outside on the porch or in the inner courtyard. In this way, it was possible to meet and talk with every resident on the floor, as well as many of the staff.

To recruit interviewees, a poster had been developed, and approved for use by the IRB, asking for volunteers. In the poster, residents were given a brief description of the project and were encouraged to put their name in a nearby box. Senior staff were asked about good locations to hang the poster and put the box. They recommended that instead of the box, they would hang the poster on the counter next to the snacks and invite me to give a brief description of the project and ask directly for volunteers at noontime meals. Over a period of two days each of the three wings were visited during the noon meals and requests made for volunteers. Many people were interested. In addition, floor managers and kitchen staff recommended residents they thought would be good people to interview. After the initial interviews those residents spoke with their peers and this snowball sampling method resulted in additional interviews. During the many

observation periods, residents had become familiar with my face, which was also on the poster, and were comfortable approaching me to ask for and schedule an interview.

Over a seven-month period, 21 visits were made, mostly between the hours of 9 a.m. and 6:30 p.m. on two consecutive days every other week, to observe and record activities related to food and food services. Residents were observed at meals, at activities, and between meals. Observations were recorded each day and analyzed using NVivo 12 Plus software. In addition, seven interviews with residents and three interviews with food-services personnel – floor cook, executive chef and head dietician – were conducted after observations had concluded.

Interviews were recorded on a digital recorder, transcribed by this author, and analyzed using NVivo software. Two secondary coders reviewed the data coding. Eventually, after clarifying discussions, consensus of 85% was reached on coding. Member-checking was performed with two resident interviewees from the facility. They read the case study reports and agreed about the overall conclusions. Both actions were designed to increase the reliability of the data. In addition, results were triangulated from a combination of semi-structured interviews, participant observations and document analysis, which improved the validity of the results.

The interviews with elders started with questions about their childhoods – specifically whether they had had a garden growing up, whether they helped in the gardens and what was grown. Next-tier questions asked who had taught them to cook – if they had been taught how to cook – including whether they had learned to preserve foods grown in the garden. The final questions were about their experience at the facility. The questions had been tested at an unrelated assisted-living facility in March and April of 2018 and reviewed by the director of the University survey center. Test interviews showed that starting with questions related to the full span of their lives

led residents to be more mindful of their overall food experience as they answered later questions about food and food services in their current residence. The questions are in Appendix A.

Most of the elders who live in this Green House were born just before or during the Great Depression and many remember Victory Gardens and food rationing. Resident Lily gleefully recalled underwear her mother made from flour sacks, saying that when her skirt blew up "everyone would see 'Pillsbury's Best' on my pookyak". Encouraging residents to think about their lifelong experiences with food provided nuance and shape to their current attitudes and perspectives about the food and food services at this facility. NVivo software offers an easy-to-use program to help code observations and interviews. Exploring common themes and using pattern-matching helped better explicate the facility's ability to provide satisfactory mealtime experiences for residents and meet regulatory responsibilities of providing person-centered care.

Staff interviews were used to understand day-to-day workloads including assessing and implementing changes to current elders' diets, assessments of new residents, food costs, purchasing decisions, food-related staff training and education, dining room protocols, menu planning, religious protocols, waste management, managing state and federal rules and regulations, as well as meal preparation and serving. The questions are in Appendix B.

Residents were observed at least once during each daily meal time, during snack times, at activities related to food, such as an ice-cream social, and at specialty meals.

Analysis and Findings

Cooking meals on the floor is a big step toward making a long-term care facility more like a home. The smell of food cooking at appropriate times is a clue that helps orient everyone to time

of day and upcoming activities. It whets the palate and feels homey. The more common practice of cooking in a central production kitchen, putting food into hot-boxes to go to the floor, or using a steam table, does not generate those same smells and orientation. Cooking on the floor means the meal is as hot or cold as it should be and can be easily tailored, on the spot, for what the resident would like to eat out of the options available. No one needs to call the kitchen because something was forgotten or to order a sandwich for a resident who, at the last minute, opts out of the main meal options.

Federal law requires any facility that accepts CMS funding to adhere to some common food rules, including providing a main meal and a main meal alternative. Here, in addition to the main and alternate choices, residents can eat peanut-butter-and-jelly, egg- or tuna-salad sandwiches. Kosher rules prevail, so grilled cheese, for example, is not available during a meat meal.

Medicaid rules also regulate the offering of "nutritious" snacks at 10 a.m. and 2 p.m. daily. This Green House doesn't provide them at specific times, according to the dietician, because shelf stable snacks are always on the counter. This can confuse residents, particularly those who lived here before it was a Green House or who came from another facility. They will sometimes comment that the snacks seem to be late. Those who cannot wheel themselves to the snack counter -- or who don't remember that snacks are there -- often go without snacks. On occasion, a tray of pudding or slices of cheesecake will appear on the kitchen counter. Sometimes an announcement is made about them; other times an aide will ask who brought them, when they arrived and what is supposed to happen with them. The lack of communication around snacks reflects concern in other areas as well, such as understanding job responsibilities, and management goals and intents.

Combing through the interviews and observations revealed common themes related to the impact

of the Green House innovation on the elders. Not surprisingly, the diffusion of innovation related

coding was a strong category as the conversations with employees focused on the innovation.

Resident comments related to the innovation were more limited. Menu is also a frequent code

showing up in most observations and interviews. Codes under "menu" that were also coded

under the "mealtime experience" were of primary interest to the self-efficacy research. Overall,

focusing on the food and food services experience of the elders brought to the front primary

findings highlighting self-efficacy/agency, plus support and lack of support for agency,

employee training – encompassing the mealtime experience, and personalized foods – plate

waste, and caring for others.

Key Themes	Green House	Green House total number of references	Number of files per theme	Number of references per theme
	Files	References	Combined	Combined
Employee training	24	121	35	148
Support for self-efficacy	17	57	46	186
Lack of support for self-efficacy	10	15	22	39
Caring for others	17	28	36	59
Plate waste	8	24	18	50
Agency	20	85	37	152

Table 4 Key themes and number of references and files for the Green House model innovation

Changes related to the innovation and employee training had 13 instances where the coded

material overlapped. While the physical environment is a big part of the Green House model, it is

employee training under the Eden Alternative principles that truly define the Green House

philosophy. Most of the overlap came from interviews with the executive chef and the cook for

the fourth floor who spoke of the difficulties they are encountering with nursing staff who have not been schooled in the Green House approach. Those principles – related to resident agency – echo the objectives of the OAA, including hospitality, respect, choice, courtesy and friendliness, yet are practiced very unevenly in the various activities of the facility.

Graphing the overlap between employee training and support or lack of support for agency (Fig. 11) shows that employee training could be improved – particularly in a facility with the goal of achieving person-centered care.
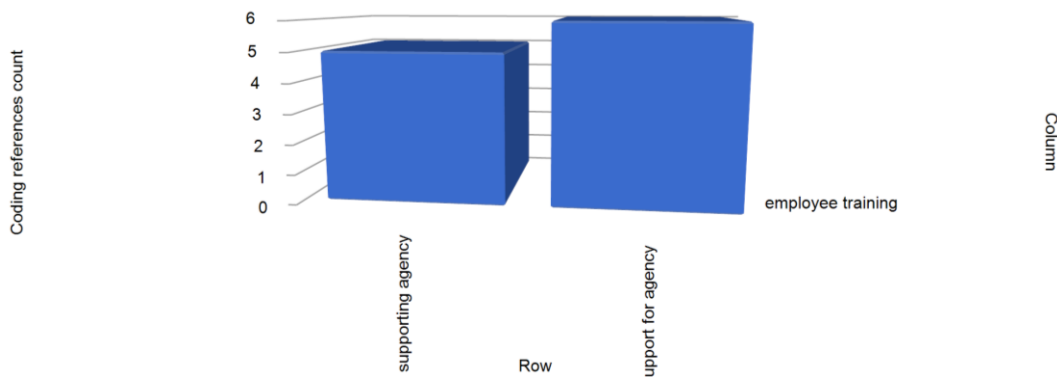

Fig. 11 Comparison between employee training and support/lack of support for agency

The role of the Shahbaz in the Green House model is supposed to embody the concepts listed above – hospitality, respect, choice, courtesy and friendliness. The variation practiced here, of having one aide as the Shahbaz and everyone else as a standard aide does not lend itself to the full intention of the role as envisioned in the model. Instead, there is confusion among the aides and the residents about care structure, individual responsibilities and the meaning of person-centered care. "The structural impediments to the continuance of productive lives include institutional arrangements, role expectations, and social norms that curtail opportunities and withdraw incentives to exercise the competencies the elderly possess" (Bandura, 1997, 2008).

At various times, staff would comment openly on their experience, particularly when they were frustrated. Aides remarked several times that they were not sure of their job responsibilities within the Green House model. An activities aide said one day that she liked what she called "the greenhouse effect" because she thought the smaller houses provided better care than in another facility she had worked at. She clearly had some knowledge about the Green House model, but also indicated some confusion about what it is, compared to the greenhouse effect that disrupts the global climate.

In other facilities visited during the past five years, it has been common to see kitchen aides responsible for plating and general oversight of meals. They typically have the meal tickets and keep track of diet restrictions. There are three levels of diet – regular, ground and puree. LNAs serve food and drinks, then clear tables when meals are completed. A cook prepares meals under supervision by the executive chef and a kitchen aide serves it. In this Green House, the Shahbaz – who takes over from the cook during each meal – is supervised by the floor manager who does not report to the executive chef. This additional disconnect challenges staff.

A Shahbaz who does not follow ServSafe procedures creates a problem for the executive chef, who has no standing to discipline the staff member. Watching a Shahbaz use the same knife in the peanut butter jar then the jelly jar showed a poor understanding of best kitchen practices and a lack of culinary training. The lack of employee training influences the mealtime experience . Graphing the mealtime experience and employee training showed 22 instances of overlapping codes Fig. 12). None of the mealtime experience data were positive. "If new practices are forced upon unwilling sectors, they will implement them in deficient ways that ensure their failure" (Bandura, 1997, p. 513).
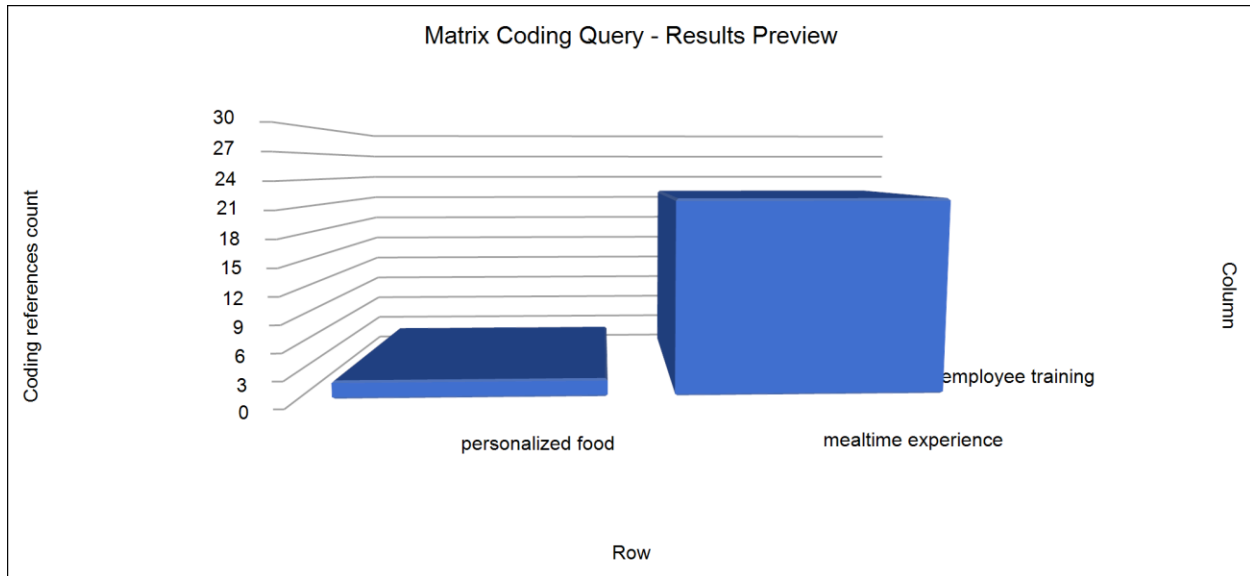
Fig. 12 Comparison between employee training the mealtime experience and personalized food

When asked about her training, the cook said she had stepped in at a sister facility eight years ago for a cook who called in sick; she has worked as a cook ever since. She had been an LNA and her only culinary training was home-based. The executive chef worked in restaurants and then as a caterer for many years before becoming the executive chef. He paid for his completely unrelated college degrees through his restaurant and catering work. When the facility began looking for an executive chef, the directors thought of him because they knew him from successful catering events at the site. It is common in restaurants for employees to work up, over time, from dishwasher to line cook to chef. In this case, the chef indicated that the management liked his overall approach to food and were willing to train him in less comfortable arenas, such as long-term budgeting. Practices specific to food for elders was not part of either of their training.

Research into the differences between traditional, household (such as this one) and small-house facilities has been limited. One of the more interesting conclusions of this research is that there

are co-occurring components, highlighting the multilayer, cooperative nature of culture-change elements. So, for example, co-occurring components of staffing cluster together – direct-care workers consistently working with the same resident and fulfilling resident requests without prior approval (Elliot et al., 2014). There has not been enough research to know whether each practice by itself would affect change or whether practices are more successful when combined. Existing research cautions that implementing changes in advance of well-established evidence is complex, and thoughtful strategies are prudent. As in all diffusion research, early adopters do not have the luxury of drawing on others' experience as later adopters can.

Much of the research on elder-care culture-change focuses on leadership and staffing changes that support person-centered care. Culture-change research also acknowledges changes in the resident mix at nursing homes more recently as hospitals have begun discharging patients sooner into nursing homes. Residents with higher needs and more complex medical problems are having an influence at all levels in nursing homes (Miller et al., 2010).

A Health Services Research editorial (Bernstein & Munoz, 2012) evaluated prior studies on culture-change elements and found that, among other things, the "staffing model needs careful attention" (p. 347). Research into the culture-change movement includes similar concerns about staffing. Researchers see high-quality care compromised by "chronic staff shortages and turnover and inadequate reimbursement" (Miller et al., 2010, p.66S).

This not-for-profit facility is supported in part by a foundation. This is not the foundation's first Green House, but it is the first one renovated from a typical nursing home into a Green House. In diffusion research, adopters of innovations are categorized by when they choose to adopt an innovation. This Green House variation is hard to classify. Technically, this facility would fall

under the "early adopter" category. Yet the variations in practice here may put it closer to the "innovator" category (Rogers, 1995). Even as limited research on the outcomes of a perfectly executed Green House model becomes available, boundaries of the innovation are being pushed into new territory. Leadership and cost, often identified as the biggest barriers to culture change (Miller, et al., 2010), are clearly not barriers to culture change here – management put time and money into the physical changes needed to convert to a Green House model.

Green House model homes are still rare enough – somewhere between 1% and 2% of all nursing homes in the United States – to be considered positively deviant. Positive deviance research typically looks for interventions that can be made with resources at hand and that are common to similar situations. Adding plants and animals would be one such set of interventions. Leadership and staffing training to support person-centered can be done without needing construction or incurring huge expenses and are central to the Green House philosophy. Early research showed that training, such as the Eden Alternative training, supports beneficial outcomes in culture-change areas such as resident and family satisfaction, quality of life, employee satisfaction, and staff turnover (Grabowski et al., 2014). Yet in this facility, which formerly operated as a typical nursing home, there are struggles. "Those who run such systems have a vested interest in preserving the existing arrangements and are wary of trying new approaches" (Bandura, 1997, p. 514).

The Green House models overall veer away from being positively deviant in that a true Green House also requires investment in facility design. A complete conversion to the Green House model requires more than the resources at hand for nursing-home administrators. Yet many components central to Green House principles can be adopted by any organization hoping to effect change.

A definition of "positive deviance" in research by Bradley et al., (2009) is "organizations that consistently demonstrate exceptionally high performance in an area of interest" (p. 3). The limited research on Green Houses so far supports a high-performance designation. From there, next steps should be additional in-depth studies using qualitative research, testing generated hypotheses in larger representative samples and then working with key stakeholders to disseminate the evidence (Bradley et al., 2009). More than 200 Green Houses have been built and limited qualitative studies are available. Next would be large-scale testing of hypotheses, yet no published data are available. Somewhat inexplicably, key stakeholders -- including potential adopters and funders --were willing to overlook the lack of evidence and spend millions of dollars supporting the diffusion and research into Green House models. Time, and considerably more research, will tell if the Green House model and variations are credible and valid.

This facility is not a "replication with fidelity" but rather a variation well outside the boundaries: It has 50% more residents than the ideal; one-quarter of the ideal number of staff trained as Shahbazim; no access for resident participation in meal preparation. A holistic view of this facility shows that it also lacks live plants and animals and has a very limited activities staff and attendant programming. The loneliness, boredom and helplessness identified by the founder of the Green House model have not been abated here by the changes implemented so far. "Structural changes that expand the roles and opportunities available for older people would make it easier for them to pursue fulfilling productive activities over their entire lifetime" (Bandura, 1997, p. 208).

Donald was slowly fading into dementia and struggling to eat. Dementia residents are unusual on this floor, so aides may have lacked training to help him as effectively as the dementia-floor staff would. Four of his sisters already lived on this floor when he came here, and the family asked

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that he be housed with them. He was cognitively alert when he moved in, but when his son moved away Donald deteriorated quickly. During the observational period he stopped using silverware and started using his hands to eat.

Aides made few adaptations to help him. If his sandwich was cut into squares, he would eat it. If not, it would flop when he tried to pick it up and he would hastily put it back down and leave it. If cut fruit was in a dessert bowl he struggled to access it, usually having trouble getting his fingers around each piece, but on a plate he could better grasp the pieces. Try as he might, he could not get soup to his mouth. Self-determination of residents should be honored, but aides would often wait until Donald showed frustration before helping him. By then he would eat very little. "The more the environment in which the elderly live limits them, the more they will decline in their sociocognitive functioning" (Bandura, 1997, p. 208).

It is the ignoring of small things by the staff, like noticing that a sandwich now needs to be cut, that grind at the residents. Chantalle complained to the nurse that the potatoes in a potato salad were hard. The nurse, who cut one potato piece with Chantalle's fork, said it seemed okay and moved on. That lack of support for the agency of the resident – who had a valid complaint – diminishes residents' concerns. It turned out that about half of the potatoes were still hard in that batch of potato salad, as noted by Lynne and Carol during their lunch in the dining room. Meats are served in portions that usually need to be cut with a knife, causing residents with limited dentition or hand arthritis to struggle. In addition, these activities lead to plate waste. Chantalle also notes: "The other thing is, they serve too much. Instead of letting us ask for seconds, they serve too much".

The overall mealtime experience leaves much to be desired. The mix of residents who sit in the dining room or living room all day and those with autonomy can mean that a table waits for a final resident to arrive before the meal is served. Aides try to have all tables on the same meal course, but sometimes that means every table waits until the soup is cleared, even if only one table ate soup. With that said, the aides recognize that some residents are so slow that the meal needs to move on around them. Drinks choices are often assumed to be the same each day and are not checked against the slips, and drinks are sometimes forgotten altogether until a diner complains.

Inaccurate menus were an occasional problem, so residents would get food they were not expecting. As Chantalle once commented: "You might as well have a blackboard and write down what the menu is. No sense in asking us what we want because we are not going to get what we asked for". Aides would say nothing, just serve a plate and walk away.

At one meal, the Shahbaz wondered aloud at one meal about how that meal was supposed to be served. Another aide didn't know what peas were when asked for some. Mostly, the main dish would be available, but sides or dessert would differ from the ticket. The ticketing system has many wonderful features. Tickets include information on the likes and dislikes of the resident and some medical related information, such as limits on liquid intake. Residents with agency would greatly modify their tickets when possible, ticking off individual items to build a meal if they didn't like the main dish options, and writing in adaptations such as no bun with a hamburger. Aides would not check tickets against what was served at each meal, so disparities occurred. One of the four primary factors related to the maintenance of cognitive functioning in the elders is a sense of efficacy to influence the events of everyday life. (Bandura, 1997).

Lunch and dinner feel haphazard: Once residents are seated, aides just stand and talk to each other, waiting for the person in the kitchen to get organized. Aides don't interact much with the residents; they don't always know what is for dinner or stop to help a resident fill out a meal ticket or notice that drinks have not been served.

Residents have very little time to enjoy their meals. Except for breakfast, meals are often rushed and not attractively arrayed. Residents might be forced to pile soup bowls in the center of the table to accommodate the main dish when, as often happens, the empty bowls are not removed before the main meal is served. Dessert is served while the meal is still half-eaten. Staff reach across tables when serving, plop plates down without comment and ignore the preferences indicated on menu tickets. Sometimes it's because they are serving items not on the tickets, sometimes because they have run out of an item, and sometimes because they just aren't careful. Be done! is the message. "It requires a strong sense of personal efficacy to reshape and maintain a productive life in cultures that cast their elderly into powerless roles devoid of purpose and do not expect much of them" (Bandura, 1997, p. 208).

Additionally, a resident who takes more time than others might see their plate lifted up while the tablecloth is whisked out from underneath -- so it can get to the laundry on a schedule that doesn't jibe with the dining schedule. Used linens – tablecloths and clothing protectors – are often piled on a table where a resident is still eating.

Vegetables are cooked in water and are usually poorly drained. It is visually and texturally unappealing to mix broccoli water with gravy or tomato sauce. Joanne, the resident who produced a cookbook in her late 80s, commented: "And give 'em food, not gourmet food, and don't mix the pasta. One day they gave them macaroni and cheese and pickled beets on the side.

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And the juice was running under the pasta – beet juice. You know. You don't want stuff like that".

There are no condiments on the tables. Salt and pepper packets are kept on a side counter, which is not easy for residents to get to, especially once everyone is seated. Ketchup, mustard and relish are also in small packets, which are hard for elders to use. Asking for and getting condiments in a timely fashion is problematic. Items such as balsamic vinegar, or vinegar and oil for a salad, are not readily available. As a result, residents keep a supply of their favorite condiment packets in their walkers and in their rooms.

> CHANTALLE: We have to wait for straws, we have to wait for salt and pepper if you wanted it, or sugar. To me, why can't we have it on a tray that you don't have to go back to the counter. Have one tray someplace, away from the counter, that has some straws, and has some mayonnaise, has everything, so that nothing is put on the table that has to be thrown away. There is an awful lot of waste. Now they bring me, all I have is Splenda on my cereal. I do not use any sugar in my coffee. So this way here, they bring me a handful of mixed sugar and Splenda. I've got a whole cupful, I've been saving it. So this way here, when they forget to bring me anything, I've got it over there. I'm not going to have them throw it way. And then have to wait an hour and a half for them to come back with something.

All-kosher meals cause some friction with the gentile population, some of whom were residents before the facility went kosher. Generally, having all meals kosher is fine with residents, but not being able to have a glass of milk at meat meals, or the limited variety of meats served, sometimes irritate for the residents.

> JOANNE: And then they don't change the meat. This is a Jewish place, which is fine, but you can't have brisket for every beef meal. You need to have, I can taste the flavor in everything. They make lentil soup, it's got brisket in it. They make beef stew, brisket, they make pot roast, brisket. I get sick of that taste. And you know what, for what they throw out, we could have gourmet meals. I suppose I'm speaking out of turn, but I've told the same thing to all of them.

Staff, who are not all Jewish, sometimes seem to forget the rules. Visitors don't always know what to do, either. I watched a private aide get yelled at – quite literally – when she pulled a salad out of her bag to eat while her client played bingo. The staff person who yelled muttered afterwards that "they" get into trouble when non-kosher food was seen by upper management where it should not be.

Food meetings should be a place to collect resident input and integrate it into meal planning and execution. Although Food Meeting is listed on the monthly schedule, residents often did not know what the Food Meeting was and did not attend. Meetings were short and, in one case – because the air handler in that dining room is so loud – half of the meeting was a chorus of "I didn't hear what she said". The meeting moved fast and there was little time for contemplation. Excellent snacks were served, staff took notes, and residents were specifically asked to give feedback on new or recently adapted recipes. Residents identified by the cook and executive chef as "complainers" often attend, yet these residents took pains with their criticisms to not hurt anyone's feelings. Privately they would comment that the "cook needs more training" and that the aides did not know what the meals were. "But institutional practices still lag behind the capabilities of the elderly. Their skills and wealth of knowledge to untapped despite a critical social need for their contributions" (Bandura, 1997, p. 208).

Discussion

Resident complaints have borne fruit. In August, complaints to both the food committee and resident council about how long it was taking food to get to the table had been conveyed to the staff.

Everyone who was having soup was finished, the bowls got stacked and everyone was still waiting for their dinner at 5:25, even though they had been seated at 5 p.m. The aides kept stopping to talk with each other or other employees walking through. My impression was that (residents) just wanted to eat. Lynne and Suzanna eventually asked what was taking so long.

The complaints meant that food service speeded up, but not in an organized and thoughtful way. Part of the problem is that meal tickets are placed, if they are placed at all, by a resident's usual seat just at 5 p.m. No pencils or pens are put out so those already at the table can't indicate their preferences. By the time the tickets are filled out and collected, several minutes have gone by. Then the Shahbaz sorts the tickets, figures out if anyone is having soup or salad, and starts dishing food. By then, 10 minutes have passed, and the main meal is not yet getting plated for those who did not want soup or salad. By ineffectively responding the complaints by simply speeding up the pace of the meal, the staff is showing their opinion of the changes. "Even greater obstacles to sociocultural change can be erected by privileged groups that benefit from the existing social arrangements, and thus, have a strong vested interest in preserving them" (Bandura, 1997, p. 512).

The executive chef noted that often both the main meal and the alternative are prepared in equal amounts, "just in case", wasting any extra. Small but expensive meal items, like leftover, boiled, pasteurized, eggs from breakfast could be used to make egg salad but are usually thrown away because there is no chain of custody for them. Full plates are put in front of each resident who often comment that it's too much food. Studies have shown that this can deter the elderly from eating, while also distressing the elders over the waste they know they are generating (Evans, Crogan, & Shultz, 2003). The executive chef noted that food waste is an area of concern. To address that and other concerns, a new "homemaker" position is being introduced.

The homemaker position is in response to the complaints of both the medical and dining staff. Facility directors have recognized that, as neither department is truly responsible, responsibilities are slipping through cracks. The homemaker will oversee the kitchen and dining room, as well as doing light housekeeping – such as putting away laundry and helping residents get to appointments in the building. The homemaker will replace one of the current aides, so three aides will be responsible for the day-to-day care of the 16 residents, but without kitchen and dining room responsibilities.

The homemaker will be a consistent observer who can help look for ways to reduce food waste, which is an ongoing issue. There is no way for the facility to know the total amount of food wasted each day. Food waste is ground in a sink and flushed away. From observation, few meals are completely eaten. Almost everyone leaves food on their plate. Joanne notes that: "They were making chowder very good when I first came here. Now, nobody, they leave the chowder. Don't they see people not eating? You can see them leaving it. I says, look, they could buy tenderloin steak with that food they are wasting".

The kosher need for separate dishes, silverware and serving spoons adds complexity to each meal. Kosher rules led to occasional frantic last-minute searches for the right tool by the Shahbaz and required constant vigilance by staff to assure that the rules were obeyed. The dietician noted that meals are served with an appropriately sized ladle or serving spoon, but the Shahbaz often scrambled to find the right one, leaving the actual implementation a bit haphazard, and hence wasteful.

One night, Max was still hungry after eating beef stew and cake. He was ignored in his attempts to catch an aides attention and he finally drew me in to ask for help. When asked, the aides said

essentially that the kitchen was cleaned up from dinner and that they didn't want to give him a requested banana because he had had cake, likely increasing his blood-sugar levels. None of the aides moved to do anything further to help him but he kept asking and getting more frustrated until finally someone said they would call the nurse and ask for options. I never saw them make a call and eventually one of the aides said he could have a banana later. His response was to ask, "Am I in a concentration camp?". At that point he went, still hungry, to his room. "The social environment fosters dependency in the residents but offers little support for expressions of independence" (Bandura, 1997, 2006).

During that same meal, Max's tablemate, Fred, had two nursing staff fussing with his medication port, which is near to his armpit. Fred was trying to eat while staff had their hands up his sleeve. Max was getting bumped by their efforts. It was very unclear why they didn't either move Max or wait for Fred to finish dinner. It is understandable that medications must be administered in a timely way, but the whole scene was not one of convivial dining -- or the good practice of medical care -- for anyone in the dining room.

Dietician orders are sometimes disconnected from the reality of what happens on the floor. When asked about the use of Ensure (a nutrition supplement), the dietician said that supplement use was limited and that the preference is to have residents eat well. On a day-to-day basis however, nurses on this floor routinely poured glasses of Ensure for the residents to use when taking medications.

Many residents are hard of hearing or have trouble hearing over the combination of TV and overhead speakers. They would often ask to have a sentence repeated or would not realize they were being addressed. Conversations between staff and residents were limited to immediate

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matters at hand and it was hard to discern if language, culture or disability was responsible for lack of communication – and, in some cases, infantilization of the elder. During an observation, one woman asked an aide for tea and the aide said, "Say please" The woman didn't hear her and the aide said, "Say please," twice more before getting up to bring the woman's tea. "Because social practices have not kept pace with improved aging, the problems of the elderly are partly due to the failure of social systems to support the personal efficacy they possess" (Bandura, 1997, p, 208).

Staff members often converse in Spanish, which one resident – who was herself originally a non-English-speaking immigrant – called rude. Staff members often talk over the heads of residents, even while helping the resident into a chair or into the bathroom. Occasionally, the activities staff would offer manicures and that activity generated the largest number of free-flowing conversations among staff and residents, although even those conversations often ended up being between two or more staff members.

There is an opportunity for the Culinary Institute of America and similar culinary training schools to add programs for cooking in long-term care facilities. Continuing-care retirement communities, particularly those charging residents a large up-front cost, will need to meet the culinary expectations of their residents. Baby boomers are already asking for foods not on typical nursing home menus while they are in rehab. Eventually, that is likely to change the training requirements of cooks and chefs in all nursing homes.

Additionally, there is an opportunity for nurse-training programs to understand how food and food services affect residents' day-to-day life. Watching aides pile dirty linen on a table while an elder is still eating; or reach between two diners and their meals to serve a third person, rather than serving from the side; or leaving a sticky knife on the table after using it to stir thickener

into a drink. All these observations show that food service training – and perhaps culturally relevant training – is lacking. These practices are not meeting the OAA objectives of supporting elders through respect, choice, courtesy and friendliness. "New practices usually threaten existing status and power relations. In addition, adopters have to abandon secure routines and learn new ways of doing things" (Bandura, 1997, p. 512).

Research has shown many reasons that eating well improves health and wellness, so nursing-home aides should understand that good service at meals is also good nursing care.

> It took intervention by Chantalle, Lynne, and Suzanna's daughter to get the drinks correct, to get the straws they all need, with Carol thickening her own drinks and everyone a little unhappy because the meal was not as advertised on the tickets and the aides did not take or read the tickets or apologize for the errors. At one point Suzanna's daughter commented that Chantalle had not said thank you and her [Chantalle's] response was "She did not acknowledge my request, and I will say thank you when she returns with it. I don't say thank you any more until they have either acknowledged my request or fulfilled it".

Although developing friendships is fraught with the potential for loss in a nursing home, residents do form relationships with each other. They pay attention to the care given to other residents by the staff, and they support each other where they can. Even when they may not like another resident, they notice, and even complain to management, if they see poor care of someone who cannot advocate for themselves.

> LYNNE: The second shift, they have pretty good CNAs except for one, she's a mean son of a gun. And one day, she was giving Lily a hard time. She picked on that Lily like nobody's business. And one day she was picking on her and she's very rough with her, I went to see Wanda and I said to her, she's being very mean and very rough with Lily. I says, that's not fair. I say's Lily doesn't, half of the time, she doesn't know what she is doing. I says, and she's giving her such a hard time and [so] they put [Lily] on a schedule to go to the bathroom.

The high staff turnover and lack of training also show in the care as well. This graph (Fig. 13) shows the overlaps of agency and caring for others
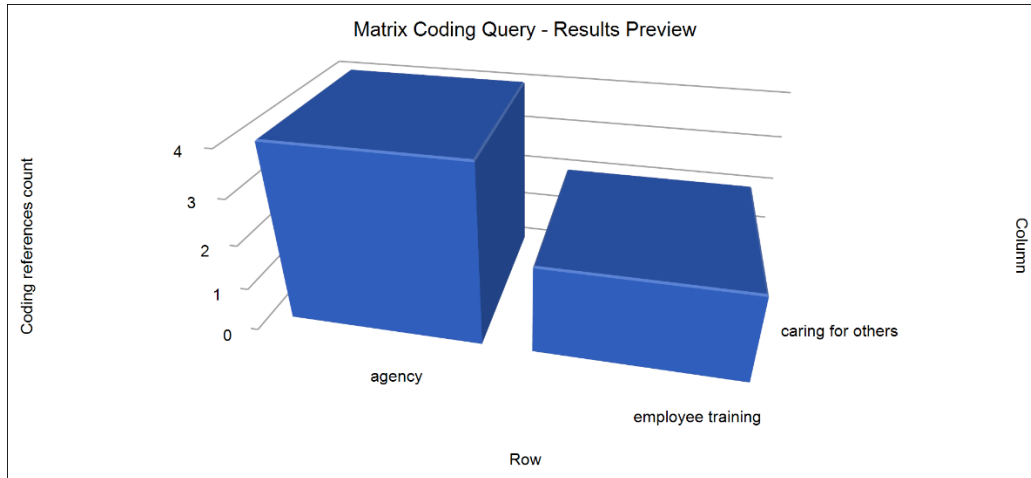

Fig. 13 Comparison between caring for others, employee training and agency

One overheard conversation between two staff members was a good reminder of the varying levels of care offered by staff:

> As I was heating the tea, Carol was wheeled back into her room by the tall aide. She came back and the aide with multiple piercings said "Carol was a real bitch last week" and the tall one said "Was that when her sister died?" and the piercings one said "I don't know, but she was in a bad mood". The tall aide asked how they wanted to divide up the work ahead and earring said, "I don't care".

With employees showing a level of disregard, the residents need to advocate for themselves. Those who can't get substandard care. If they are lucky, someone else on their wing or floor notices and used their agency to effect change. Of the 28 coded references to "caring for others" only eight were related to staff, the rest were all examples of the elders caring for each other. While residents evince a strong showing of self-efficacy and agency, the practices and employee training at this innovative facility do not support them.

Conclusion

In this facility, rooms and bathrooms are private and everything seems clean and well cared for. Having a cook on each floor preparing the meals lends a homey feel and allows kitchen staff to better understand residents' preferences. Yet the facility struggles to meet the goals of the Green House model – to eliminate the boredom, loneliness and helplessness of aging in a residential-care facility. The physical changes to the facility are an excellent start towards more person-centered care although there are still concerns: a lack of plants and animals, severely limited areas where a puzzle, for example, can be worked on over time, limited comfortable chairs in the main living room and a crowded dining room. However, the combination of differences between Eden Care principle based and traditional nursing training, cultural differences between care givers and residents and the lack of opportunities for residents to enjoy a variety of activities shows that more is needed than changes to the physical environment to support self-efficacy and agency and to meet the objectives of the Older Americans Act.

This facility was chosen in part because Green Houses advertise themselves as a new model in nursing-home care. Practiced as intended, it may be an excellent model. But here, after a year of implementation, there are big gaps in the practice of the ten Eden Alternative principles that underpin the Green House models. An editorial in the Health Services Research journal by representatives of both the Robert Wood Johnson Foundation and the Green House Project (2016) discusses the "lack of empirical evidence about whether the model can be replicated with fidelity… and whether there are measurable differences in quality of care or clinical outcomes" (p. 346).

Observing kosher rules is a challenge to both staff and residents, particularly because, while not all are Jewish, all must learn to adapt to these specific rules. The challenges of different eating and serving tools depending on the meal, the restrictions on what can and cannot be served together, the limitations on what is served at all, and the constant vigilance needed by the Shahbaz to avoid violating kosher rules, adds a layer of complexity that influences the mealtime experience of the residents. Residents who are not Jewish do not always appreciate the limitations on what they can eat. One resident commented: "But I think the trouble with it is they stick too much to the Hebrew ways and there's a lot of people that are not Jewish and we would like a little more leeway". In addition, eating outside foods is permissible only in limited areas – the kitchen and dining area cannot be used to reheat, eat, or store non-kosher foods. This erodes the sense of "home" intended by the Green House model.

The concept of co-occurring components of care related to the Green House principles offers opportunity for further research. The "feel" of the facility would be different if there were live plants on the floors, if there were animals – even fish or birds – for distraction, if the day-care children visited the wings on occasion, if there were "variety and spontaneity" leading to "unexpected or unpredictable interactions" (Thomas, 2004, p. 189). None of those things are here and the result is a sterile and not "home like" atmosphere that does not meet the objectives of the OAA.

The sheer size of the facility also presents obstacles. Residents are discouraged from leaving the floor without an aide, family member or friend. Because of the ongoing shortages of aides, there are rare times when someone is free to take residents outside to the courtyard or front porch. Negotiating the elevators, the Great Room, and the distance to either outdoor space by themselves is a bit of an adventure for these residents. They do the trip so infrequently that they

don't have the confidence to assure success in the journey and that may limit their willingness to try. Many of the elders in wheelchairs need help to get outdoors at all. Residents exhibit noticeable hesitations when they exit the elevator at the Great Room about which way to go to get to the courtyard, which is not obvious from the bank of elevators.

To get residents outside more during the summer, a barbeque was held every Thursday in the courtyard for the fourth-floor residents. In addition, complaints about lack of access to the outdoors led to a directive from the administration to have one aide take interested residents outside after dinner each day when the weather was appropriate. The practice of getting residents outdoors will likely improve their ability to make the journey by themselves, supporting their self-efficacy – although there will still be a facility rule that requires the presence of an aide. Limits imposed on the elders speak to the difficulties faced by every elder-care facility in supporting resident self-efficacy – at what point does it become unsafe for elders to do what they want, and who controls those decisions? Bandura (1997) notes that "Residents of nursing homes who are given opportunities to exercise some control over events in their daily lives are more active socially, more engaged in activities, happier, remain in better health, and live longer than those who are kept dependent on the staff" (p. 206).

In addition to the building's size, there are other facility impediments. The space is very crowded when all residents eat together. The addition of the kitchens took over part of the dining room. The tables, as noted before, are too small for multiple wheelchairs to occupy without someone getting banged. The chairs removed to make room for the wheelchairs are shoved against the window wall. That blocks access to the windows and crowds the space even further. Residents who sit closest to the windows must take care when backing away from the tables to avoid tangling with chairs behind them.

In the living room, comfortable chairs are each dedicated to a specific resident, leaving the couch and padded dining chairs for everyone else . Any other resident who wants to be there needs to be able to get on and off the couch by themselves – or sit in their wheelchair. Getting in and out of a wheelchair by themselves is strongly discouraged. That leaves residents who are not allowed to be alone in their room – where they typically have a comfortable chair – sitting for hours in their wheelchair at a dining table. The whole shared space is crowded but some adaptations, such as stackable chairs or slightly larger round tables might help, at least in the dining room. Space designers such as those used by architectural firms might have suggestions to improve the furniture and functionality of the space.

Residents who complain are not usually seen as the bellwethers – the ones who are leaders of change. These complainers are articulating problems that warrant a review by facility directors. In this case, some complaints articulated by these residents are gaining traction. The homemaker position, if done well, could solve many of the current concerns. Among other things, homemakers could help with resident meal choices in time to limit the duplicate dinners that are currently made and wasted, evaluate meal concerns on the spot and alert the kitchen staff to problems, and bridge between the nursing staff and the dining staff to support resident's needs. For example, rather than just putting meal serving on high speed, a more thoughtful approach could achieve the same end – resident satisfaction with their meals – without the rush.

This facility may need to regroup and reconsider its approach to the Green House principles. Changes are starting to occur that may address the problems that are most obvious; hopefully the homemaker position, as stated before, will provide a bridge between the dining staff and the nursing staff. The homemaker could become a source of information to management about day-to-day practices that do not support the self-efficacy of residents or meet the innovation's intent.

Other Green House principles not currently in practice – such as live plants and animals, greater resident participation in meals and meal planning, and maximum possible resident decision-making authority in the hands of the elders or those closest to them (Thomas, 2004) – may prove to be necessary co-occurrences for these elders to live free from the boredom, loneliness and helplessness the model was designed to avoid.

A new paradigm in training LNA personnel that integrates a better understanding of the importance of food and food services to their job, and specific elder-care-related training in culinary-training facilities would offer opportunities for more satisfactory meal experiences for the elders. Facility managers are already caring for the next generation of elders in their rehabilitation wings and are seeing the generational differences in expectations of quality of care – particularly expectations around food and food services. Those expectations will need to be met with different training to attract elders with private funding or long-term-care insurance, which will ultimately influence all facilities.

Current experiences highlight the time lag seen in the residential elder-care industry between implementation of innovative care models and necessary adaptations in training caregivers and food-service personnel. Additional research in this area will be critical to assess whether, and how, the needs of this or other innovations can be met. Joanne has the last word: "(T)he most important things for nursing homes, I see, is food and comfort. Because they know they're gonna pay their rent. Give them the best you can for the amount of money they give you. We need that. And we can't help ourselves, so we need somebody to care a little bit".

CHAPTER VII

CROSS CASE ANALYSIS

Innovative leadership

The Older Americans Act is still as relevant and vibrant a piece of legislation as it was the day it was passed. The objectives of the OAA have remained the same, but changes in legislation related to person-centered care have finally given a shape to the objectives as they influence care in residential facilities. Innovations that focus on person-centered care, require little capital investment, are inexpensive to implement and show promise for improving person-centered care in residential care facilities will increase in importance as the number of elders in care homes increases. Facilities will be competing for self-funding elders in particular and for the soon-to-be-elder baby boomers in general.

More research is needed to help understand which cost effective innovations more typical residential care facilities could adopt to support person-centered care – and the objectives of the OAA – for their residents. During rehabilitation stays, baby boomer patients are already showing differences from the current elders particularly regarding the kinds of foods they expect will be available for them – like gluten and dairy free foods.

The current number of residents in nursing homes represent about 2.6% of the over-65 years of age population and 9.5% of the over-85 population (CMS Nursing Home Data Compendium, 2015). In 2031 the first of 60 million baby boomers will turn 85 years old. That's only twelve years away. "In 2010, before any of the baby boomers turned 65, 11 percent of the total

population in the United States was between the ages of 65 and 84. As the baby boomers begin to turn 65, the share of the population in this age group is projected to increase, reaching 18 percent by 2030, and then declining lightly to 16 percent by 2050, when the baby boomers transition from this age group into the oldest age group" (Colby & Ortman, 2014).

Sixty-five percent of the residents in the nearly 15,000 nursing homes with Medicaid certified beds rely on Medicaid to support them. As the percentage of elders in the total population increases so will the actual number of old elders who are likely, based on current experience, to need nursing home care. The Green House model project started over twenty years ago, and there are still only roughly 260 of them in existence, representing a tiny fraction of nursing home beds. The conversion or building of Green Houses or similar person-centered model homes is unlikely to come close to supporting this impending influx of very old elders unless a much more rapid pace is adopted.

The fascinating end result of this research are the comparisons between the two facilities of interest and the experiences of the elders in each. One comparison is how at some point the newer, more modern facility is passed by the older traditional style facility in adopting and integrating innovative person-centered care and positively deviant practices that are satisfying for the residents.

Innovative thinking can happen anywhere. Leaders who can visualize how change might benefit their facility and a willingness to try new ideas work in places with few resources and in places with excellent resources. Innovative leadership is crucial to person-centered elder care implementation because no matter how agentic the elders in care may be, they are not typically

in control of their facility. Sixty-nine percent of nursing homes are owned for profit, 24% are not-for-profit and 6% are government owned.

This research did not delve into descriptions of the leadership at either facility other than that they are clearly willing to be early adopters of innovations. One area where innovative leadership may be stymied is through the training, or lack of training, of the workers who are critical to the success of innovations at their facilities.

Employees

Both facilities in this research struggle to find and retain trained workers. The person-centered care they would like to provide for their residents is hampered by the available personnel. In a society of incredible wealth, direct care workers are paid well less than an affordable living wage – at least in the Northeast – making those jobs not very desirable.

In addition to not providing enough for current living standards, low pay means low payments into the social security system, ultimately leading to low payouts when these individuals retire. Low pay for hourly direct care workers means they may need to work additional jobs to support their families, have a partner who can help support them, or they may need to receive public monies such as SNAP benefits and public housing support. Over their working lives, earning low pay will mean a limited ability to save money towards their own eventual old age care as well as smaller Social Security payouts on retirement. The financial consequences of these systemic low wage care jobs last far into the future. There is no way this research can do more than touch upon these broad societal issues, but they influence the personnel and resident care and the quality of life for both.

Beyond the issues surrounding pay are the training and skills of the workers themselves. Many of the younger workers seem to lack "soft" skills. These are skills like making a bed, folding or hanging up laundry and even assuring their residents look "put together" when they are out of their beds. Visits to bedrooms in both facilities showed beds where the covers were pulled up, but not neat, smoothed or tucked in. Laundry might be lying on chairs or bunched into drawers. In one facility the female residents sitting at the tables in the dining room all day would often have "bed head" at 2 pm, and in one case, a resident had dried blood in her hair from a cut on her ear from the previous day. In some cases the women will have carefully applied lipstick, earrings and other jewelry, but clearly didn't see their hair was standing on end in the back, and no one had helped them comb or brush their hair. This is not true in the other facility – hair is always combed and many female residents wear makeup and like to have painted nails. Years of working at a college showed me that many students do not regularly make their own beds or put away clothes and this is not an area nursing training dwells on; even mundane tasks require practice to do well.

Hospitality training programs are not uncommon in community and four-year colleges and universities. Formal nutrition and dietician programs are rigorous training programs, often with internship requirements. Less common seem to be culinary arts training programs specifically geared towards traditional nursing home batch cooking. It is more common in food services to be trained on the job and work up the ladder, gaining skills along the way. Even though meals are identified in elder care research as an important part of the day for a resident, requirements for hiring food service workers are not stringent and do not usually require advanced formal training. A quick scan of regional job requirements includes: a high school or equivalent education, ServSafe training and one year of experience. Complaints at both of the research sites

highlighted common problems culinary arts school training might be able to address. Schools and facilities have an opportunity for a partnership to address problems such as tough or dry meat, watery vegetables and the like.

On a national level, both nurse and care-related personnel and food services personnel training should be updated to meet the needs of the 21st century residents along with ways to improve pay and prestige for those jobs. Workers who feel underpaid and marginalized in society may not feel compelled to provide excellent service.

Concurrent innovations.

In the publicly funded facility in this research, there is an active and engaged activities department providing opportunities for elders to be active and engaged as well. Even those elders who do not want to participate in activities are visited weekly by an activities staff member. Multiple points of contact help support residents by providing a fresh set of eyes on each person, a willing ear and an outlet for them to share their concerns. While the activities director tracks all contacts between her staff and the residents, has final say in the monthly calendar and supports her staff with the materials they need for projects, she does not micromanage them. This provides her staff with a degree of freedom in making decisions. Staff can engage with the resident's in ways that work for each of them, rather than having to conform to an overall activities approach.

One of the more interesting hidden gems at this facility is the number of routine activities not on the monthly schedule. Flower arrangements are produced every Friday by a small group of (usually) women, with flowers donated by a local grocery store. One resident enjoys tracking every birthday in the facility and finding a card for them, and then has it signed by the activities

and appropriate nursing staff. Residents, with support from the activities department, have recently begun a writing group, a book club and a craft making group. The crafts will be used as prizes for bingo and Pokeno games. A very strong volunteer cadre helps with these and other projects, as well as providing a variety of faces in the facility each week or month.

The not-for-profit Green House model under study has only one element of the overall model in practice – the addition of kitchens on each floor. The lack of a robust activities department and the lack of skills present in the activity aide of the floor under study were a glaring comparison between the two facilities. There were no other volunteers on the 4th floor during any visits by the researcher. The primary activities were limited to daily exercises, bingo twice a week, music in the great hall once or twice a week, a monthly meal from a takeaway shop – such as fried seafood - offered to some residents, and a twice monthly painting hour. Over seven months there were a few other odds and ends, but a comparison of the printable activities calendars between the two sites showed a stark difference in the number and variety of activities on offer.

As other Green House models have shown, the inclusion of live plants and animals makes a facility feel homier and, particularly the animals, provide a visual distraction for residents who otherwise see the same walls and the same views day after day. These interventions do not have large expenses associated with them. Recruiting and maintaining a cadre of volunteers would also be in the low-cost category and would offer the elders a larger variety of people to interact with and more opportunities to attend events, play games or engage in other activities.

This Green House model is implementing changes even now, as the management has realized that just adding kitchens to each floor has not fundamentally changed the experience of the elders. The other site is in a major building expansion that will offer more space and more

privacy for their elders. There will be a research opportunity to go back to each of these facilities in the coming two years to see how changes currently underway influence the experience of their elders.

More research.

Elder residential-care facility leadership are in a conundrum. Do they keep trying various interventions and hope for the best or wait for evidence-based research to lead the way towards the best in person-centered care? Research will be important to understand the effectiveness of low-cost innovations and a better understanding of the co-occurrence of interventions.

Residents want tasty food that is visually and texturally appealing and also smells good. They want to be able to eat it in a comfortable setting and they would like input on the menu. This has been shown true in a variety of elder care research. To that end, this research suggests improved staff training modified to suit younger workers who bring different skills and habits than previous generations, and some formal training for food service workers. Finding, training and retaining workers is expensive – losing them because of low pay limits the resources that can go towards innovation. Constant worker upheaval makes attempts to be innovative difficult if worker training is an important component of the innovation. Addressing low pay and marginalized jobs on a societal level is an ongoing and critical component to the spread of innovative practices.

As indicated above, the looming baby boomer bubble seems likely to force change in residential elder care facilities. The baby boomers who are using nursing home rehabilitation facilities now could be an excellent resource for these facilities. They provide an in-house opportunity to better

understand what changes the facilities may need to make to attract and support these soon-to-be-elders when they need long-term care.

Limitations of the study

There are clear limitations to this study. Research at two facilities should not be generalized to the other 15,000+ nursing homes in the United States. In addition, this in-depth qualitative study needs quantitative research to test the hypotheses statistically with a larger, representative sample.

Research at one of the 260 or so Green House models is more generalizable to other Green Houses but with a word of caution that this model was not replicated "with fidelity". All research comes from a perspective and therefore contains bias. It can be difficult in ethnography to avoid developing sympathy with those being researched. Boundaries were maintained with residents in this research by limiting inter-personal discussions and, when possible, observing rather than participating in discussions between residents. Observations were not constant so there may be a bias related to the intermittent immersion in each facility. This research was not designed to understand the perspective of the staff and administration, outside of what was observed, or remarked on by residents during interviews. Finally, these residents are from a certain era and their concerns may be different from the coming cohort of elders.

APPENDIX A

Questions for Residents

1. Tell me about the food you ate when you were growing up. Who cooked and what kinds of food?

2. Did you have a garden when you were growing up? What was grown in the garden? Did your family do canning or preserving foods? Did you have a garden as an adult?

3. Did you have animals growing up or as an adult?

4. Did you learn to cook from your mom? Did you learn to bake? How old were you?

5. What were your favorite things to eat or make? Can you tell me about other meals?

6. Did you work when you were younger? Who did the cooking when you got married?

7. Do you like the food here?

8. If you could make a change or an improvement, what might it be like?

9. Do you take any medications that influence your taste buds?

10. What is the favorite thing you have eaten here?

11. If you were going to cook a meal or go out for a meal, what would be your favorite thing to have?

12. Does your family take you out to eat sometimes?

13. What was the last thing you remember cooking?

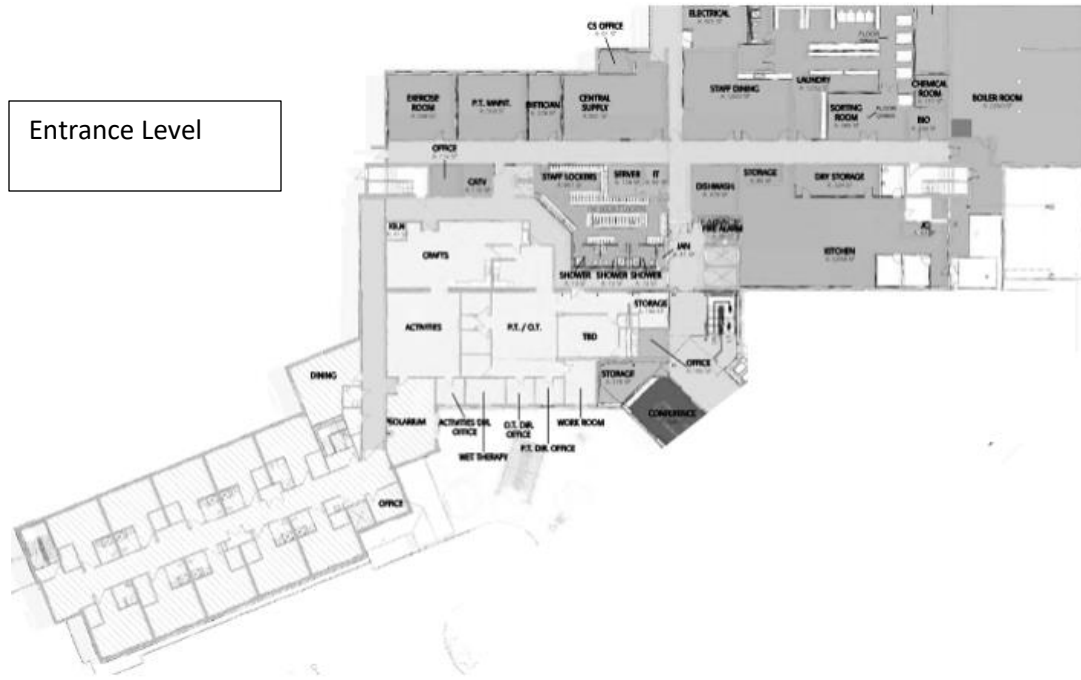14. Is there anything else you'd like me to know?

APPENDIX B

1. What is your background, professionally?

2. Do you do this (work) full time here?

3. Tell me about your job here (for dieticians that included clinical component and overall monitoring of nutritional changes).

4. Are there any committees that look at the resident bodily changes?

5. How do you learn about resident medical issues related to nutrition?

6. Who do you meet with?

7. How do you learn about resident medical issues, especially related to nutrition?

8. When do residents/families get involved?

9. Are there care plan meetings?

10. Meal tickets; how do they inform your work/assignments?

11. Are you able to spot trends related to resident eating patterns from the meal tickets? Are they reliable

12. How are portion sizes adhered to?

13. Do you have input into the menu? In what ways?

14. How are the variables (different types of meals and textures) managed?

15. How do you manage menu clashes/balancing for nutrition?

16. What happens if the resident doesn't eat, for example, their fruits and vegetables?

17. Do you use supplements (such as Ensure and multi-vitamins) and how is their use determined?

18. How do you manage the snacks, both the prescribed ones at 10 am and 2 pm, as well as a resident's own private snacking?

19. Do the CNAs and LNAs give you feedback about snacking and other food-related issues?

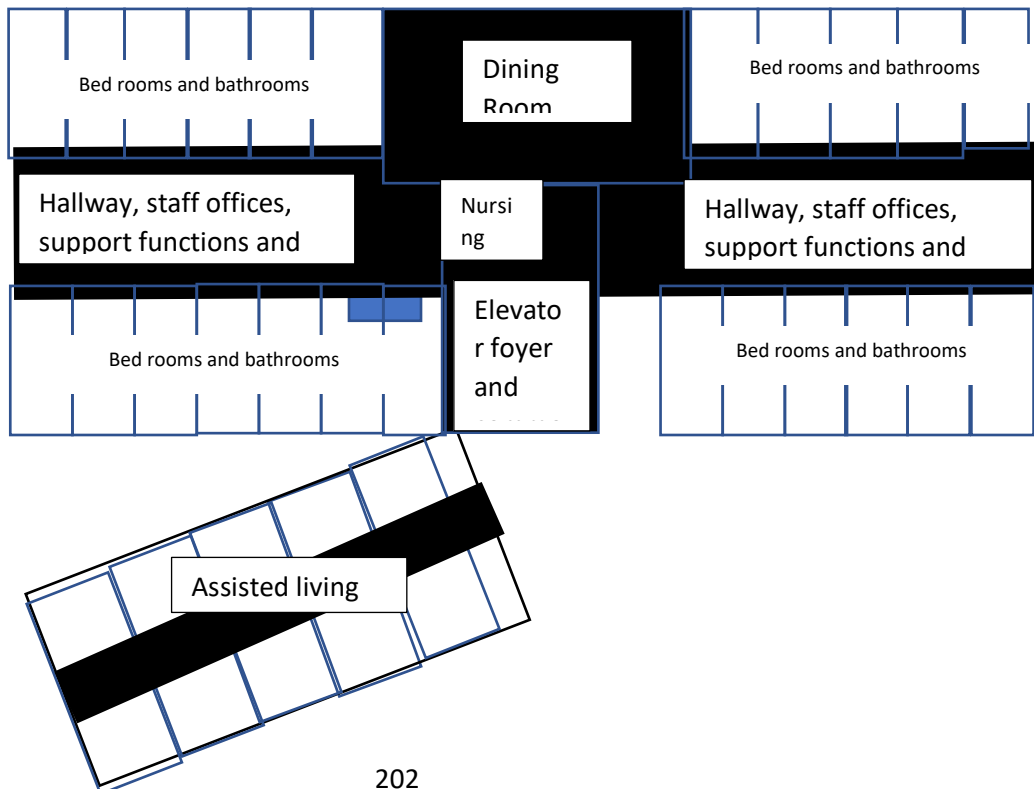20. What can residents themselves access for food and snacks?

21. What happens if a resident wants a grilled cheese at 2 p.m.?

22. How have the changes in this facility changed options for accessing food?

23. What do you do when a new resident moves in?

24. How do you manage cultural/religious preferences or vegetarian/vegan diets?

25. Is adaptive equipment used, how is it managed and who manages it?

26. Do regulations related to food constrain you? What can you give, or not give, residents?

27. Are there food policies about food that is outside of the food vendors, such as donated fruits and vegetables?

28. Who do you work for?

29. How do you keep track of changes in federal and state rules and regulations regarding food?

30. What are your biggest challenges?

31. How do you learn about issues on the floors?

32. How do you negotiate those issues?

33. What about when you are not here?

34. What does a day look like for you?

35. Residents have opportunities to influence change. How do you learn about them?

36. How do you manage requests that are outside of what you can offer (rare meat, lobster)?

37. Are there cost constraints that impact you or your work with the dining services?

38. Menu variety. Are you looking at any changes?

39. This is a cohort that is different from the coming cohort. How do you see the demographics influencing the services provided here? Flavors? Choice? Variety?

40. Is there anything I haven't asked you about?

APPENDIX C

Kind Dining floor plan

Entrance Level

Second Floor

Bed rooms and bathrooms

Dining Room

Bed rooms and bathrooms

Hallway, staff offices, support functions and

Nursing

Hallway, staff offices, support functions and

Bed rooms and bathrooms

Elevator foyer and

Bed rooms and bathrooms

Assisted living

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APPENDIX D

Green House floor plan

APPENDIX E

University *of* New Hampshire

Research Integrity Services, Service Building
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19-May-2017

Jensen, Mary
Natural Resources and Environment, James Hall
238 Hutchins Rd
West Chesterfield, NH 03466

IRB #: 6686
Study: Dish it Up! Happiness and Eating Well Later in Life
Approval Date: 17-May-2017

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved the protocol for your study as Expedited as described in Title 45, Code of Federal Regulations (CFR), Part 46, Subsection 110.

Approval is granted to conduct your study as described in your protocol for one year from the approval date above. At the end of the approval period, you will be asked to submit a report with regard to the involvement of human subjects in this study. If your study is still active, you may request an extension of IRB approval.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the document, *Responsibilities of Directors of Research Studies Involving Human Subjects.* This document is available at http://unh.edu/research/irb-application-resources. Please read this document carefully before commencing your work involving human subjects.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,

Julie F. Simpson, Director

 cc: File, Carroll, John

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