A CASE STUDY ON ASSESSING QUALITY OF LIFE IN A RESIDENT OF AN ASSISTED LIVING FACILITY

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The Supervisory Committee certifies that this ***disquisition*** complies with North Dakota State University's regulations and meets the accepted standards for the degree of

MASTER OF SCIENCE

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ABSTRACT

Lorna (a pseudonym) is an 81-year-old African American female who resides in an assisted living facility in a small town in southern Kentucky, where she was born. She has some minor health issues, and her family alleges she has emotional issues going back to childhood. She is mentally competent, and until ten years ago resided independently in the home purchased by her deceased parents. Since leaving this home, Lorna has become increasingly withdrawn from family members and society; she has also lost weight and seems to have declined mentally. This case study used five different assessments to build a profile of Lorna's current state and develop recommendations for her care. These tools could potentially form the basis of a standardized assessment protocol for other older adults who are not thriving in assisted-living facilities.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

ALF	Assisted Living Facility
QOL	Quality of Life
HRQOL	Health-Related Quality of Life
WHOQOL-100	World Health Organization Quality of Life Scale – 100 Item
WHOQOL-BREF	World Health Organization Quality of Life Scale - Brief Version
FRAIL	Fatigue, Resistance, Ambulation, Illnesses, and Loss of Weight
MNA	Mini-Nutritional Assessment
BMI-MNA-SF	Body Mass Index – Mini Nutritional Assessment – Short Form
MCI	Mild Cognitive Impairment
ADL	Activity of Daily Living
IADL	Instrumental Activity of Daily Living
MMSE	Mini Mental Status Examination
GDS	Geriatric Depression Scale
GDS-SF	Geriatric Depression Scale Shortened Form

LITERATURE REVIEW

Quality of Life in Assisted Living Facilities

Long-term care facilities in the United States exist on a spectrum according to the level of care provided (Degenholz et al., 2013). Nursing homes, with 24-hour nursing care, are towards the far end, while assisted living facilities (ALFs) fall in the middle. ALFs are typically defined as settings that provide health and personal services within a secure residential environment, but not 24-hour care (Hogan, Freiheit, Strain, et al., 2012). According to the National Center for Assisted Living (2021), over 835,000 Americans currently live in ALFs, and the majority of residents are female, white, widowed, and over age 80. Quality of life (QOL) for these individuals is often lower than desired (Degenholz et al., 2014).

QOL is broadly defined as an individual's well-being, comfort, and ability to participate in desired life activities (Degenholz et al., 2014). The landmark 1986 Institute of Medicine report on nursing facility quality, and the subsequent 1987 legislative reforms, placed high priority on QOL in long-term care facilities (Degenholz et al., 2013). One major outcome was the development of a standardized resident assessment instrument, which all facilities that accept Medicaid (the majority of facilities) must administer regularly to all residents and submit for continued remittance. Despite these reforms, QOL for residents of ALFs continues to be lower than that of community-dwelling older adults (Degenholz et al., 2013). Reasons for this discrepancy may include lack of autonomy for residents, and inconsistent implementation of residents' personal care plans, often due to staff turnover (Degenholz et al., 2013). Other, more individualistic factors involved in QOL are health-related quality of life, nutritional status, cognitive status, and depressive symptoms. These factors can be assessed with practical, well-

validated self-report instruments. Further information about each factor, as well as assessment tools, is provided below.

Health-Related Quality of Life in Assisted Living

Health-related quality of life (HRQOL) is a subcategory of QOL that focuses on the changes in physical and mental health dimensions that may occur with disease, aging, or alterations in functional status (Amarantos, Martinez, & Dwyer, 2001). Health-related quality of life is considered especially important among older persons because many of them are affected with chronic health problems and therefore traditional indices, such as reduced morbidity, may be less meaningful to them than subjectively assessed symptomatic improvement (Amarantos et al., 2001). Some causes of decreased HRQOL, such as issues with nutrition, are preventable and others are treatable with appropriate interventions.

Assessing Heath-Related Quality of Life

The World Health Organization, which has established the most widely accepted definition of "quality of life", has developed several self-report tools for assessing this concept. The World Health Organization Quality of Life-100 Item (WHOQOL-100) consists of 100 items with 24 facets grouped into six domains (Power et al., 2005). The WHOQOL-BREF is an abbreviated version of the WHOQOL-100, with only 26 items. The WHOQOL-BREF was developed specifically for use with older adults who might have difficulties completing lengthy assessments (Vahedi, 2010).

Items of the WHOQOL-BREF can be categorized into four domains: 7 items are physical, 6 items are psychological, 3 items are social, and 8 items are environmental (Vahedi, 2010). The physical health domain includes items on mobility, daily activities, functional capacity, energy, pain, and sleep, while the psychological domain considers the factors of self-

image, negative thoughts, positive attitudes, self-esteem, mentality, learning ability, memory concentration, religion, and mental status (Vahedi, 2010). The social relationships domain contains questions on personal relationships, social support, and sex life (Vahedi, 2010). The environmental health domain covers issues related to financial resources, safety, health, social services, physical environment, opportunities to acquire new skills and knowledge, recreation, and transportation (Vahedi, 2010). Although there is little current literature available on the usage of the WHOQOL-BREF in assisted living facilities in the United States, there are studies on its usage for self-reported QOL in assisted living facilities from other developed countries, such as Sweden (Vahedi, 2010). Moreover, the WHOQOL-BREF can also be used for measuring health-related QOL.

HRQOL, in addition to being assessed by the WHOQOL-BREF, can also be assessed by measures of frailty, particularly in assisted living settings. Short and simple instruments are most feasible and preferred in clinical settings (Walston et al., 2018). Such instruments include the Clinical Frailty Scale and the FRAIL scale. The Clinical Frailty Scale is based on clinical observation by a physician, while the FRAIL scale is a self-report measure. FRAIL stands for fatigue, resistance, ambulation, illnesses, and loss of weight (Walston et al., 2018).

Nutritional Status in Assisted Living

Good and sufficient nutrition is important at any age but is crucial to well-being for those over the age of 65. Up to 85% of individuals residing in long term-care facilities experience some degree of malnutrition, and an estimated one in 10 community-dwelling older Americans also suffers from malnutrition (Marshall and Hale, 2018). In addition, individuals over the age of 65 increase their risk of becoming malnourished by 60% after a hospitalization, according to the American Geriatrics Society (2018). A loss of 10 or more pounds or 10% of body weight over a

6-month period can leave an older person at risk for malnutrition; a body mass index (BMI) below 18.5 is considered underweight, and a BMI of 17 or lower may indicate a state of malnutrition (Marshall & Hale, 2018). According to Suominen et al. (2005), long-term consequences of malnutrition include frailty, pressure sores, increased risks of falls, and higher levels of sarcopenia. Malnutrition is often thought of as undernutrition (not eating enough), but overeating can also cause malnourishment. In fact, one third of adults over age 65 suffer from obesity, yet also have nutritional deficiencies (Marshall & Hale, 2018). Common causes of nutritional issues among all older adults are poor oral health and lack of knowledge about daily intake requirements. Psychological issues such as depression also predict malnutrition (Yoshimura et al., 2013).

Residents of assisted living facilities may be particularly vulnerable to nutritional issues. One study of older adults in an assisted living facility, carried out in Finland, found that residents were more likely to suffer from cognitive decline and higher rates of dependency on others for care needs than community dwelling older adults, which in turn predicted poorer nutritional status (Suominen et al., 2005). Reasons for the increased rate of malnutrition in long-term care facilities include dysphagia, aversive eating behavior, cognitive impairment, and anxiety (Suominen et al., 2005). Diseases and symptoms in the mouth were also found to be more prevalent among institutionalized residents and contribute to poor appetite (Suominen et al., 2005). Another study, carried out in the United States, found inadequate staffing to be a significant barrier to adequate nutritional intake by residents (Crogan & Pasvogel, 2003). Residents were most commonly found to be deficient in calcium, vitamin D, vitamin B6, zinc, folate, and vitamin B12 (Crogan & Pasvogel, 2003). The literature shows that nutrition should be

considered when creating treatment plans and improving the quality-of-life older adults in institutionalized settings.

Assessing Nutritional Status

The Mini-Nutritional Assessment was developed to rapidly detect malnutrition and has become the most widely used tool among those working with older adults. The Mini-Nutritional Assessment is composed of 18 questions and can be given in 10 minutes. The test involves (1) anthropometric assessment (weight, height, arm and calf circumferences, and weight loss); (2) general assessment (six questions related to lifestyle, medication, and mobility); (3) dietary assessment (eight questions related to number of meals, food and fluid intake, and autonomy of feeding); and (4) subjective assessment (self-perception of health and nutrition). The scoring for each part categorizes patients in the following manner: (1) well-nourished (normal); (2) at risk for malnutrition (borderline); and (3) malnourished (Guigoz, Vellas, and Garry, 1996). Further investigation is recommended for those categorized as at-risk or malnourished.

There are two shorter versions of the Mini Nutritional Assessment. The Body Mass Index-Mini Nutritional Assessment-Short Form (BMI-MNA-SF) requires the patient's current weight and height to calculate BMI, while the Calf Circumference-Mini Nutritional Assessment-Short Form requires a measurement of the calf in centimeters (Montejano-Lozoya et al., 2017). Both short scales have a subset of the original eighteen items, but the point assessment and result categories remain the same. While all versions of the MNA were designed for use in assisted living facilities and nursing homes, the short forms are practical for screening.

Cognitive Functioning and Assisted Living

Intelligence takes on two forms, crystallized and fluid. Crystallized intelligence refers to skills, ability, and knowledge that is overlearned, well-practiced, and familiar (Harada, Natelson,

& Triebel, 2013). Fluid intelligence refers to abilities involving problem-solving and reasoning about things that are less familiar and are independent of what one has learned (Harada et al., 2013). According to Murman (2015), there is an improvement in crystallized abilities until approximately age 60, followed by a plateau until age 80. However, there is steady decline in fluid abilities from age 20 to age 80, with a nearly linear decline in processing speed. Moreover, cognitive abilities can be divided into several specific domains, including attention, memory, executive cognitive function, language, and visuospatial abilities (Murman, 2015). Each of these domains shows measurable declines in normal aging. However, these declines are not usually great enough to affect QOL, unless they cause measurable impairment (Murman, 2015).

Evidence suggests that residents of assisted living facilities show higher levels of cognitive impairment and rates of dementia relative to community-dwelling older adults (Burdick et al., 2005; Hyde et al., 2007). Eshkoor et al. (2015) found that mild cognitive impairment (MCI) may be particularly prevalent among residents in assisted living. MCI is characterized by a deterioration of memory, attention, and cognitive function that is beyond what is expected based on the patient's age and educational level (Eshkoor et al., 2015). MCI may not interfere significantly with the patient's ability to complete Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); however, the condition progresses to full-blown dementia at rates of 10%–15% per year (Eshkoor et al., 2015). It is therefore important to screen residents of assisted living facilities for cognitive impairment, in order to minimize its impact on QOL.

Assessing Cognitive Status

There are several brief screening measures of cognitive status that are practical for use in clinical and long-term care settings. The Mini Mental State Examination (MMSE) is one such

tool. The MMSE is the most widely used, best studied, and favored because it does not require any equipment or special training to administer. It consists of two sections that, together, contain 11 tasks of cognition (Pangman, Sloan, and Guse, 2000). The time it takes to administer the screening normally ranges from 5 to 10 minutes (Pangman et al., 2000). Scores range from 0 to 30, with a score of 24 and higher identifying individuals who are cognitively intact. Scores of 23 and lower are indicative of cognitive impairment (Pangman et al., 2000).

Depressive Symptoms and Assisted Living

Symptoms of depression among older adults are a significant public health problem, especially in developed countries. One study associated symptoms of depression with increased medical burden, health service utilization, longer hospital stays, disability, and more functional impairment than most medical disorders (Zivin et al., 2010). Low socioeconomic status, lack of social support or contact, bereavement, mortality, and increased risk of suicide in later life are also associated with symptoms of depression in later life (Zivin et al., 2010). African American race may also be a risk factor for depression (Pickett et al., 2013). Uchmanowicz and colleagues (2020) found that clinical depression was underdiagnosed in older adults, due to the presence of comorbid physical illnesses. The study further found that there was an overlap of the following symptoms in both depression and frailty: fatigue, weight loss, slowness, and reduced physical activity. This may make it difficult to recognize depression among residents of long-term care facilities (Uchamanowicz et al., 2020).

Symptoms of depression are particularly important to recognize and treat in assisted living settings, where 1 in 4 residents (24 to 27%) have clinically significant symptoms (Smith & Haedtke, 2013). Residents of such facilities are more likely to have risk factors for depression, such as functional limitations, advanced age, and living alone (Smith & Haedtke, 2013). In

addition, caregivers in assisted living facilities often dismiss symptoms of depression as a normal part of aging (Smith & Haedtke, 2013). Last, depression may reduce engagement in essential self-care routines (Smith & Haedtke, 2013), which may contribute to further health declines. The earlier the signs can be identified, the better chance there is to provide treatment and maintain the individual in assisted living.

Assessing Depressive Symptoms

There are a number of tools which can be used to measure and assess the risk of depressive symptoms in older adults. A widely used and well-regarded tool is the Geriatric Depression Scale (GDS), a self-report measure developed specifically for older adults. The original GDS has 30 items. However, there are also shortened versions of the GDS which have 15 items, 10 items, 4 items, and 1 item, respectively (Yesavage et al., 1982). The 15 item GDS, which is also called the GDS-SF (Geriatric Depression Scale Shortened Form) is preferred in long-term care settings (Stone et al., 2019). The higher a respondent's score on the GDS, the more likely it is that the respondent is experiencing depressive symptoms and needs to be evaluated further.

The Current Study

As reviewed above, health related QOL, nutritional status, cognitive status, and depressive symptoms are important determinants of overall QOL in long-term care settings. Practical measures of these factors could be administered to residents of ALFs with QOL concerns; the results could then help inform their future care, especially regarding changes to level of care. When a resident is initially admitted to an ALF, a comprehensive assessment of their needs is often conducted. However, ALFs are not governed by federal nursing home regulations, and are not required to provide regular, standardized resident assessments. Thus,

assessments vary in quality and frequency between facilities, and may omit important domains of QOL (Bowen et al., 2017). The current paper utilized a case study to illustrate a potential assessment protocol that could be conducted on an as-needed basis. The subject was an 81-year-old female ALF resident with apparent declines in her QOL. The goals of the current paper were as follows:

- Assess the subject's current HRQOL, nutritional status, cognitive status, and depressive symptoms using practical self-report measures.
- Determine how well the subject's needs are being met in the current facility and make recommendations for the subject's future care.
- Identify a common theme or source for the subject's decline.
- Illustrate how this assessment protocol could be applied more broadly in assisted living settings.

METHODS

Subject of Case Study

The subject of the current paper is called Lorna (a pseudonym). Lorna identifies as an African American female, and she is 81 years old. She resides in an assisted living facility in Kentucky close to where she was born. She has never been married or had children. Thus, Lorna fits the demographic profile of a typical ALF resident in terms of her sex and age, but not in terms of her race, parental status, or marital status. She was selected for this paper because she stood out in the facility as socially isolated and unhappy, which led to her being recommended for a program that brought about our meeting.

I initially encountered Lorna in March 2020, as the COVID-19 pandemic was just beginning. I have had regular contact with Lorna since which includes remote conversations, in person visits, and some observations. Through many conversations, I formed the opinion that Lorna was unhappy in her current environment; however, she was strongly opposed to being transferred to another environment. Her opposition stemmed from two previous relocations about which she was not consulted and felt a lack of autonomy. She was placed in the facility by a family member six years previously after her home needed major repairs and attempts to settle her in a low-income apartment building failed. The apartment building had rules about noise levels, company, and clutter, which Lorna had difficulty following. When she needed to leave, her family member decided to move her to the only assisted living facility that was subsidized. Thus, in a period of less than ten years, Lorna had gone from living in her own home, the home inherited from her deceased parents and having complete control over her day-to-day activities, to living in a facility with set rules and routines. With this in mind, I set out to evaluate Lorna

and determine what measures (if any) could be taken that would allow her to stay in her current environment with improved quality of life.

Lorna was fully ambulatory when she arrived at the facility and according to members of staff who have been employed there for as long as Lorna has been a resident, she could often be seen walking the halls just to move around. She stated that she did this because "the bed will take your strength" meaning that prolonged inactivity would cause one to become physically weak and hasten death. She was not on any medications aside from an unspecified mood stabilizing drug. She could do everything for herself, and apparently her designated payee felt that she only needed general supervision. Lorna is legally considered mentally competent, and does not have a guardian, although she does have a payee who is a family member.

From staff members, I learned that some action had been taken when Lorna first arrived to help her settle in. Lorna was given a suite mate and encouraged to participate in offered activities. However, according to the staff, when she began to realize the relocation was permanent, she withdrew. Also notable was that she did not have contact with her family aside from when bouts of brief illness required her to be hospitalized (all within the last 2-3 years). When she returned to the facility, she became increasingly surly with staff. Her appetite decreased. She began having memory lapses, and her physical mobility declined. She developed symptoms suggestive of a metabolic disorder. Over the last 12 months or so the facility's staff again made efforts to alleviate Lorna's perceived loneliness by enrolling her in a surrogate family program. I met her through that program.

The facility that Lorna resides in bills itself as an ALF with 44 beds. The most notable feature is a team of round-the-clock Certified Nursing Assistants (CNAs) and a Registered Nurse that clients may utilize. Some residents are fairly independent, requiring medication reminders,

blood pressure or blood sugar checks, and basic first aid. About half of residents in the facility require assistance with at least two Activities of Daily Living (ADLs). There are daily activities on site or clients may choose to utilize provided transportation to participate in trips and activities off site. Meals are served in a communal dining room, but snacks are brought to the clients' rooms. Some special diets are accommodated, although these types of requests are few.

Measures and Procedures

Overview

Several measures were used to assess Lorna's functioning and quality of life. These measures included the WHOQOL-BREF to measure quality of life/health related quality of life, the FRAIL questionnaire to measure overall frailty, the BMI-MNA-SF to measure nutritional risk, MMSE to measure cognitive status, and the GDS-SF to measure depressive symptoms.

These assessments were administered verbally via Skype from December 2020-January 2021 to protect Lorna from a resurgence of COVID-19 in the area. I scheduled an hour session for each of our six meetings so that Lorna would not feel any time pressure to respond. We then engaged in conversation after she completed the assessments. Lorna verbally indicated that she understood answering the questions was her choice, she could refuse any questions, her identity would remain anonymous, and she would not be judged in any way. Lorna did not have any assistance from staff to complete the questions. She was able to repeat back the questions and rating scales. Overall, she was relaxed and unconcerned about her performance. Oddly during more than one session Lorna made statements that she was "tired of the way I'm living" and "I wish I didn't have to stay here much longer" which directly contradicted her earlier attitude.

Foundations

As previously mentioned, I had known Lorna prior to the commencement of this study. Our relationship began in March 2020. The facility where Lorna resides began circulating an advertisement in the local community asking for volunteers to teach classes, hold events, or just communicate with some of the residents. COVID-19 was an emerging concern, so the residents were assisted to set up email and social media accounts for remote communication. Lorna received assistance in this aspect and created an email account and Skype account. It was possible to make a specific request for someone to communicate with or to allow the staff to assign an older adult to correspond with; I chose the latter and was paired with Lorna.

At the beginning, I had weekly half hour conversations with Lorna. She was not familiar with Skype, but was encouraged by staff members to utilize Skype because it adds a visual element to communication. It was during these initial virtual encounters that I observed how uncooperative and hostile Lorna could be to the staff of the ALF. When a member of staff placed a hand on her shoulder and leaned in to say something, she would jerk away and her whole demeanor changed. She often shouted, “I don’t need y’alls help!”. I observed similar reactions when I was later able to visit in person.

Once Lorna became comfortable, she began to disclose more about herself, her past, her situation, and her current thoughts. She repeatedly indicated that she did not like “nosey folks” and would not speak to me about anything besides myself if we were not alone. I did not at any time observe anyone eavesdropping. Lorna presented as unhappy, bitter, or resentful, and emotionally closed off although she was willing to talk to me under the aforementioned conditions. By the time I approached Lorna about this project, I had begun to share based on my

own observations and interactions with Lorna, the opinion voiced to me by a member of staff that Lorna was not doing well at the ALF.

Implementation

The focus topic of quality-of-life is composed of many domains including physical, psychological, and environmental. While I was primarily focused on quality-of-life, the decision was made to use assessments on nutrition, depression, cognition, and frailty based on knowledge of common areas of wellbeing or lack of in old age and the foundation information I had obtained about Lorna. Lorna's appetite had decreased, and she was said to have memory lapses such as forgetting the day of the week in addition to her statements about not enjoying life and "not getting out much".

I approached Lorna in August 2020 and asked her if she would be interested in participating in a graduate school project for educational purposes. She agreed when I assured her that her participation was entirely voluntary, could be terminated at any time, and nobody would know who she was. She was briefed on the assessments that would be used, and once dates were firm, told when the sessions would occur. The medium chosen was Skype and I reminded Lorna that Skype is capable of recording, so a video might be taken but would only be viewed by me or placed into transcription software. I further advised Lorna that while some of the things she said might be described in the paper, her identity would be anonymous. The paper would also be used for educational purposes only. She verbally agreed to all of the terms and did not ask for any more explanations beyond those offered.

RESULTS

Health-Related Quality of Life

The WHOQOL-BREF has 26 items, each scored on a scale of 1 to 5, where higher scores indicate greater quality of life. Total raw scores can range from 6 to 130. Lorna's total score was 53, indicating mediocre health related QOL. Of the four domains of HRQOL, Lorna's scores were 16 (of a possible 35) for physical health; 7 (of a possible 15) for social relationships; 16 (of a possible 30) for psychology; and 14 (of a possible 40) for the environment. Lorna's ratings for individual items are reported in Table 1. In general, she reported satisfaction with her physical appearance, and little physical pain. She indicated that she felt good about herself and her appearance most days and showed me two wigs that she likes to wear in addition to some jewelry she puts on "for funerals and church dinners" but said she had not attended any such event in "about 3 or 4 years". Beyond her satisfaction with her appearance and self, she indicated that she did not enjoy life. She was not satisfied with the services provided by the facility, including transportation and leisure activities. The facility offers bingo and other table games as well as occasional rhythm classes and other courses. However, Lorna stated there was nothing she liked. She enjoys going on outings and being around people, yet she did not enjoy out with people in the facility or participating with the activities offered. She spoke often of her past activities talking about her rich social life and a family member who she had phone contact with confirmed her statements but told her she could not "get out" like she used to do, and she should not think she is missing out.

Lorna indicated in tandem with her dissatisfaction with her environment, a dissatisfaction with relationships and social support, then provided some elaboration. Lorna never married or had children of her own. One of ten siblings, she shared in the upbringing of her siblings'

children who she considers as close as her own children. One of her nephews, who is in charge of her affairs including acting as her payee, does not visit her. She very rarely receives any family visits, although she does regularly receive colorful greeting cards (often containing a $20 bill) in the mail from a niece who lives out of state, which she displays in her room. Lorna admitted she has not pursued any friendships in the facility but could not give a reason for her lack of desire to reach out. She had many long-term friendships prior to being relocated to the facility and frequently spent time with these friends. She felt her placement was a way to curtail her freedom and cut her off from her friends. Lorna had spent nearly her entire life in the same community where her parents' home was located, a neighborhood dominated by African Americans, and attended the same church for a number of years, which she spoke of very fondly. She knew everyone in that community including subsequent generations. Lorna did not speak of the ALF or any of the activities or amenities offered with a hint of fondness.

Lorna has strong convictions about family and caregiving. She believes her family has abandoned and "dumped" her in the ALF evidenced by statements such as "I lived with (my) mama and daddy until the end. I did everything for (my) mama." and "When you're old you're supposed to be living in your own house and enjoying your family." Lorna's statements suggest she is unhappy with her environment and social relationships because she expected to age in her own home, and displacements which she was not consulted about have caused her anxiety and distress.

Table 1

Lorna's Ratings of the WHOQOL-BREF Items

Item	Rating
1. How would you rate your quality of life?	3-Neither Poor nor Good
2. How satisfied are you with your health?	2 - Dissatisfied
3. To what extent do you feel that physical pain prevents you from doing what you need to do?	4 – A Little
4. How much do you need any medical treatment to function in your daily life?	4 – A Little
5. How much do you enjoy life?	1 – Not at all
6. To what extent to you feel your life to be meaningful?	1 – Not at all
7. How well are you able to concentrate?	2 – A Little
8. How safe do you feel in your daily life?	3 – A moderate amount
9. How healthy is your physical environment?	2 – A Little
10. Do you have enough energy for everyday life?	1 – Not at all
11. Are you able to accept your bodily appearance?	4 - Good
12. Have you enough money to meet your needs?	3 – Neither poor nor good
13. How available to you is the information you need in your day-to-day life?	1 – Very poor
14. To what extent do you have the opportunity for leisure activities?	1 – Not at all
15. How well are you able to get around?	2 - Poor
16. How satisfied are you with your sleep?	2 - Dissatisfied
17. How satisfied are you with your ability to perform your daily living activities?	2 - Dissatisfied
18. How satisfied are you with your capacity for work?	1 – Very Dissatisfied
19. How satisfied are you with yourself?	4 - Satisfied
20. How satisfied are you with your personal relationships?	2 - Dissatisfied
21. How satisfied are you with your sex life?	3 – Neither Satisfied nor Dissatisfied
22. How satisfied are you with the support you get from your friends?	2 - Dissatisfied
23. How satisfied are you with the conditions of your living space?	1 – Very dissatisfied
24. How satisfied are you with your access to health services?	2 - Dissatisfied
25. How satisfied are you with your transport?	1 – Very dissatisfied
26. How often do you have negative feelings such as blue mood, despair, anxiety, depression?	4 – Very often

Frailty

The FRAIL scale contains five yes/no questions. Lorna answered "yes" to the questions "are you fatigued" and "have you lost more than 5% of your body weight in the past 6 months". She answered "no" to the questions "cannot walk up one flight of stairs", "cannot walk one block", and "do you have more than 5 illnesses." These results are suggestive of frailty (Walston et al., 2018). Lorna's answered invited further conversation. When asked when she had last attempted to walk up a flight of stairs or the length of one block Lorna could not remember. When asked why she had not attempted to do these things she stated, "I just don't see no reason (sic) to go out." but did not state she felt physical pain or weakness. The ALF is a single-story main building with adjoining single-story buildings and Lorna resides in a room in the main building, so she does not need to go outside and walk any distance to reach the dining room. Lorna has no explanation for her lack of motivation to move around compared to when she first arrived at the ALF.

Nutritional Status

Lorna's results for the items on the BMI-MNA-SF are shown in Table 2. Total scores can range from 0 to 14, with higher scores indicating better nutrition. Scores of 8-11 are considered "at risk" for developing malnutrition, while scores of 0-7 signify malnutrition. Lorna's total score of 8 fell into the "at risk" range. She was also considered overweight, with a Body Mass Index of 28.3. Lorna has lost weight but insisted that she had not knowingly decreased her food intake in any way. She said she went to the dining hall for all meals and ate the snacks brought to her. As noted previously Lorna does not undertake physical activity of her own accord and her physical activity has decreased during her stay at the ALF. Lorna's BMI indicates she is overweight, but weight loss remains a concern in tandem with Lorna's MNA score which

indicates she is at risk of malnutrition. I could not get any member of staff to elaborate on Lorna's eating habits and what might have caused her unintentional weight loss beyond mention of recent issues with blood sugar.

Table 2

Lorna's Scores on BMI-MNA-SF Items

Item	Score/Answer
Weight	160 pounds
Height	63 inches
Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	2 = no decrease in food intake
Weight loss during the last 3 months	0 = weight loss greater than 6.6 lbs.
Mobility	1 = able to get out of bed/chair but does not go out
Neuropsychological problems	2 = no problems
Body Mass Index (BMI) (weight in kg)/ (height in m)^2	3 = BMI 23 or greater

Cognitive Status

The MMSE contains tasks that assess orientation, attention, memory, language, and copying shapes. Scores can range from 0 to 30 (all items correct); a score of 23 or less suggests cognitive impairment (Pangman et al., 2000). Lorna's score was 14, indicating severe impairment. She was unable to complete several of the tasks. Lorna indicated that she understood the instructions given for the assessment, however, she could not consistently reproduce the desired responses. I personally observed through Skype Lorna linger for several minutes over questions before responding. She did not ask for assistance but persisted until she answered, although her answers were more often than not incorrect.

Depressive Symptoms

The GDS-SF contains 15 yes/no questions regarding how the respondent has felt over the past week. Scores can range from 0 to 15, with 9-11 indicating moderate depressive symptoms, and 12-15 indicating severe depressive symptoms (Greenberg, 2007). Lorna's score was 12, which falls into the severe range. Lorna did not indicate in any way that she was satisfied with her present setting and conditions, although she did not express any fear of harm from the environment or those around her and did not express suicidal ideation. As mentioned earlier Lorna spoke at length about how happy she was with her original community and the positive aspects of being a member of said community, but did not express any warm or familiar feelings about her present environment. Lorna expressed to me on more than one occasion that she did not feel at home in her current environment. Around holidays she would say, "When I was in my house I would……" and "It's no fun when you don't have nobody here with you (sic)."

DISCUSSION

Recommendations for Lorna

The assessments showed that Lorna's quality of life in the current facility is poor overall. She scored lowest in the domain of social relationships. Lorna expressed to me and showed by her behavior that she feels distant from other people at the ALF. She also lacks strong connections to family and friends. Prior to living in the ALF, Lorna was socially engaged in her community and had many friends. Lorna was unable to express specific reasons for her increasing social isolation. Even though she did not say so, her race may play a role in her lack of trust and cooperativeness with the facility's staff. Lorna is African American, as are most of her friends and family, but most of the staff are white and Lorna does not have the opportunity to interact with African Americans on the same level as she did prior to entering the ALF. Since Lorna has diminished contact with her family members, she does not have anyone to bridge the disconnect and advocate for her. The few studies that focus on race and residential facilities have found that older adults, when given a choice, overwhelmingly favor facilities with significant portions of residents and caregivers of their own race (Howard et al., 2002). As previously stated, Lorna was not given a choice about her placement, and this made her feel powerless. She should have an active role in choosing any future placements. That way, she could select a facility with a greater presence of African American caregivers and residents, if that is important to her.

Since autonomy appears central to Lorna's QOL, she should be given as many choices as possible each day. She should be presented with different options for food, clothing, activities, and outings. Although the reasons behind her dissatisfaction with the communal transportation should be further explored, it would immediately be helpful to ask Lorna what places she liked to

visit prior to moving into the ALF and investigate whether it is possible to arrange for her to personally visit these places.

The assessment showed that Lorna has experienced a deterioration in her physical condition. According to her score on the FRAIL questionnaire, she is frail. She can no longer walk up a flight of stairs or around the block, and she feels fatigued. Lorna had no explanation for her inability to do these things or recall when she had last done them. These changes may have come about due to Lorna's increased sedentariness and the risk of malnutrition demonstrated by Mini Nutritional Status Assessment. Lorna has an overweight BMI, yet she is still at risk of malnutrition and has decreased mobility. Therefore, I recommend consultation with a physical therapist and a dietician.

Lorna's score on the Geriatric Depression Scale is indicative of severe depression. She does not enjoy her life or have much hope for the future. She could benefit from a full evaluation by a trained mental health professional. Also troubling is Lorna's low score on the Mini Mental Status Exam. A score of 14 is indicative of severe cognitive impairment. However, this is only a screening assessment and given over Skype where unknown factors could have influenced the results. For these reasons, I recommend further neuropsychological testing to determine if Lorna truly has cognitive issues or is at risk of developing cognitive impairment.

From the outset, I had hoped to create a treatment plan to keep Lorna in her current environment. This remains a possibility. However, in light of these assessment results, a relocation to a full-time nursing facility should be considered if the above measures do not increase Lorna's QOL and further assessment confirms cognitive issues or significant risk of malnutrition. With the reassurance of a higher level of care, those involved in Lorna's care could better address her health issues and provide the support she lacks.

Central Emerging Themes

The most striking assessment results and pertinent disclosures from Lorna point to two main themes concerning her case, social isolation, and a sense of "aging out of place". Lorna was very attached to her previous community and has been displaced two times without her attachments, preferences, and opinions being taken into consideration. The removal of Lorna's autonomy to choose where she would age appears to have led to her social isolation. According to Wiles et al. (2002), older adults typically wish to age in place in their own homes, which they link to a sense of independence and autonomy. They associate being moved to a residential facility with a loss of autonomy. Lorna expressed these sentiments repeatedly throughout the entire interview and assessment process. Wiles et al. (2012) further found that older adults derived satisfaction from their environment not so much from a physical standpoint, but rather from the deeply rooted social connections and familiarity that come from being an "insider" of a community. This is particularly true in Lorna's case.

An ALF is not jail. Lorna retained a certain measure of independence and control over her life as to how she spent her leisure time and who she interacted with, yet the setting was unfamiliar and did not offer the security of one's long-term community. Moreover, she did not choose the facility and its location is physically removed from her former community with no measures undertaken to assist her to retain her connection to her wider social networks and community institutions. Lorna stated repeatedly that she felt cut off from all that was familiar and comforting to her, although she was unable to accurately describe how these feelings affected her current state of well-being. The staff of the ALF identified her as socially withdrawn and noted this as such a pressing concern that action was taken through enrollment in an outreach program. According to van Dyck et al. (2020) social isolation and by extension loneliness is

associated with negative health outcomes, including increased morbidity and mortality, along with significant mental health consequences. Lorna currently presents with depressive symptoms and cognitive decline.

Broader Applications

The current study illustrates the usefulness and feasibility of administering self-report questionnaires to assess QOL among residents of ALFs who are not thriving. Assisted living facilities usually conduct a formal needs assessment of each resident upon admission. Residents' functioning may periodically be assessed thereafter, and informal monitoring is also carried out by staff. However, assessments of QOL vary in quality, scope, and frequency between ALFs (Bowen et al., 2017). The facility where Lorna resides does not have a standardized assessment procedure. Lorna was flagged by staff members as needing attention, but the nature of her difficulties was not examined in a systematic way. The assessment process provided a clearer picture of her needs; such a process could help other residents of ALFs as well.

Self-report questionnaires provide valuable information about QOL, since it has subjective components (Degenholz et al., 2013). The five questionnaires utilized in the current study cover several broad domains of QOL. They are relatively brief and have been validated for use among older adults with functional and cognitive impairments. They can also be administered verbally. Lorna was able to provide responses over video conferencing without assistance from staff. Thus, these questionnaires are strong candidates for inclusion into standardized assessment batteries for use by ALFs. The assistance of staff might affect the results and should be kept to a minimum when carrying out assessments on clients.

The current study illustrates an assessment approach to QOL as applied to a single resident in an ALF. This subject was not randomly selected, and some of her characteristics do

not fit the average ALF resident (e.g., race, marital status, social engagement). Thus, the current subject's assessment scores are not generalizable to a larger population. Additionally, the current assessment protocol is limited in breadth and depth since it only includes brief screening measures of a few constructs. However, determinants of QOL for any one person are ultimately individualistic and subjective (Degenholz et al., 2013). The current paper illustrates how QOL can be assessed in a structured way, using standardized instruments, while also considering a subject's individual needs and circumstances. Future studies should continue to examine approaches to promoting QOL in long-term-care settings in the context of personhood.

Conclusion

Relative to community-dwelling older adults, older residents of assisted living facilities often experience a lower quality of life. ALFs offer daily supervision and assistance, but not 24-hour nursing care. Many ALFs do not regularly and rigorously assess QOL among residents, although assessments are informative for guiding future care (Degenholz et al., 2014). The current paper utilized a case study approach to assess five aspects of QOL (health-related quality of life, frailty, nutritional status, cognitive status, and depressive symptoms) in a single resident of an ALF. The subject, an 81-year-old African American female, exhibited notable impairment in each area; recommendations for future care were given. The current assessment approach is presented as a potential model for broader application in ALFs.

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