Boston University

OpenBU **http://open.bu.edu**

Boston University Theses & Dissertations Dissertations and Theses (pre-1964)

1962

Institutional housing for the aged. A study of five categories of homes within 106 sheltered care homes for the aged in Rhode Island

https://hdl.handle.net/2144/24453

Downloaded from DSpace Repository, DSpace Institution's institutional repository

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

INSTITUTIONAL HOUSING FOR THE AGED

A STUDY OF FIVE CATEGORIES OF HOMES WITHIN ONE-HUNDRED AND SIX SHELTERED CARE HOMES FOR THE AGED IN RHODE ISLAND

A thesis

Submitted by

Charles Heffner

(B.A., University of Denver, 1953)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1962

TABLE OF CONTENTS

CHAPTER | PAGE

I. INTRODUCTION

The Problem.................................. 1
Purpose...................................... 2
Justification................................ 3
Method....................................... 5
Limitations.................................. 7
Definitions.................................. 7

II. ANALYSIS OF CHARACTERISTICS OF HOMES

Ages of Homes................................ 10
Remodeling and Additions..................... 14
Insured Values of Homes...................... 16
Beds per Home and Patient Distribution... 18
Rates of Occupancy........................... 22
Staffing of Homes............................ 24
Staff Ratio.................................. 27

III. ADMISSION POLICIES AND REQUIREMENTS

Policies and Requirements.................... 31
Sources of Funds for Care of Residents... 37

IV. CHARACTERISTICS OF RESIDENTS AND THEIR CARE

Age and Length of Residence.................. 42
Physical Condition and Care Required..... 43

V. RECREATION

Activities of Residents...................... 47
Recreational Facilities...................... 50
Deterrents to Recreation..................... 54

VI. SUMMARY AND CONCLUSIONS

Summary...................................... 58
Discussion................................... 62

APPENDIX - SCHEDULE.......................... 64

BIBLIOGRAPHY................................. 67

LIST OF TABLES

TABLE		PAGE
1.	Comparative Age of Homes and Range in Years	11
2.	Remodeling or Additions Made to Homes Since Construction	15
3.	Insured Value of Plant and Equipment	17
4.	Average Number of Approved Beds Per Home and Patient Distribution	20
5.	Rate of Occupancy and Incidence of Waiting lists	22
6.	Staffing of Homes and Level of Training of Staff	25
7.	Ratio of Staff to Residents	28
8.	Admission Policies and Requirements	32
9.	Sources of Funds	39
10.	Resident Age and Length of Residence	42
11.	Physical Condition of Residents	44
12.	Activities of Residents	48
13.	Recreational Facilities	51
14.	Deterrents to Recreation	54

CHAPTER I

INTRODUCTION

The Problem

Confucius, the influential Chinese philosopher and teacher of moral principles was once asked to tell what his ambitions in life were. He replied that, "It is my ambition that the old people should be able to live in peace, all friends should be loyal and all young people should love their elders."[1] In this aphorism, Confucius, in the fourth century, B.C., voiced a concern about the aged, a concern to which we in this second half of the twentieth century, are perforce turning our attention more and more. The reasons for this increasing concern over problems of the aging in our society have been brought about by dramatic changes in our population. These changes and the factors affecting them are described by a leading social gerontologist who states that:

> One of the fundamental and the most readily measurable changes has been that of the increase in the size of the older population and the shift, within the population of all highly developed societies, in the proportion of older people. These changes have come about in response to a complex variety of factors, including the natural increase in the population, differential declines in fertility and mortality rates, immigration, growing capacity of the economy to sustain a larger population, improved nutrition and control of the sanitary environment, prevention of infectious disease, and better control of all disease.[2]

---

[1] Lin Yutang, "The Aphorisms of Confucius," in The Wisdom of China and India, p. 815.

[2] Clark Tibbits, "Scope, Origin and Fields of Social Gerontology," in Handbook of Social Gerontology, p. 12.

This noted increase in the aged population brings new problems and a compounding of old. One of these is the need existing in a number of our aging population for institutional housing. The factors affecting this need vary with the individual aged person and may include chronic illness, convalescence, mental illness, widowhood, lack of financial resources for self care, and lack of ability or desire of grown children to care for their aged parents.

Purpose

Rhode Island census figures for 1960 show that the population of persons sixty-five and over has increased 27.1 per cent in the last decade (1950-1960);[3] a number of these persons need or will need institutional sheltered care.

The purpose of this study will be to study five categories of institutional housing for the aged in the State of Rhode Island. These five categories are: Nursing Homes, Convalescent Homes, Rest Homes, Non-profit Homes for the aged, and Family Care Boarding Homes for paroled mental patients. These categories of homes will be defined further in this section. This study will seek to determine the extent to which the five categories of homes are different or similar in the following areas:

1. Physical Characteristics, including age of, improvements made to, and insured values of homes; beds per home, and

---

[3] "R.I. Age Distribution by Sex, 1960 and 1950," 1962 Journal Bulletin Almanac, p. 72.

resident distribution within the homes, rates of occupancy, and incidence of waiting lists, staffing of homes and ratio of staff to residents.

2. Admission Policies and Requirements, including sources of funds for care of residents, characteristics of residents in terms of average ages, length of residence, physical condition, and type of care required by residents.

3. Activities of Residents, in terms of recreational and creative activities, facilities provided by the homes for recreation, and the attitudes of home operators toward providing recreational facilities.

Justification

There is a recognized definite need for more research and study of institutional sheltered care housing facilities for the aged. Dr. Eunice Minton observes that:

> For most older persons there comes a time when there is a need for care away from their own families, either for temporary or prolonged periods of time. This factor emphasizes the importance of knowledge of various types of institutional programs and of the skills to help older persons and their families prepare for periods of separation and to use this period constructively.[4]

Another social gerontologist writes of the lack of available information on sheltered care for the aged:

> Little detailed information is available about old age homes. The last inventory of congregate housing for the elderly, entitled Homes for the Aged in the U.S.,

---

[4] Eunice L. Minton, "Needs of Older People-Can Casework Help?" in Aging: Progressive Programming, p. 32.

> was published in 1941...The 1958 Conference on Retirement Villages deplored the lack of a descriptive national inventory-descriptive in terms of such items as type, location, design, size condtions of eligibility for occupance, services offered, staffing, auspices under which built and operated, method of financing and cost. Among its merits, this sort of inventory would focus attention upon the problems of congregate housing and care and upon current viewpoints in social gerontology-particularly if an acceptable system could be worked out to evaluate either the institution as a whole or certain of its aspects...far too many of the new institutions are oblivious of past developments in social gerontology, not to mention the more enlightened philosophies that are evolving in the United States.[5]

It is with the above concepts in mind that this writer undertook this study, with a view of providing a modest contribution of further data relative to the area of institutional housing for the aged in Rhode Island.

Another factor influenced this study, the details of which are presented here as this writer feels strongly that they reflect on the inherent problems of research in this area. In the early part of 1960, the U.S. Department of Health, Education, and Welfare requested all States to participate in a research effort to collect data relative to characteristics of sheltered care homes in preparation for the White House Conference on Aging-1961. Each State was supplied with survey schedules which were to be mailed to all sheltered care facilities in the individual States. On February 24, 1960, the Rhode Island Division on Aging mailed 180 of these question-

---

[5] Walter K. Vivrett, "Housing and Community Settings for Older People," in <u>Handbook of Social Gerontology</u>, Pp. 576-77.

naires to the Nursing, Convalescent, Rest, and Non-profit Homes for the aged in this State. The Division had a deadline of March 15, 1961, in order that data might be tabulated and a factual report sent to Washington by April 15. This latter factor was indicated in the covering letter sent to the homes with the questionnaires. However, since as of April 4, only thirty completed questionnaires had been returned, a second mailing was done, and another, more strongly worded covering letter was attached, indicating the expressed interest of the Governor of the State and the Director of the Department of Social Welfare. Over a period of the following months, fifty-three more completed questionnaires drifted in, but not in time for study and tabulation for the White House Conference. Thus the questionnaires remained untabulated and were filed. When this writer expressed an interest in making a survey of sheltered care homes, the present director of the Division of Aging suggested he tabulate and analyze the data from the eighty-three survey schedules.

Method

This writer, feeling that eighty-three of the one-hundred-eighty sheltered care homes for the aged in the State, was not a representative sample, and feeling also that the Family Care Boarding Homes should be included, (which were not in the original mailings), in the sample, undertook to mimeograph and mail questionnaires to the remaining 106 sheltered care homes for the aged in the State.

The return from this mailing was only fair, a total of twenty-four schedules were returned out of the 106 mailed, or 22.6 per cent. However, adding these to the eighty-three loaned to him by the division on aging, this writer now had a total of 106 questionnaires for examination and data tabulation. This was considered to be a fairly representative sample of the sheltered care homes in the State as it represents 58.8 per cent of the total homes. The total response by type of homes were: 36, or 47.0 per cent of the 75 Nursing Homes; 18, or 50.0 per cent of the 36 Convalescent Homes; 28, or 81.6 per cent of the 38 Rest Homes; 18, or 81.8 per cent of the 22 Non-Profit Homes for the Aged; and 6, or 66.6 per cent of the 9 Family Care Boarding Homes.

The data obtained was in response to the questions relating to the characteristics of the homes as discussed in the section on the Purpose of this study.[6] The schedule used may be seen in the appendix to this study.

The data was tabulated and analyzed and is presented in this study in the form of tables and discussion. The five categories of homes will be discussed in the main, individually, but where notable differences or similarities are seen in comparison to other studies, the categories of homes will be discussed collectively. In discussing the homes collectively they will be referred to as "sheltered care homes for the aged. An on-going review of the literature is presented also for further clarification and amplification of the data.

---

[6] See Pp. 2-3, this study.

Limitations

This study is limited to studying, analyzing, and tabulating data from mailed questionnaires, therefore it should be kept in mind that some of the responses may reflect subjective, and or, guesswork responses rather than objective, and, or factual responses in all cases. Since the quantity and quality of care provided in any of the homes in this study reflects rather directly on the operator(s), we may consider a further limitation as being bias in reporting in some instances. Somewhat in relation to the latter factor, there were numerous blanks left on some of the questions in the schedule, therefore in order to show the number of homes answering the various questions this writer shows at the top of each table the number of homes in each category responding to that item. Further limitations will be seen and discussed in the individual sections.

Definitions

The first three categories of homes defined here, Nursing, Convalescent, and Rest, are defined here as defined by the R. I. State Department of Social Welfare,[7] and the remaining two, Non-Profit Homes for the Aged, and Family Care Boarding Homes, are looked upon (but not specifically defined) by the Welfare Department as Rest Homes. These two latter categories differ from the Rest Homes in terms of auspices,

---

[7] R. I. Department of Social Welfare, Categories: Definitions of Service and Staff Requirements., p. 1.

in the case of the Non-Profit Homes for the Aged, and in types of patients cared for and licensing agency, in the case of the Family Care Boarding Homes. The homes are defined as follows:

1. Nursing Homes, One in which bedside care is available, with facilities and personnel to provide care to persons with illnesses which do not require hospitilization but do require extensive care. Twenty-four hour coverage by registered licensed practical nurses is mandatory.

2. Convalescent Homes, One in which facilities and personnel limit care to patients with chronic conditions which require little nursing care, or to persons convalescing from an acute illness. Patients are usually ambulatory. Twenty-four hour coverage by licensed practical nurses is mandatory.

3. Rest Homes, A home equipped with only facilities to care for ambulatory persons who are in need of no specialized nursing service, with service to be limited to board and supervision. Except in large homes (over fifteen patients) licensed staff is not required, but responsible staff is.

(The following are this writer's definitions based on information from the Welfare Department and the State Hospital for Mental Diseases-the latter in reference to the Family Care Boarding Homes.)

4. Non-Profit Homes for the Aged, the same definition as given above for the Rest Homes, the only difference being that the non-profit homes are under the auspices of sectarian or fraternal organizations.

5. Family Care Boarding Homes, the same definition as for Rest Homes differing in two respects: a.This type home cares only for mental patients paroled from the State Mental Hospital. A physician at the Hospital must recommend this type care for patients. b.The licensing agency for this type home is the State Hospital for Mental Diseases.

As noted above when the homes in this study are referred to collectively by this writer, they will be referred to as "sheltered care homes for the aged."

CHAPTER II

ANALYSIS OF CHARACTERISTICS OF THE HOMES

As noted above we are considering in this study 106 of the 180 sheltered care homes for the aged, 58.8 per cent of all such homes in Rhode Island. The questionnaires inquired about certain characteristics of the homes in terms of their age, insured value, capacity, rate of occupancy and type and number of staff in each home.

The data tabulated and presented here seems to be significant in terms of its overall implications as to the potential quantity and quality of services available to the patients and residents of the homes. The characteristics to be discussed here are considered by this writer to be an important part of the total discussion of any group of sheltered care homes for the aged.

In view of the descriptive nature of this study, the writer will confine himself to mainly descriptive comparisons relating to conditions within the State of Rhode Island. However, where notable differences and similarities are indicated, two somewhat similar studies which are felt to be quite representative of present research in institutional housing for the aged will be referred to. The first of these, <u>Nursing Homes, Their Patients And Their Care,</u>[1] is a descriptive study

---

[1] U. S. Department of Health, Education, and Welfare, <u>Nursing Homes, Their Patients and Their Care</u>.

based on responses to a schedule similar to the one used in this study; the second, The Condition of American Nursing Homes,[2] is a study conducted by the Senate Subcommittee on Problems of the Aged and Aging. Although the titles of these two studies imply that they pertain to Nursing Homes only, both studies have concerned themselves with the same categories of sheltered care homes for the aged that are discussed in the present study.

There are undoubtedly other published and unpublished studies in the field of sheltered care housing for the aged, but on the whole there is a notable lack of published research data available in this field. This problem is recognized by one investigator who states:

> Much interest has been evidenced in the problem associated with housing for the aged. This concern has centered upon many aspects of this complex subject, including such facets of the total problem as the design of dwelling units, construction of public housing, retirement communities, institutional care, and the exploration of community resources to encourage independent living. Unfortunately, the yield of research data from all this effort has not been abundant.[3]

Ages of Homes

Inquiries were made in the questionnaires relative to the ages of the homes by inquiring when the home was constructed. It was felt that this data would be meaningful in terms of showing the relative ages of the homes within the five categories being studied. Further, it would show

---

[2] Senate Subcommittee, The Condition of American Nursing Homes.

whether certain categories of homes are newer in terms of time of construction.

The data tabulated and presented in Table 1 is presented here in terms of showing first, the range in ages of the homes from the newest, (last constructed), to the oldest, (first constructed). And secondly, shows the age groups into which the various homes in the five categories fall.

TABLE 1

COMPARATIVE AGE OF HOMES AND RANGE IN YEARS

Range in years	Type of Home				
	Nursing	Convalescent	Rest	Non-Profit Aged	Family Care
	N=24[a]	N=13	N=18	N=10	N=4
Newest	2	12	1	30	40
Oldest	90	100	120	100	70
Age of homes in years					
1-24 yr. range					
No. of homes	4	1	4	0	0
Percent of homes	16	9	21	0	0
25-49 yr. range					
No. of homes	9	2	6	4	2
Percent of homes	38	16	32	30	50
50-75 year range					
No. of homes	5	8	3	3	2
Percent of homes	21	66	15	24	50
75-100 yr. range					
No. of homes	6	1	6	6	0
Percent of homes	25	9	32	46	0

[a] N= , indicates the number of homes in each category responding to this item on the questionnaire.

Table 1 shows the comparative ages of the homes first by range in terms of oldest and newest and secondly shows the age grouping of the homes. It should be noted here that because of the nature of the question from which this data is tabulated, the responses may reflect either the ages of the structures themselves or when the structures were converted to sheltered care homes. The trend in Rhode Island has been for potential operators either to convert their own homes into proprietory homes or to purchase older two or three story homes and convert these into sheltered care homes for the aged. It is apprent from the data however that the Nursing Homes, and Rest Homes are newer both in terms of age of structure and age of the business itself. It is noted that the Convalescent Homes show the highest grouping in the fifty to seventy-five year group, and the oldest homes are the Non-Profit Homes for the Aged. This latter factor would indicate a somewhat static condition existing, thinking in terms of new, Convalescent and Non-Profit Homes for the Aged, opening.

Table 1 also show that in the past twenty-four years the rate of new homes opened has not kept pace with the increase in the population of those person sixty-five years of age and older. The 1960 Rhode Island census figures[4] show a 27.1 per cent increase in persons over sixty-five in the last ten years while there has been only a 9.2 per cent increase

---

[4] <u>1962 Journal Bulletin Almanac</u>, <u>op</u>. <u>cit</u>., p.72.

in the number of homes opened over the period of the last twenty-four years. These figures indicate a significant variance with nationwide trends. Figures compiled in the Subcommittee study show that from 1954 to 1960 there has been a 48.0 per cent increase in homes for the nation as a whole.[5] This difference may reflect the fact that Rhode Island is one of the States considered an economically depressed area and may, in part also reflect the stricter licensing requirements for new homes put into effect in R. I. by law in 1939. In relation to this latter factor concerning stricter licensing requirements since 1939, we note from the data in Table 1 that eighty-four per cent of the Nursing, ninety-one per cent of the Convalescent, eighty-nine per cent of the Rest, and one-hundred per cent of the Non-Profit Homes for the Aged and Family Care Boarding Homes were contructed prior to 1939. It follows that only a relatively small number of the responding Nursing, Convalescent, Rest, and none of the Non-Profit Aged and Family Care Homes have been constructed since the stricter licensing requirements of 1939. The latter findings, relative to the Non-Profit Homes, are in direct relation to the findings of another investigator in this field:

> Construction of Homes by fraternal lodges, social agencies, trade unions, churches-their usual

---

[5] Senate Subcommittee, op. cit., p. 6.

sponsors- reached its peak in the latter part of the nineteenth century but has lagged far behind in the twentieth.[6]

Remodeling and Additions

Table 2 below shows the tabulation of data from responses to an inquiry which related to the remodeling of, or making additions to, the homes. It was felt by this writer that such data would be meaningful in terms of assessing the profressiveness or non-progressiveness of home operators within the various categories of homes. This writer does not hold that the lack of remodeling or additions is a reliable indication of a lack of progressiveness on the part of a home operator nor is the reverse true; if one's roof should fall in, one would certainly have to replace it and this would not indicate progress but rather commonsense. However it is felt that since, as shown in Table 1 of this study, the greater number of responding homes are well over twenty-five years old, it would seem to follow that in any commercial structure housing a number of residents over the years, one might reasonably expect that sometime during the course of years remodeling might need to be done or additions made.

The number and per cent of homes reporting remodeling or additions is shown in Table 2.

---

[6] Julietta K. Arthur, You and Yours: How to Help Older People, p. 166.

TABLE 2

REMODELING OR ADDITIONS MADE TO HOMES SINCE CONSTRUCTION

Homes reporting additions or remodeling	Nursing N=22	Convalescent N=9	Rest N=6	Non-Profit Aged N=9	Family Care N=3
No. of homes	10	5	5	4	0
Percent of homes	27.7	27.7	17.8	22.2	00.0

Table 2 shows that only twenty-four of the total one hundred and six homes responding indicated remodeling or additions made since construction, or eighteen per cent of the total homes. This finding is of interest since as noted above in Table 1 a large number of the homes are over twenty-five years old, and the Non-Profit Homes and the Rest Homes show that forty-six per cent of the former, and thirty-two per cent of the latter type homes are over seventy-five years old and these two type of homes show the least number reporting remodeling or additions in Table 2. This writer feels these factors to be notable because, even without considering providing better facilities and accommodations for residents, we would feel that just the factors of time, and wear and tear over the years would necessitate certain remodeling. Thus, we feel that the findings of this study are in agree-

ment with the findings of W. K. Vivrett, a social gerontologist who has made extensive personal visits to sheltered care homes for the aged throughout the U. S.; he states that:

> Few boards of directors during the first half of the twentieth century felt that they could afford fireproof buildings. As a result, their buildings are almost invariably frame with stucco or brick veneer or, at best, masonry shells with wood joist floors-sometimes provided with a sprinkler system in more recent years and more often not. In some cases, an energetic board member has preached continued maintenance, and the buildings are in relatively sound condition; but generally this is not so - cornices have rotted, roofs have been patched and are still leaking, windows and window frames are coming apart as the building settles, and the plumbing, heating, and electrical systems have long since become outmoded.[7]

The data in Table 2 also show that the Nursing and Convalescent Homes show the highest number and per cent of homes reporting remodeling, which may reflect the more stringent licensing requirements of these homes in terms of physical facilities. None of the Family Care Homes reported remodeling or additions, and this latter category of homes have less stringent licensing requirements and supervision than all other categories of homes in this study.

Insured Values of Homes

It was felt that if information were available as to the approximate worth of the various homes within the five categories, it might be possible to gain some further appreciation of the differences in quality and quantity of physical

[7] Walter K. Vivrett, op. cit., p. 581.

facilities in the homes and available to residents. Thus data was collected as to the insured value of the homes. The data is presented here in Table 3 in terms of the highest and lowest insured value of homes and the average insured value of homes within each of the five categories of homes.

TABLE 3

INSURED VALUE OF PLANT AND EQUIPMENT

Insured value of homes	Type of Home Nursing N=25	Convalescent N=13	Rest N=20	Non-Profit Aged N=10	Family Care N=3
Highest per home	$ 125,000.	$ 40,000.	$47,000.	$1,275,000.	$65,000.
Lowest per home	3,500.	6,000.	3,000.	40,000.	12,000.
Average per home	37,800.	20,800.	18,500.	357,000.	32,300.

Table 3 shows the hihest, lowest, and average insured value of the homes and their equipment. The Table indicates that the Non-Profit Homes have the highest insured value, and highest average insured value per home with a notable range between these and the other four categories of homes. The latter factor probably reflects the differences in the nature of sources of finances of the Non-Profit and the commercial type home, with the non-profit, organizationally or church sponsored endowed, while the commercial type homes must rely for the

most part on income from resident's fees.

The higher insured values of the Non-Profit Homes for the Aged might suggest at first that these homes are therefore larger and have superior equipment and facilities for residents. However, as is shown below in Table 4, the Non-Profit Homes have, on the average, more beds per home and are allowed to have more than two patients to a room, (again, reflecting less stringent licensing requirements). Thus, although the higher insured values of the Non-Profit Homes might indicate better facilities, etc., by comparing the data in Tables 3 and 4 we can see a relationship between insured values of homes and the number of beds per home in all categories excepting the Family Care Homes. Therefore we feel that the data in Table 3 does not in itself give any meaningful indication of quality or quantity of service or facilities, again excepting the Family Care Homes. This latter type home shows a somewhat lower insured value in relation to the number of beds per home and shows a notably higher per cent of residents per room than the other categories of homes. If we consider then a relationship between insured value and number of beds per home and residents per room in the Family Care Homes, we might speculate as to this being an indication of overcrowded conditions and less adequate facilities.

Beds Per Home and Patient Distribution

Inquiries were made on the questionnaires in order to collect data that would show the average number of beds per

home in the five categories and that would also show how residents are distributed in terms of private care, semi-private caree and dormitory care.

The Social Welfare Department of the State of R. I. vented its feelings about dormitory care of the aged in 1960:

> For the past fifteen years no more than two patients have been permitted to occupy one room. This policy was adopted after observations indicated that, in those instances where more than that number shared a room, there was a lack of harmony and indication of regression of personalities of the occupants. In practically all cases rates were very little, or no lower than in semi-private (2 bed-room) and it was quite evident that such arrangements were not only socially undesirable but conducive to exploitation, since this department has no control over rates for services. Since this policy has been in effect, it has been discussed with physicians and specialists in the field of geriatrics. All have concurred with the theory and commended the position taken by this department.

The data in Table 4 shows the average number of beds per home and the number and per cent of total patients in private and semi-private rooms and in dormitories.

---

[8] Rhode Island Department of Social Welfare, *op. cit.* p.2.

TABLE 4

AVERAGE NUMBER OF APPROVED BEDS PER HOME AND PATIENT DISTRIBUTION

Average number of beds per home and patient distribution	Type of Home: Nursing N=32	Convalescent N=18	Rest N=28	Non-Profit Aged N=18	Family Care N=6
Avg. number of beds per home	22	18	28	18	6
Patient Distribution					
Patients in private rooms					
Number	206	70	130	334	5
Percent	33.7	44.5	57.7	46.5	3.5
Patients in semi-private rooms					
Number	405	87	95	133	59
Percent	66.2	55.4	42.2	18.5	42.1
Patients in Dormitories					
Number	*	*	*	251	76
Percent				34.9	54.2

* Dormitory housing not allowed by nature of license.

Table 4 shows the average number of beds per home and the distribution of patients in rooms. As noted above, the Non-Profit Homes have a notably higher average number of beds per home and yet afford a relatively high per cent of private accommodations. The Rest Homes show the highest per cent of private care while the Family Care Homes show a notably lower ratio of both private and semi-private care than the other

categories of homes. Both Non-Profit Homes for the Aged and the Family Care Boarding Homes show a relatively high per cent of their patients as being housed in dormitory facilities; as again this reflects the lack of uniformity of licensing requirements and also the lack of authority of the social welfare department to enforce their feelings about dormitory care as noted above.

Although theoretically the Non-Profit Homes came under the jurisdiction of the social welfare department in 1953, it would seem apparent that they are still operating under the terms of the "grandfather clause," and neither they nor the social welfare department have taken steps to cease operation of dormitory facilities. Many practical problems would also interfere with any attempt to do away with dormitory facilities, some of these were stated by the Senate Subcommittee:

> Because of the shortage of nursing home beds, many States have not fully enforced the existing regulations, the failure to do so reflecting the policy of the States to give ample time to the nursing home operators to bring the facilities up to the standards. Many states report that strict enforcement of the regulations would close the majority of the homes.[9]

Further, it is of interest to note that in the only State operated home for the aged, "The Rhode Island Veterans Home," 201 of the 269 residents, or seventy-five per cent, are in dormitory accommodations. This home is under the super-

---

[9] Senate Subcommittee, op. cit., p. 20.

vision of the State Department of Social Welfare whose regulations state that no more than two patients may occupy one room.

Rates of Occupancy

In the interest of providing some appreciation of the total number of sheltered care beds available and approved for occupancy among the five categories of homes, the number and per cent of these beds that were occupied at the time of this study, the number and per cent of the homes that were filled to capacity and the number and per cent of those homes reporting waiting lists, inquiries were made relative to these areas. One hundred per cent of the homes in the study replied to this item and this data is presented below in Table 5.

TABLE 5

RATE OF OCCUPANCY
AND INCIDENCE OF WAITING LISTS

	Type of Home				
	Nursing	Convalescent	Rest	Non-Profit Aged	Family Care
	N=36	N=18	N=28	N=18	N=6
No. beds approved for occupancy*	813	188	251	821	157
Beds occupied					
Number	611	157	225	718	150
Percent	75.1	83.5	89.6	87.4	95.5
Homes filled to capacity					
Number	19	6	7	3	0
Percent	52.7	33.3	25.0	16.6	00.0
Homes reporting waiting lists					
Number	16	3	5	7	0
Percent	44.4	16.6	17.8	38.8	00.0

* Approved for occupancy by State Social Welfare Department.

Table 5 shows the number of beds approved for occupancy, the number and per cent of beds occupied, the number of homes filled to capacity, and the incidence of waiting lists in the different categories of homes. The Nursing Homes show a notably higher proportion of homes filled to capacity while the Family Care Homes show the highest per cent of occupied beds. This latter factor should be clarified; if it were not for a unique item in the State Hospital for Mental Disease licensing requirements for the Family Care Homes, these homes would show a one-hundred per cent occupancy rate. This item is, that each Family Care Home may, (and does, in each case), have one bed approved for a "private patient," that is, a patient not referred by the State Hospital. There are two reasons behind this thinking; (1) In case the State Hospital does not have enough available patients to fill vacancies as they exist in the homes and, (2) In the even that one occupant of these homes has a close relative who wishes to reside in the home also. In five out of the six Family Care Homes there was only one vacant bed and this proved to be the "private patient" bed; in the remaining home there were two vacant beds, one of these being the "private patient" bed.

The incidence of waiting lists as shown in Table 5 in Nursing, Rest, and Convalescence Homes would seem to be in almost direct proportion to the per cent of these homes that are filled to capacity. The Non-Profit Homes however, seem to present contrary figures, in that only three homes reported

as being filled to capacity, while seven of these homes reported waiting lists. One might speculate then that the waiting lists reported, reflect persons awaiting admittance to sectarian homes or those limited to one sex of resident. The findings show that three of the Non-Profit Homes reporting waiting lists are non-sectarian, two are sectarian, and two are limited to female residents. One writer offers further material for speculation in this area in discussing the study of a waiting lists for sheltered aged care:

> This study revealed that most of the persons on the waiting list were there for a variety of reasons other than their need for institutional care. Reasons given by the older persons registering for institutional care were that they "thought it was the thing to do;" "my children expected me to do this;" "fear that there would not be room in the institution later when actually needed;" "it gave me security to have my name on the list."[10]

The above presents evidence, as does the data, that some older persons put their names on waiting lists of homes as insurance against the day when they "may need it."

Staffing of Homes

In describing and discussing the differences in the categories of sheltered care homes the question of staffing of the homes was felt to be an important factor to consider. The writer feels that in addition to other factors and characteristics of homes, the quality and quantity of staff in the

---

[10] Eunice L. Minton, *op. cit.*, p. 24.

homes would be, at least in part, a direct indication of quality and quantity of care of residents. Therefore inquiries were made as to the number of full and part time staff and these figures were broken down into the type of staff in terms of level of training. The level of training is shown by the professional training of the nurses employed, this because the data indicated no other professional persons on the staff of the homes. The State Department of Social Welfare's requirements relative to staff of the homes insist upon only two levels of professional training, these being, (1) Registered Nurses and, (2) Licensed Practical Nurses. The number and level of training of staff is shown, the number of staff who are full and part time, and the number of present residents is shown to give clarity for comparative purposes, in Table 6.

TABLE 6

STAFFING OF HOMES AND LEVEL OF TRAINING OF STAFF

Staff of Homes	Type of Home				
	Nursing N=35	Convalescent N=17	Rest N=26	Non-Profit Aged N=18	Family Care N=6
No. of present residents	611	157	225	718	150
Total number of paid staff	456	76	35	177	35
Full time	343	36	10	104	25
Part time	113	40	25	73	10
Total no. of					
Registered nurses	61	9	0	9	2
Licensed nurses	156	20	6	14	2
Nurses aids	23	8	1	26	5*
Other staff	215	36	28	128	26

* "Psychiatric aids."

Table 6 shows total personnel and their distribution in terms of level of training. It should be noted that the classification of staff under the category "other" staff includes attendants, housekeeping and dietary personnel. No home in any category indicated any professional personnel such as, dieticians, or occupational, physical or recreational therapists although it is conceivable that some of the personnel may have had some training in these areas. Not shown in the table but indicated by the data was the fact that one Nursing Home, One Convalescent Home, and one Non-Profit Home for the Aged, reported they had social workers on their staff; one each in one Nursing Home and one Non-Profit Home, and three on the staff of one Convalescent Home. The professional training of these workers was not indicated.

The large number of "other" staff in proportion to trained staff is shown in Table 6 and it is interesting to note that "other" staff comprises 47.1 per cent of the total staff in the Nursing Homes; 47.3 per cent in the Convalescent Homes; while the remaining three categories show much higher proportions of "other" untrained to trained staff: "other" staff comprises 80.0 per cent of staff in the Rest Homes; 72.3 per cent in the Non-Profit Homes and 74.2 per cent in the Family Care Homes. These findings would seem to make it appropriate to quote comments on staff in sheltered care homes made by Vivrett:

> The working staff of these institutions are a direct reflection of the antiquated concepts of business and

> and public welfare which many of the institutions hold ... It is true that some institutions have devoted employees who are well trained and who may be willing to work for low salaries. But, by and large, these "devoted servants" to the institution are the rejects, the discards, or those who have resigned or retired from other areas of work. These seldom appear qualified to perform the duties required in such a complex, human, and technical field of endeavor. On the other hand, an increasing number of institutions are evaluating the jobs to be done and seeking out qualified individuals to do them, with immediately observable benefits.[11]

Although the author of the above has done extensive research in the field of institutional housing for the aged in the United States, it would not be appropriate to apply his findings indiscriminately to the present study. In this study, this writer did not attempt to obtain data relative to the qualifications of the staff in terms of their character, personality traits, efficiency, etc., but rather, qualifications only in terms of level of professional training. This writer does feel however, that the type and qualifications of personnel who are caring for an appreciable number of our aged poplation, is an important factor for consideration and merits further study.

STAFF RATIO

In the interest of providing a further appreciation of the different characteristics in the five categories of homes in this study relative to staff, the data was further broken down to show ratio of present staff to present residents. This

---

[11] Walter K. Vivrett, *op. cit.*, p. 281

was done with a view of providing further data for comparison of the homes in terms of quality and quantity of care available to residents. Table 7 shows the ratio of staff to residents by type, (level of training), of staff and also shows the ratio of total full time, and full time equivalent staff to residents.

TABLE 7

RATIO OF STAFF TO RESIDENTS BY TYPE OF STAFF

Type of Staff	Type of Home: Nursing N=35	Convalescent N=17	Rest N=26	Non-Profit Aged N=18	Family Care N=6
	Stf.[a]-Res.[b]	Stf.-Res.	Stf.-Res.	Stf.-Res.	Stf.-Res.
Reg. nurse	1 - 10	1 - 17	0 -225	1 -102	1 - 75
Lic.prac.nurse	1 - 39	1 - 7	1 - 37	1 - 51	1 - 75
Nurses aid	1 - 26	1 - 19	1 -225	1 - 28	1 - 25
Full time equivalent[c] staff	1 - 4	1 - 8	1 - 30	1 - 15	1 - 15

[a]Abbreviation for staff.

[b]Abbreviation for residents

[c]Full time, plus half the number of part time staff.

Table 7 shows the overall distribution and ratio of staff to residents by level of training and the ratio of full time equivalent staff to residents.

We may note from the data in Table 7 that in almost all categories of homes the level of professional staff is in proportion to the number of residents as required by the State Social Welfare Department. In the category of the Family Care Homes, whose licensing agency is the State Hospital for Mental

Diseases, there are no requirements for professionally trained nurses. In lieu of nurses, The Family Care Homes are required only to have one person on their staff who has taken the psychiatric aid course (six weeks), at the State Hospital. The content of this course is not known to this writer but we would assume it is geared at the care of mental patients.

Concerning the Family Care Boarding Homes it is of interest to note that although the section of the Rhode Island Law which covers sheltered care homes for the aged puts the Family Care Homes under the jurisdiction of the State Social Welfare Department, this Department's Division of Nursing, Rest, Convalescent and Homes for the Aged does not supervise the Family Care Homes nor do its regulations governing licensing, staff requirements, etc., apply to the latter homes.[12] Further, there are no written regulations per se governing the Family Care Homes, nor by the same token, are the Non-Profit Homes for the Aged defined or mentioned specifically in the welfare department's regulations in terms of licensing or staff requirements. The latter homes are looked upon by the welfare department as Rest Homes. The R. I. State Department of Social Welfare is currently in the process of revising regulations governing Nursing, Rest, Convalescent and Non-Profit Homes for the Aged. After reading and re-reading these regulations a number of times in connection with compi-

---

[12] State of R. I., Dep't. of Social Welfare, "Licensing and Regulation of Homes for Aged or Convalescent Persons," (September 1958) p. 1.

ling this study, this writer feels that the revision of the regulations is a positive step in the right direction.

Table 7 shows notable differences in ratio of staff to resident in all categories of homes, with the Nursing and Convalescent Homes providing the largest number of staff per patient, and with the Family Care, Non-Profit, and Rest Homes providing notably fewer staff per resident. The Rest Homes showed a very low ratio of staff to resident, with an average of only one staff member for every thirty residents.

In regard to staff the Senate Subcommittee found:

> The staffing of nursing homes with registered and licensed practical nurses is inadequate in most homes. Only a third of the homes have these trained personnel. The largest portion of nursing care received by patients is administered by nurses aids and orderlies. On the other hand, both the quality and amount of skilled nursing care is directly related to the requirements set and enforced by the State.[13]

Overall, this writer feels that the findings in Table's 6 and 7, this study, agree substantially with the above findings of the Subcommittee.

---

[13] Senate Subcommittee, *op. cit.*, p. 13.

CHAPTER III

ADMISSION POLICIES AND REQUIREMENTS

In measuring characteristic differences in the homes, the admittance policies represent an important criteria to be discussed. This writer considers this to be true whether one is considering country clubs, fraternal lodges, or other social institutions. It would seem that we might be able to formulate some idea of the potential quality and quantity of services and living conditions to be expected, not only from the surroundings and facade of the home itself, but also from its intake policies.

It follows then that we may glean an approximate idea also, of who is served by the various homes in terms of cultural groups, sectarian groups, sex and age groups, and the physical condition of persons served.

With the above in mind, policies and requirements concerning minimum ages, sex, sectarian affiliation, physical condition, and state residency requirements were studied from responses to the schedules.

This data will be shown in Table 8. The number of homes reporting no admission requirements will also be shown. The data will be shown in terms of showing the number and per cent of homes reporting such requirements as: age, sex, church or fraternal affiliation, state residency requirements, and that a patient be ambulatory upon admission to the home.

TABLE 8

ADMISSION POLICIES AND REQUIREMENTS

Policies and Requirements	Type of Home Nursing N=34	Conva-lescent N=16	Rest N=23	Non-Profit Aged N=18	Family Care N=6
Minimum age					
Number	3	0	0	12	3
Percent	8.3	00.0	00.0	66.6	50.0
Sex....Male					
Number	0	1	1	0	2
Percent	00.0	5.5	3.5	00.0	33.3
...Female					
Number	4	1	3	8	1
Percent	11.1	5.5	10.7	44.4	16.6
Church or Fraternal Affiliation					
Number	0	0	0	6	0
Percent	00.0	00.0	00.0	33.3	00.0
Residency					
Number	0	0	0	3	0
Percent	00.0	00.0	00.0	16.6	00.0
Must be Ambulatory					
Number	0	2	9	6	2
Percent	00.0	11.1	32.1	33.3	33.3
No requirement					
Number	28	14	15	0	0
Percent	77.7	77.7	53.5	00.0	00.0

The data in Table 8 shows overall that the commercial homes are much less selective in terms of admission requirements than are the Non-Profit Homes for the Aged. However in considering this data this writer feels that one important factor should be kept in mind; the data shows that over three-fourths of the Nursing, Convalescent, and over half of the Rest Homes

reported no admission requirements; would it then, be safe to conclude that any person, regardless of race, creed, or color would be admitted to any one of these home? This writer thinks not and admits this as a further limitation of this study and one which raises questions for further study. Out of the total sample of 106 homes, only one reported specifically that "no colored persons were allowed," further, only one home in the total sample designates itself as a home for colored persons and this home restricts itself to women. Neither regulations of the Department of Social Welfare nore R. I. State Law prohibits denial of admission to these homes for reason of race, creed, or color. The question seen then, and not answered by this study is, are there enough homes in this State that do not limit their admissions in terms of race, creed, or color, (and especially the latter), to accommodate the number of persons in the above groups who are in need of sheltered care by reason of advanced age, illness, etc.

A minimum age requirement was reported in eight per cent of the Nursing Homes, fifty per cent of the Family Care Homes, and close to seventy per cent of the Non-Profit Homes, while none of the Convalescent or Rest Homes reported minimum age requirements. Interestingly, although not indicated in the table, one Non-Profit Home reported a maximum age restriction of eighty. Had this latter restriction been reported in a substantial number of homes it would lead us to recognize a community need for homes for the "aged-aged."

This writer would tend to agree with the reporter of the Chicago Study who states that "The reason for admission to a home should be the existence of a need for care in a home and chronological age itself has nothing to do with need."[1]

This leads to a consideration of how one finances need. The practical consideration in a minimum age requirement is that an "aged" man must be sixty-five and an "aged" woman, sixty-two years of age before he or she may qualify for Old-Age, Survivors, and Disability Insurance (OASDI) or Old-Age Assistance (OAA) under the public assistance laws. Therefore an older person requiring and applying for sheltered care before these respective ages must be able to finance his or her own care. Table 9 in this study shows that well over fifty per cent of the residents in most of the homes studied, finance their care with either OASDI or OAA or a combination of both. It is evident then, that a minimum age requirement is implicit for a good number of prospective residents, although not stated specifically by many homes.

Overall, twenty-one of the one hundred and six homes reporting, indicated a sex requirement, or eighteen per cent of the homes. Seventeen of these restrict admission to women and only four restrict admission to men. The 1960 Rhode Island census figures indicate that there is a ratio of six women to five men in the sixty-five and over, age group; this would

---

[1] Barbara C. Wallace, "Intake Policies And Procedures At Eighteen Homes For The Aged," Social Service Review, vol.25 (September 1951), p. 346.

lead one to question why the ratio of homes accepting women only is so much higher than the apparent need, in terms of population figures, would suggest. Relative to this it is notable that forty-four per cent, or almost half of the Non-Profit Homes for the Aged, accept only women, with none of these homes restricted to men only. In a finding somewhat similar in its scope, Sloan, et al., state that:

> This undoubtedly reflects the greater longevity of women in this indirect respect: Many more women than men are widowed. Widowhood, in turn, more strongly disposes to residence in a nursing home or other protected environment than if a marital partner is present.[2]

The above answers only one part of an implicit question arising out of the findings that seventeen, or eighty per cent of the twenty-one homes reporting sex restrictions, restrict themselves to women only. The other part suggesting a need for further study might be considered in terms of whether aged women are easier to care for or perhaps have more financial resources to pay for sheltered care than aged men. It was of interest to note that one home, "The King's Daughter's and Son's Home" suggested by its name that it cares for both women and men, however this home reports that it restricts its applicants to women only, or, just the "King's Daughter's."

The Non-Profit Homes were the only type reporting sectarian or fraternal policies relating to admission; of the six having this requirement only one restricted applicants to

---

[2] U. S. Public Health Service, op. cit., p. 9.

membership in a fraternal order. One investigator in the field of institutional housing for the aged sees a need for organizationally sponsored homes:

> Organizationally sponsored residential care facilities are desirable, since they house residents who have homogenous background and who are, therefore more likely to be congenial.[3]

It was of interest to note that one home in the study while not mentioning a particular church affiliation per se, indicated such a requirement in a not too subtle way by stating that "attendance at Protestant Services in the home is required."

None of the commercial homes reported a State residency requirement and only three of the Non-Profit Homes indicated such a requirement. This contrasts to the findings of the Chicago Study which reports that "ten of the eighteen homes stipulated a residency requirement."[4]

The Nursing Homes were the only homes not requiring that patients be ambulatory at admission; the remaining four categories of homes all reported relatively high percentages of homes that required patients be ambulatory at admission. This factor is an important one for consideration and has been given increasing thought by investigators in the field of aging. Kutner reflects current thinking when he states:

---

[3] Bernard Kutner, and others, <u>Five Hundred Over Sixty</u>, p. 240.

[4] Barbara Wallace, <u>op</u>. <u>cit</u>., p. 347

> The more advanced homes for the aged are showing more reluctance to accept the well, ambulatory, aged. This is a reflection of the recognition that a home for the aged is perforce an abnormal setting tending to impose serious limitations on the independence of residents, thereby creating a major social dislocation.[5]

Another writer, in assessing intake policies relative to the physical condition of its residents, states that:

> Nowadays if homes admit the physically well and mentally competent, it is because their policies were set years ago, before old age assistance, social security and private pensions gave dependent old people a financial choice.[6]

It seems evident that the implications here indicate other areas deserving of further study in terms of clarifying different admission policies and relating these to actual existing needs.

Sources of Funds For Total Care of Residents

The Social Security Act of 1935 and its subsequent amendments have made possible the granting of federal aid to states to share in Old-Age Assistance payments to the needy aged. Dependent upon individual State regulations, this financial assistance is extended to the needy aged requiring sheltered care. The 1950 amendment provided for federal sharing in medical payments made directly to vendors of medical care. One source states that:

> ...This provision enable some states that had not previously provided for medical care to begin to pay

---

[5] Kutner, op. cit., p. 241.
[6] Julietta K. Arthur, op. cit., p. 162

> the cost of some medical services and others to expand their existing medical care provisions...In December of 1958, thirty-eight different states were providing medical care with federal participation through vendor payments for one or more categories of federally aided Public Assistance...Nursing, Convalescent home care through money payments or vendor payments was the item most frequently included for adult categories as of January 1958.[7]

7 The sources of funds and financial arrangements for the total care of residents was considered a necessary part of a study of sheltered care homes for the aged. Therefore, sources of funds, the amount of payment allowed under Old-Age Assistance and the operating budgets of the homes will be discussed. The amount of the budget's of the homes was considered to be important in view of the fact that some of the Non-Profit Homes for the Aged accept persons who are unable to pay home fees that would be in excess of the Old-Age Assistance grants and we therefore speculate that these homes' operating budgets would have to be higher than the commercial type homes.

The need for data on sources of funds was stated by the Senate Subcommittee:

> It is notable that no complete information is available on other sources of income of nursing home patients. Basic data should be collected on how many patients receive income from social security and other pensions, from relatives and from private health insurance policies.[8]

---

[7] Jay L. Roney, Social Work Yearbook, 1960. p. 467.

[8] Senate Subcommittee, op. cit., p. 6.

TABLE 9

SOURCES OF FUNDS

Sources of Funds for Total care of Residents	Type of Home				
	Nursing N=35	Conva- lescent N=18	Rest N=26	Non- Profit Aged N=18	Family Care N=6
OAA[a] [b]					
Number res.	306	106	128	168	150
Percent "	50.0	67.5	56.8	23.3	100.0
OASDI[c] [b]					
Number res.	139	51	54	108	54
Percent "	22.7	48.1	24.0	19.2	36.0
[b]Relatives					
Number res.	238	27	18	64	13
Percent "	38.9	25.4	8.0	8.9	8.6
Amount per month paid by OAA to home per resident[d]	$186.50	$156.00	$113.00	$113.00	$120.00[e] 130.00[f]
Avg. operating budget of homes	$57,411.	$14,444.	$7,100.	$77,272.	$7,000.

[a]Old-Age Assistance

[b]Care paid for entirely or in part by this source.

[c]Old-Age, Survivors, and Disability Insurance.

[d]The amount shown excludes a $6.00 personal needs allowance per month, plus all medical care.

[e]This amount if resident is continent.

[f]This amount if resident is incontinent.

Table 9 shows that over half of the residents in the commercial type homes have their care paid for entirely or in part by funds from OAA or OASDI. The Family Care Homes report that all of their residents are supported entirely or in part by OAA payments. It is of note that less than one-fourth of

the residents in the Non-Profit Homes for the Aged are recipients of Old-Age Assistance; this finding would seem to reflect the charitable nature of some of these homes. Also of note is the finding that over one-fourth of the residents of the Nursing and Convalescent Homes have part of their care paid for by relatives while the remaining three types of homes all show that only eight per cent of their patients have care paid for entirely or in part by relatives. The latter finding would suggest that the residents in these three types of homes may have fewer living relatives and are therefore more in need of sheltered care.

The data in Table 9 relative to recipients of Old-Age Assistance would seem to bear out the findings Solon, et. al., in their study of homes in thirteen states:

> Perhaps the outstanding fact which emerges from the study regarding the financing of care of patients in nursing homes is the role of public assistance funds. Fully half of all proprietary nursing home residents are receipients of public assistance.[9]

The data in Table 9 also seem to bear out another investigator's feeling that:

> Many institutions are dependent upon old age assistance grants to the individual resident and direct contributions in money or in kind such as foods and volunteer services.[10]

---

[9] U. S. Public Health Service, *op. cit.*, p. 22.

[10] Walter K. Vivrett, *op. cit.*, p. 579.

The same writer's further findings suggest important areas for further evaluative study in terms of the level and quality of care provided by the various homes when he states that:

> The quality of environment and level of care in many of our institutions have been pegged to the level of the old-age assistance grant. Thus, while old-age assistance funds have provided relief as well as some independence and security to the individual, the level of these grants has all too often set both the floor and the ceiling for standards of care and environment.[11]

As noted in the footnote to Table 9, the amounts shown as paid by Old-Age Assistance are for board, room, and nursing care only and do not reflect additional medical expenses which are also paid by OAA. The $6.00 personal needs allowance is intended to defray expenses of clothing, miscellaneous toilet articles, etc. In personal communications with several nursing home operators this writer was interested in one complaint voiced that the $6.00 personal needs allowance should be added to the amount given to the home itself for board and room since, "The patients have nowhere to go to spend this money anyway!" One would hope that the degree of profit consciousness expressed in this complaint would represent the minority of home operators.

---

[11] Ibid., p. 579.

CHAPTER IV

CHARACTERISTICS OF RESIDENTS AND THEIR CARE

In order to gain an appreciation of the incidence and degree of similarities and differences in the homes studied in terms of characteristics of residents served, data was sought that would describe resident's characteristics in terms of age, length of present residence in the home, and the physical condition of the resident determined by the level of care required. Table 10 shows data relative to resident's age and present length of residence in the home by years.

TABLE 10

AGE AND LENGTH OF RESIDENCE

Age and length of residence	Type of Home				
	Nursing N=36	Convalescent N=18	Rest N=27	Non-Profit Aged N=18	Family Care N=6
Median age of present residents	78.2	78.4	77.5	79.0	73.2
Median length of residence of present residents by years	2.5	3.4	3.0	7.9	3.3

Table 10 shows no striking differences in the homes in terms of the median ages of residents served. The Family Care Homes show a slightly lower median age but overall the age findings closely approximate the findings of the thirteen

state study which showed the median age of residents to be eighty.[1]

The Non-Profit Aged Homes show notable longer length of residence indicating much less mobility in the residents of these homes. The median length of residence of present residents in the remaining four categories of homes, however does not indicate temporary nursing, convalescent or rest care. Rather, the findings shown in Table 10 relative to length of residence would substantiate findings of the thirteen state study:

> From the standpoint of the advanced ages of the patients, the Nursing Home was characterized as a form of home for the aged. This characteristic seems strengthened by the information on length of stay in the Nursing Home. Not counting the time which may have been spent in other Nursing Homes or the time still to be spent in the present home, the average patient had at the time of the survey been in the present home for a full year.[2]

It was of interest to note that one home operator reported the median length of residents as "five-feet, four-inches."

Physical Condition of Residents And Kind of Care Required

Actual physical disease entities were not sought in terms of determining physical condition of residents, it was felt rather that in a general type of descriptive study our

---

[1] U. S. Public Health Service, *op. cit.*, p. 8.

[2] *Ibid.*, p. 15.

purpose would be better served by seeking a more inclusive type of data in terms of level of care required. Hence, data was sought that would show the number and per cent of residents capable of caring for themselves, number and per cent requiring help in getting about, those requiring help related to incontinence, and those requiring help because of their mental state. This data is shown below in Table 11.

TABLE 11

PHYSICAL CONDITION OF RESIDENTS

Care Required by Residents	Type of Home				
	Nursing N=36	Convalescent N=18	Rest N=27	Non-Profit Aged N=18	Family Care N=6
Res. capable of self care					
Number	68	14	174	390	47
Percent	11.1	8.9	77.3	54.3	29.9
Res. requiring bed care*					
Number	487	26	4	89	12
Percent	79.7	16.5	17.7	12.3	7.6
Res. requiring help in getting about					
Number	449	24	0	116	10
Percent	73.6	15.2	00.0	16.1	6.3
Res. requiring help related to incontinence					
Number	275	38	3	20	4
Percent	45.0	24.2	13.3	3.2	2.5
Res. requiring help due to mental condition					
Number	311	30	21	78	136
Percent	51.0	19.1	9.3	12.7	86.6

* Some, part, or all of the time.

Table 11 shows that in terms of level of care required as related to physical condition, the Nursing Homes showed notably higher percentages of disability, with the Rest and Non-Profit Homes showing notably lower figures. The latter finding suggests that there may be a considerable number of older persons in the Rest and Non-Profit Homes who could conceivably be cared for in their own homes or other facilities were these available.

The data shown relative to Nursing Home patients bear out findings of the Subcommittee:

> Health-Disability is high. Most nursing home patients suffer from two or more disabilities. Two out of three have some type of circulatory disorder, and more than 50 percent have periods of disorientation. Less than half can walk with assistance, and one-third are incontinent.[3]

The high percentage of residents in the Family Care Homes requiring help due to mental condition is related to their source of referral, the State Hospital for Mental Diseases. It is of note that three of these Family Care Homes are "closed homes' that is, they have the traditional bars on the windows, locked doors, etc. One could conceivably see these homes as extensions of the traditional state mental hospital but with no psychiatric care available other than the "psychiatric aids."

Table 11 shows a relatively low incidence of disability

---

[3] Senate Subcommittee, op. cit., p. 4.

among the Convalescent Home residents and might be seen to bear out the feeling of one writer in this field:

> Convalescent homes have several purposes; they may be a good bridge between hospital and home, or they may give a breather to a family while something permanent is being worked out.[4]

However the findings in Table 10, this study, which show that the median length of residence is 3.4 years in the Convalescent Homes, would indicate a fairly long "bridge," in the homes studied here.

---

[4] Julietta K. Arthur, *op. cit.*, p. 206.

CHAPTER V
RECREATION

Activities of Residents and Facilities Available

The need for physical mobility and some type of recreational or creative activity is widely recognized currently; not only as a rehabilitative agent in illness but also in promoting mental health in all ages. One writer states this need:

> Creative activity of any sort has a tremendous therapeutic value. It is a great "untier of inner knots," an unscrambler of confusions, a safety valve for blowing off steam. It preserves the mental and physical well-being and can help one to find inner peace and... give meaning and substance to the so-called empty years that stretch ahead after the children have left the home. It will help establish a new and heart-warming pattern of living that will endure through all the remaining span of life.[1]

The inclusion in this study of recreational activities of residents, facilities as provided by the homes, and the home operators feelings about recreational activity, were considered to be important factors in considering different characteristics of the five categories of homes. The following three tables will describe and discuss findings from the data in terms of residents activites, facilities as provided by the homes, and the home operator's opinions as to the main deterrents to organized recreation programs.

Table 12 will show activities of residents in terms of visits received; passive activities-reading, watching television,

---

[1] Henry Schmidt, Jr., "Creative Expression For All," in Aging In The Modern World, p. 168.

listening to radio, and writing or receiving letters; active participation in activities- in the home or out, crafts or work around the home; and those residents going off the grounds regularly-which is felt to be more desirable than being inactive.

TABLE 12

ACTIVITIES OF RESIDENTS

Activities of Residents	Type of Home: Nursing N=36	Convalescent N=18	Rest N=26	Non-Profit Aged N=16	Family Care 6
Res. receiving visits once a week					
Number	513	98	73	307	13
Percent	83.9	62.4	32.4	50.2	8.6
Res. participating in organized recreation in the home					
Number	140	21	57	274	64
Percent	22.9	13.3	25.3	38.1	42.6
Res. going off grounds regul.					
Number	176	29	112	177	36
Percent	28.8	18.4	49.7	24.6	24.0
Res. doing craft work or helping around the home					
Number	21	16	26	155	46
Percent	3.4	10.1	11.5	21.5	30.6
Res. taking part in recreation outside the home					
Number	12	5	4	92	10
Percent	1.9	3.1	1.7	12.8	6.6
Res. ambulatory*					
Number	68	14	174	390	47
Percent	11.1	8.9	77.3	54.3	29.9

* The number and percent of residents who are ambulatory was shown in Table 12 to form a basis of comparison between the number of residents able to take part in some form of activity, i.e., ambulatory - and those who are not, due to their disability.

Table 12 shows that the incidence of residents receiving weekly visits is somewhat higher in the Nursing and Convalescent Homes than the Rest and Non-Profit Homes, with a notably low percentage of Family Care Home residents receiving visitors. These findings may in part, reflect the factor that some Nursing and Convalescent Home residents are in the homes primarily because of illness rather than because of old age per se, and further, that these persons may have more interested relatives and friends. Conversely, the low incidence of Family Care Home residents receiving visits obviates the fact that in most cases these former mental patients have few, or no, interested relatives or friends.

Although not shown in Table 12, the data show that one-hundred per cent of all residents in all five categories of homes are reported by the operators as participating in the passive activities mentioned above - reading, watching television, etc. This writer feels that in some instances these must be highly subjective responses and also may reflect a defensive attitude on the part of the operators who are in effect saying "All of our patients have something to keep them occupied and thus they are happy and content; there is therefore, no need for us to extend ourselves further." One cannot help but get a similar impression from data shown in Table 14 further in this study.

Interestingly, the Family Care Homes show the highest per cent of residents participating in organized recreation

within the homes and doing craft work, with the Non-Profit Homes showing next higher figures. One might expect the Non-Profit Homes and Rest Homes to show somewhat higher figures relative to recreation in view of the fact that a higher number of residents in these two types of homes are ambulatory.

Overall, the data in Table 12 indicates that residents in the Family Care and Non-Profit Homes for the Aged participate in more recreational activities, and the residents in Rest Homes enjoy more mobility - in terms of going off the grounds regularly. This latter factor may be a reflection of the comparatively high percentage of residents in Rest Homes reported to be ambulatory.

In interpreting the data presented here, the subjectiveness of some of the responses must be kept in mind as a limitation. In part however, the data in Table 12 seems to substantiate further findings of the Subcommittee:

> Routine care in these homes permits little recreational activity beyond a lone television set; floor space between beds and in hallways is at a premium making activity difficult and often dangerous.[2]

<u>Recreational Facilities Provided by Homes</u>

Table 13 shows data on the number and per cent of homes providing some kind of organized recreational activities, and also shows the nature of their responses, (yes or no), to an item which questioned their desire for a recreation program if they had none. The Table also shows the number of homes not

---

[2] Senate Subcommittee, *op. cit.*, p. 7.

responding to this item, rather than the form followed thus far to indicate the number of homes responding to an item, (N=).

TABLE 13

RECREATIONAL FACILITIES

Facilities and Attitudes	Nursing N=31	Type of Home Conva-lescent N=18	Rest N=22	Non-Profit Aged N=16	Family Care N=6
Homes sponsoring organized recreation					
Number	12	4	4	3	4
Percent	33.3	22.2	14.2	16.6	66.6
Homes desiring organized recreation					
Number	11	6	2	4	4
Percent	30.5	33.3	7.1	22.2	66.6
Homes not desiring organized recreation					
Number	5	7	3	5	1
Percent	13.8	38.8	10.7	27.7	16.6
Homes not responding *					
Number	8	19	1	6	1
Percent	22.2	67.8	5.5	33.3	16.6

* The homes shown as not responding-did not respond to the item asking whether or not they wished recreation if they now had none. This does not indicate that these homes did not respond to the other items on recreation.

Table 13 shows what this writer feels to be somewhat surprising findings in terms of what types of homes seem to provide organized recreational activities. The Non-Profit Homes for the Aged and the Rest Homes show the least organized

activities, with the Family Care Homes showing the highest per cent of homes reporting activities, and with the Nursing and Convalescent Homes showing next highest percentages respectively. Further, only four of the Non-Profit Aged Homes, and two of the Rest Homes, not presently having recreational activities indicated a desire for same while the greater percentages of these homes either indicated they were not interested in recreational activities or did not respond to this item.

Here again the limitations of this study must be considered in terms of the possible subjectiveness of responses in this area of recreational activities. As an example, one home operator who holds a birthday party once each month for all residents whose birthdays fall within that month, considers this to be organized recreational activity. Another operator may have similar positive activities and yet not report this as organized recreation. Thus, with the need for some type of recreational or creative activity recognized, this writer sees a need for more extensive and definitive research in this area in terms of determining what kinds and types of activities are existent and to what extent they are available in relation to the needs of persons in sheltered care homes for the aged.

This writer further sees a definite need for at least some kind of organized recreational or creative activity in any sheltered care home, regardless of the physical or mental condition of the residents. One writer in this field

admonishes relative who are considering sheltered care homes for their aged relative:

> "By their deeds ye shall know them," is never truer than in a home for aged men or women. If residents are sitting about just "resting" or herded in a group doing nothing, no matter how luxurious the parlor or how handsome the lawn, take your relative elsewhere. A chance to develop new hobbies or reactivate dormant ones, to help with small duties in accordance with strength, to retain contacts with the outside world - these are the balance wheels which keep people from desicating in a small, enclosed community.[3]

The Rhode Island Council of Community Services, recognizing the need for recreation services for the confined aged and chronically il, in Nursing, Convalescent, and Homes for the Aged, formed a committee to explore the extent of this need in this state. This committee visited what they felt to be a representative sample of the above homes. In a preliminary report the committee stated:

> We learned that: 1) Proprietary nursing homes often have 80% of their patients bedridden and with near to complete breakdowns. 2) That there is a great need for recreation for the confined and that some places are using recreation with good results. 3) The aged and chronically ill should be regarded as people who have the same needs as all other people plus special medical and social needs. 4) The sense of being part of a group is necessary for confined persons.[4]

The committee concluded that:

There were three areas in which Rhode Island might move

---

[3] Julietta K. Arthur, op. cit., p. 178.

[4] R. I. Council of Community Services, Preliminary Report of the Committee on Recreation Services for the Confined Aged and Chronically Ill, Providence, R. I., 1960. p. 1.

forward in providing additional recreation services to the confined aged, and chronically ill. 1) Education of personnel concerned with the confined...2) Legislation concerned with finances and standard setting...3) Demonstration projects...[5]

Deterrents To A Recreation Program As Seen By Home Operators

Table 14 will show operator's responses to an item on schedule which asked what they saw to be the primary deterrents to an organized recreation program. The Table shows the number and per cent of homes responding to each item.

TABLE 14

DETERRENTS TO RECREATION PROGRAMS

Deterrents	Type of Home: Nursing N=33	Convalescent N=17	Rest N=21	Non-Profit Aged N=13	Family Care N=6
Lack of money					
Number	9	7	9	5	0
Percent	25.0	38.8	32.1	27.7	00.0
Lack of patient interest					
Number	21	7	15	11	3
Percent	58.3	38.8	53.5	61.1	50.0
Lack of professional interest					
Number	8	3	2	3	2
Percent	22.2	16.6	7.1	16.6	33.3
Lack of volunters					
Number	7	3	2	4	3
Percent	19.4	16.6	7.1	22.2	50.0
Lack of equipment					
Number	6	3	3	5	0
Percent	16.6	16.6	10.7	27.7	00.0

Of interest is the fact that Table 14 shows that half

[5] Ibid., p. 2.

or over of all homes excepting the Convalescent Homes indicated lack of patient interest as being the main deterrent to a recreation program; almost thirty-nine per cent of the Convalescent Homes also mentioned this deterrent. These figures lead one to wonder if the patient's opinions had been solicited as to whether or not they were interested in recreation programs. This writer considers this latter factor to be a further limitation of the present study and a question for further research. We would wonder what the actual attitudes of the residents of these sheltered care homes are, relative to various kinds of recreational activities. In the summary of the Seventh Annual Southern Conference on Gereontology, the need for more research in this area is expressed:

> Recreational activities themselves, and other services, need to be planned in a way which meets the ascertained wishes of the older persons who will participate, and not, as is sometimes the case, designed by younger people who think they know best what older people want...It is only too easy for individuals and social agencies working in this field to become overprotective, to treat older people as if they were children instead of mature personalities, and to impose upon them with implacable benevolence, things they really do not want.[6]

It would seem appropriate in concluding this chapter on recreation to quote from one questionnaire returned to this writer by a Nursing Home operator in the southern part of the state. We note first that this home has a bed capacity

---

[6] Univ. of Florida Institute of Gerontology, Services For The Aging, vol. 7 (1957), Pp. 155-56.

of thirty-seven and is filled to capacity at this time with a waiting period for admission of one to three months. The operator notes that while only five per cent of her residents are fully ambulatory, seventy-five per cent of the residents participate in some kind of organized creative or recreational activities at the home. The paid part-time staff at this home includes a professional pianist who plays for the residents' band, and a ceramic crafts instructor. The operator of this home hopes to be able to acquire the services of an occupational therapist in the near future. The operator of this home included a letter to this writer which is quoted here in part:

> It's wonderful to own a Nursing Home...I enjoy most of all helping these people to stay normal human beings and live an interesting normal life by keeping them interested in <u>something</u> and <u>themselves</u> most of all. I found out many years ago that elderly people love fun, love to have their hair done by a hairdresser, love to dress up in their best, that they love parties, love music. <u>They actually enjoy just what younger people do</u>; with a little tender, loving care, thrown in, you are bound to come up with some happy patients.[7]

The author of the above letter, whether by training, experience, or intuition and a feeling for people, expresses what this writer feels to be an ideal attitude of a home operator who is entrusted to a greater or lesser degree to help fulfill the needs of a number of persons in a sheltered care environment. This ideal attitude is justified and

---

[7] Personal Communication from the "Shelter Cove Nursing Home," Westerly, Rhode Island.

substantiated by the following statement of an investigator in the field of care for the aging:

> After basic maintenance needs have been met, probably the most vital need of the older person is the creative use of time. The rocking chair as the symbol of contented old age was surely the concept of a very young person. On the contrary, the dread of the aging person is loneliness, isolation, lack of purpose and failure to be productively active.[8]

---

[8] William P. Sailer, "Administrative Planning for Services for the Aging," in Aging: Progressive Programming, p. 5.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The purpose of this study was to describe and compare five categories of sheltered care homes for the aged in Rhode Island and to determine the extent to which the five categories differed or were similar. The five categories of homes studied were: Nursing Homes, Convalescent Homes, Rest Homes, Non-Profit Homes for the Aged, and Family Care Boarding Homes.

The study sought to describe, compare, and determine differences and similarities in characteristics of the homes in the following three general areas:

Physical Characteristics

The Nursing and Rest Homes were found to be somewhat newer in terms of time of construction, with the Convalescent, Family Care, and Non-Profit Homes for the Aged falling into older age groups, respectively. The most impressive finding in this area was that only sixteen per cent of the Nursing, nine per cent of the Convalescent, twenty-one per cent of the Rest, and none of the Non-Profit or Family Care Homes have been constructed since stricter licensing requirements relative to physical facilities and staffing, were made law in 1939. It was also found that the rate of new homes being constructed has not kept up with the rapidly increasing aged population in Rhode Island. This writer concluded that with better facilities and more trained staff required, potential

operators of commercial homes foresaw too little return on their contemplated investments and sectarian or fraternal organizations foresaw too high operating costs as related to contemplated charitable contributions or endowments to make them willing to invest in improvements.

The incidence of remodeling and additions was shown to be somewhat higher in the Nursing and Convalescent Homes, with none of the Family Care Homes reporting building improvements since construction. This factor was seen by this writer as again reflecting stricter licensing requirements in the former two types of homes. Collectively, only 22.6 per cent of the 106 homes in the study reported building improvements. This writer feels that since at least forty-six per cent of the homes in each category are over fifty years old, we could speculate as to run-down and even unsafe conditions existing in some of the homes in all categories.

Concerning beds per home and resident distribution, the most impressive finding was that although State Department of Social Welfare regulations expressly prohibit more than two residents to a room, this condition exists in all of the homes within the two categories of Non-Profit and Family Care Homes.

It was found that the Family Care Homes showed the highest per cent of occupancy, with all categories showing at least seventy-five per cent occupancy.

The data showed that the number and ratio of staff to residents related almost directly to the requirements of the licensing agency in all categories of homes. The Rest, Non-Profit, and Family Care Homes respectively, showed the lowest ratios of staff to patient and also showed notably higher numbers of their residents being cared for by untrained "other," staff.

Admission Policies and Requirements

It was found that the Non-Profit Homes for the Aged reported more entrance requirements and were the only homes reporting sectarian or fraternal affiliation as entrance requirements. It was found that some homes in all categories reported sex of resident as an entrance requirement, with 44.4 per cent of the Non-Profit Homes for the Aged limiting their applicants to women.

It is concluded that age, sex, and sectarian affiliation are not determinants of need for sheltered care within themselves, although sectarian or fraternal affiliation requirements might create a little more cultural homogeneity among residents. The need then, for further research and study in the area of admission policies is seen by this writer.

It was found that in the categories of Nursing, Convalescent, and Rest Homes, over 50.0 per cent of all patients have their care paid for entirely or in part by public assistance funds. The exceptions being in the Non-Profit Homes category which show slightly fewer, 42.5 per cent, and the

Family Care Homes which show much higher, 100.0 per cent of the residents of these homes have their care paid for entirely or in part by public assistance funds.

Differences were seen in length of residence of patients in some categories of homes. The Non-Profit Homes showed the longest length of residence of patients with the Nursing Homes showing the shorter lengths of stay. This writer feels however that even the shorter lengths of residence reported by the Nursing Homes do not imply temporary care.

In reference to the physical condition of residents, as might be expected, the Nursing Homes showed the highest level of disability and least level of mobility of residents with the Non-Profit Homes for the Aged and Rest Homes showing the lowest levels of disability and the highest level of mobility. This writer concludes that there are probably a good number of residents in the Non-Profit and Rest Homes who might be cared for in their own homes or other facilities and further that this factor indicates a need for social casework services in terms of helping older persons and their families select proper old age care which would be related more to the needs of the individual.

Activities of Residents

Some type of recreational or creative activity was seen as a necessity in both rehabilitation and mental health. The Family Care Homes reported the highest per cent of their

residents participating in organized recreation or craft work with the Non-Profit Homes, Rest, and Nursing Homes and Convalescent Homes showing the least percentages of patients engaging in recreational activity, respectively. The Non-Profit and Rest Homes also indicated the least interest in providing recreational or creative activity programs in the homes although the data shows that these latter two types of homes have the highest number and per cent of residents who are ambulatory and would then, be more able to participate. This factor leads this writer to wonder why this apparent dis-interest exists in the operators of these homes toward activity programs.

The 'lack of patient interest' was reported as the most important deterrent to recreation programs by 50.0 per cent or more of the homes in all categories excepting the Convalescent Homes, in which 38.8 per cent of the homes reported this deterrent. This writer wondered about the subjectiveness of the answers to this item and concludes that a need for further research into especially the feelings of the residents of these homes toward activity programs as sponsored by the homes.

Discussion

Aside from noting the similarities and differences of homes within the five categories, this writer recognizes a definite need for further research and study into the problems of sheltered care housing for the aged. Specifically,

research that would be aimed at evaluating standards of homes in terms of the physical condition of the homes themselves and standards of staff requirements in order to evaluate the quality and quantity of care being given the aged persons in these homes. This writer would see this type of research aimed at providing data from which legislation could be drafted on both federal and state levels setting adequate minimum standards for care of residents and patients in sheltered care homes for the aged. As shown in this study the federal and state governments share considerably in the support of over half the residents of these homes, therefore this writer sees the need for more direct and indirect interest in the quality and quantity of care being given these residents. Further research should also be aimed at considering the problems of home owners and operators.

This writer further sees a need for research into the areas of admission policies of homes and recreational activities as provided by homes, and attitudes of residents toward recreation. This research would be aimed at providing material for home operators to hopefully re-evaluate their own programs and attitudes in these areas.

Approved May 1962 Barbara Ayres

1961 QUESTIONNAIRE ON SHELTERED AGED CARE

Section 1 General Size & Age of Home

A. Name______________________________
B. Location__________________________
C. When Constructed__________________

oldest part__________
newest part__________

D. insured value of plant and equipment_________
E. How many beds approved for occupancy_________
F. Present number of residents_________
in single bedrooms______
in rooms for two_______
G. Amount of land occupied________
amount of floor space_________

Section 11 Admission Policies and procedures

A. State briefly the criteria (in reference to age, sex, financial status, residency requirement, religious or fraternal affilication and other requirements for admission to the home.
Age______Sex______Financial status_______and or

fee______, Religion_____________Fraternal__________

Other entrance requirement__________________________

____

B. Give median age of present residents_______________
C. Give median length of residence of present residents_______
D. Give number on "waiting list" at present________
E. Give number admitted in 1954, 1955, 1956, 1957, and 1959____
F. If you are serving both men and women, are couples permitted to occupy own private rooms?__________
G. Give average duration of waiting period before admission (in months)__________

Section 111 Kinds of Care Administered

A. How many residents are totally capable of self care________
B. How many residents require some of following kinds of care. are in bed
part of the time________
most of the time_______
all of the time________

Specify: need mechanical aid such as walker or wheelchair_____
need help of attendant to walk_______
do not get about__________

require help due to mental condition__________
Specify: Confused part of the time__________
Confused most of the time__________
Diagnosed as having a mental illness?______

C. Require help, related to continence__________

D. Require other personal help_________

Section IV. Resident's activities

A. How many receive vistiors as often as once a week____

B. Write and receive letters______

C. Enjoy TV or radio______

D. Read an hour or more daily______

E. Enjoy games, or group recreational activity______

F. Go off grounds regularly_______

G. Do graft work or help around the home________

H. How many take part in some supervised recreation program at the home________ Outside the home__________

I. Who provides this program?
Staff_______
Outside recreation agecny______
Outside volunteer________
Other paid worker________

J. Would you like such a recreation program, if you now have none?__________

K. Would you like to expand such program as you now have?_____
Specify kind of program you would like ideally

____

____

____

L. What deterrents do you see to a recreation program:
Lack of money______
Lack of patient interest_______
Lack of professional leadership_______
Lack of volunteers__________
Lack of equipment and supplies________
Other_____________________________

Section V. Staffing of Home:

A. Total paid personnel______________
part time__________
full time__________

B. Number of licensed nurses: R.N.______ L.P.N.______ Nurses Aid_____
" " Social Workers______
" " Attendants__________
" " Housekeeping personnel______
" " Other personnel(type:)______

C. How many physicians visits were received by patients in
past year_________
past month________

D. How many "well" aged receive annual physical exams_______
E. How many required dental care in past year______
F. How many received examination for sight or hearing_______
past year__________ past month_______

Section VI Financial arrangements for total care of all patients:

A. Are there "life-time" contracts in effect to finance care of residents from a single lump sum? Yes_____ No______
If so, what percentage of your present patient population have such contracts in effect now?__________

B. How many residents have costs met entirely or in part by Public Assistance payments?___________

C. How many residents finance care from OASI benefits_______
D. How many have care paid entirely by relatives___________
E. What is your operating budget for this fiscal year$____________

F. What percentage of your budget represents expense not met by payments from residents, relatives or regular tax-supported funds, (i.e., percent met by gifts, endowments, United Fund or other receipts?)_______________

G. Are you considering any changes in size, kind of care, fiscal policy, admission policy, staff, programs(recreation,etc.) in the near future?
If so, please specify____

Section VII Would you consider favorably an effort to organize either of the following for the exchange of information and mutual cooperation?

A. An association of homes for the aged-Yes______ No_________

B. An association of nursing, convalescent, rest and homes for the aged? Yes_________ No____________

C. If your answer to A. or B. above is no would please specify the deterrents you see to such associations.

BIBLIOGRAPHY

Books

Arthur, Julieta K. You and Yours: How to Help Older People. New York: J. B. Lippincott Company, 1960.

Kleemeier, Robert W. "Behavior and Organization of the Bodily and the External Environment," in Handbook of Aging and the Individual, James E. Birren (ed.). Chicago: University of Chicago Press, 1959. Pp. 400-51

Kutner, Bernard, and Others. Five Hundred Over Sixty. New York: Russell Sage Foundation, 1956.

Roney, Jay L. "Public Assistance," Social Work Yearbook, 1960 Pp. 460-70.

Rosen, George. "Health Programs for an Aging Population," in Handbook of Social Gerontology, Clark Tibbitts, (ed.). Chicago: University of Chicago Press, 1960. Pp. 521-43.

Schmidt, Henry Jr. "Creative Expression For All," in Aging in the Modern World, Clark Tibbitts, (ed.). Ann Arbor: University of Michigan, 1957. Pp. 166-171.

Tibbitts, Clark. "Origin, Scope, and Fields of Social Gerontology," in Handbook of Social Gerontology, Clark Tibbitts (ed.). Chicago: University of Chicago Press, 1960. Pp. 3-26.

Vivrett, Walter K. "Housing and Community Settings for Older People," in Handbook of Social Gerontology, Clark Tibbitts (ed.). Chicago: University of Chicago Press, 1960. Pp. 549-623.

Yutang, Lin. "The Aphorisms of Confucius," in The Wisdom of China and India, Lin Yutang, (ed.). New York: Random House, Inc., 1942 Pp. 311-44.

Periodicals and Pamphlets

Minton, Eunice L. "Needs of Older People- Can Casework Help?" Aging: Progressive Programming, Chicago: American Public Welfare Association, 1962. Pp 37-41.

Sorum, William R., M.D. "Basic Emotional Needs of the Older Person," Aging: Progressive Programming, Chicago: American Public Welfare Association, 1962. Pp. 37-41.

BIBLIOGRAPHY - (Continued)

Towle, Charlotte. Common Human Needs. New York: National Association of Social Workers, 1957.

Committee and Annual Reports

Rhode Island Council of Community Services, Inc. Preliminary Report of the Committee on Recreation Services for the Confined Aged and Chronically Ill. Providence: 1960.

Rhode Island Department of Social Welfare, Office of the Fiscal Agent, Aged, Convalescent, and Nursing Home Program. Categories: Definitions of Service and Staff Requirements. Providence: April 1960.

Senate Subcommittee on Problems of the Aged and Aging. The Condition Of American Nursing Homes. Committee Print, 86th Congress U. S. Government Printing Office, Washington: 1957.

University of Florida Institute of Gerontology. Services For The Aging, Vol. 7. Gainesville: University of Florida Free Press, 1957.