

Nursing Homes

A Health-promoting or Dependency-promoting Environment?

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Health promotion and disease prevention in nursing homes (NHs) are important but highly neglected issues. This study compares the care of residents in 2 proprietary NHs (a dependency-promoting environment) with the care of residents on a hospice unit at a government-owned facility (a health-promoting environment). Inadequate staffing, supervision, and education contributed to the lack of health promotion and ultimately a low quality of care. The care in proprietary NHs, however, must be examined within the context of NH corporations, a multibillion dollar profit-making industry. When making profits is a priority, it is challenging for staff to provide quality care. **Key words:** *exercise, health promotion, nursing homes, nutrition*

AS I arrived at a nursing home (NH) one evening, a man rushed down the corridor. He entered a room and began to feed his mother, a 93-year-old Chinese woman. “Do you often come to feed your mother?” I asked. “I come every day, 7 days a week,” he replied. His mother had fallen and broken her arm. “You can see that she can’t use her hand,” he said. “She can’t eat. They bring the tray in, and then they just take it away. When I ask the staff about it, they say she doesn’t want to eat.” “Does she eat when you feed her?” I asked. “Oh yes,” he replied. “She will always eat. I have children, too,” he said, “but my mama is still here. I still have my mama. When I feed her, then I can go home and sleep at night.”

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One might ask, “Why discuss health promotion in NHs?” The average resident is 82 years of age, with multiple comorbidities. Why invest money in promoting the health of NH residents when there are so many major health-care issues—cardiovascular disease, cancer, and obesity—that need our attention? These are important issues; however, health promotion and disease prevention in NHs are also important, but *highly neglected*, issues in healthcare.

THE RESEARCH STUDIES

The data presented in this study are from 2 anthropological studies conducted by my colleagues and me. My goal in this study paper is to present data from these studies to illustrate the importance of health promotion and disease prevention in NHs. The aim of the first study was to investigate the social, cultural, clinical, and environmental factors that influenced nutritional care in NHs. The purpose of the second study was to investigate the multiple factors that influenced the process of providing care to terminally ill NH residents.

METHOD

In both studies, participant observation, in-depth interviews with physicians, nursing

staff, residents and their families, event analysis, and chart review were used to obtain data. When conducting the event analysis for the nutritional study, we followed 100 residents, in 3 proprietary NHs, who were not eating well. We observed each resident 2 to 3 times a week at mealtime for a period of about 6 months. Each resident had a dental examination and a bedside dysphagia screening. We also conducted a dietary analysis of 40 of these 100 residents. For 3 days, we recorded exactly what they ate and drank.

When collecting data for the study on the care of terminally ill residents, we inducted 150 residents into the study, 117 residents in 2 proprietary facilities, and 33 residents on the hospice unit of a large government-owned facility. We observed the care of the residents from the time they were diagnosed as being terminally ill until they died.

FINDINGS

In both studies, we found that residents did not receive adequate nutritional care and had little opportunity for exercise. Mrs Trent (all names are pseudonyms), an alert 101-year-old woman, was admitted to the NH from an acute care hospital after hip surgery.¹ She was not terminally ill, but she had been losing weight and was on "comfort care only." Shortly after inducting Mrs Trent into the study, I stood in the hallway and observed while she was eating dinner. She was trying to eat mashed potatoes with her fingers. I entered the room and asked, "How are you getting along?" "What an awful way to have to eat," she replied. "It's hard to eat like this." She had dropped her fork. "I can't always hold the silverware," she said. "I try as hard as I can." Her arthritic hands were in a partially contracted position, and she spoke of them as being paralyzed. With her permission, I began to feed her; she ate well.

On another day, we observed that Mrs Trent had not eaten any of her food. The only utensil on her tray was a knife. We left the room to find some silverware. When we returned, Mrs Trent said, "They took my tray away from me.

I was still hungry, and they just came in and took it away."

On admission to the NH, Mrs Trent weighed 128 lb. When she died, 14 months later, she weighed 98 lb. She had lost 23% of her body weight.

When Mrs Trent was admitted to the NH, she was able to walk. One year later, she was wheelchair-bound and had 3-stage II pressure ulcers (PUs) on her buttocks. She was left in the wheelchair all day, and when she became tired, she fell forward onto the floor, resulting in a black eye, a cut on her head, and an abrasion and laceration on her wrist. "They're going to put a belt on me," she said. Although restrained, Mrs Trent fell again. Three days before she died, she remarked, "I was a minister for 20 years. I helped a lot of people. Who would have thought that I'd spend my last days strapped to a chair?"¹

Several factors contributed to poor nutritional care. There was lack of attention to individual food preferences as well as a lack of ethnic food; 33% of the residents were members of a minority group, yet Western food was served to everyone.

Swallowing disorders also affected the intake of food and fluids; 55% of the residents had a swallowing disorder, yet only 10 residents (22%) were referred to a speech pathologist for evaluation. Someone with a swallowing disorder should be fed slowly; but because the staff had so many people to feed, residents were fed hurriedly. They were not given enough time to swallow one bite before another was forced upon them. They coughed and choked, and some developed aspiration pneumonia.

Dysphagia was complicated because many residents had poor oral health; 51% of the residents had no or few teeth and no dentures or poorly fitting dentures. Only 3 residents had dentures that fit properly. When residents did not have teeth, they were often placed on a pureed diet. When the doctor ordered a pureed diet, all of the food was pureed—the entrée, vegetables, bread, pancakes, cookies—everything. The pureed food was prepared by blenderizing whatever was

being served on the regular diet, which resulted in very unappetizing food.²

Inadequate staffing and lack of professional supervision were the most significant factors that influenced how people ate and drank. A director of nursing remarked, "The nurse aides (NAs) get through 50% of the meal, and the patients start slowing down, and they can't take the time. Each NA has about 8 patients; 4 to 5 of them need to be fed. Each one should take 30 minutes to feed, but that would be impossible."^{2(p1394)}

Inadequate staffing had serious consequences. Because it took time to move residents from their rooms to the dining room, many ate their meals in bed. When eating in bed, residents were often poorly positioned. Mrs Carter ate all of her meals in bed in a semireclining position with the tray placed at the chin level. Unable to use utensils, she ate with her fingers, dipping her fingers in her soup and licking them.

Because of inadequate staffing, residents were forced to eat quickly; some were not fed even though trays were taken into their rooms. A resident with advanced Alzheimer's disease had been in the NH for 13 years. Her husband came every day to feed her. When he fed her, she ate every bite of food on the tray. One evening, the tray was taken into her room and in a few minutes, the NA returned, collected the tray, and returned it to the food cart. Only a small amount of food had been eaten. When I asked why this woman had eaten so little, the NA replied that the resident had been gaining weight and that her husband did not want her fed too much. I went to her room. The head of her bed was elevated; her eyes were wide open as if she were waiting for her dinner.²

When analyzing the data, a typical pattern began to emerge. Many of the residents had poor oral health, few or no teeth, and undiagnosed swallowing disorders. In addition, there was not enough staff to assist them at mealtime. They began to lose weight, but the cause of the weight loss was never addressed. When residents lost weight, they were placed on an unappetizing, pureed diet. The resi-

dents continued to eat poorly and continued to lose weight. Next, commercial supplements were ordered. The supplements destroyed their appetite for regular food. The residents continued to lose weight and became frail, and some died.²

In the study in which we investigated the factors that influenced the care of terminally ill residents, we again found that often residents were not fed, and they did not receive adequate liquids. We know that in the final stages of life, some people become anorexic. However, in some cases, we observed the residents' care for several months. Many of them were hungry. They complained of thirst and often asked for something to eat and drink. Containers of water were out of reach, and in 1 facility, there was a shortage of water pitchers; some residents had no water at their bedside.^{3,4}

Mrs Lane was dying of cancer of the thyroid. Her sister was trying to give her some water with a spoon. Offering to assist, I positioned her carefully, and using a straw as a pipette allowed a small amount of water to trickle down the side of her cheek into her throat. After the first swallow, she said, "I want water!" Each time I gave her a bit of water, she repeated, "I want water!" As I left the room, she grabbed my hand and thanked me. The next day, when my research assistant visited her, she pleaded, "Water, please God, let me have water!" She died 4 days later.

LACK OF EXERCISE AND LOSS OF MOBILITY

An area in health promotion in which some progress has been made, especially in the community, is in educating people about the importance of exercise. In NHs, however, there is little opportunity for exercise. In many NHs, once residents enter the facility, they seldom, if ever, have an opportunity to enjoy the outdoors.

Falls are very common in NHs; 75% of NH residents fall each year,⁵ and 10% to 25% of these falls result in fractures or hospitalizations.⁶ Gait and balance disorders,

visual and hearing deficits, and hip and knee pain are among the factors that contribute to falls.⁷ However, I believe that some falls are due to muscle weakness and loss from lack of exercise. Residents, however, had few opportunities for exercise. Even residents who could walk seldom got out of bed.

Although exercise promotes health, lack of exercise contributes to physical decline, and remaining in bed has serious consequences for residents. One of the most serious consequences is the development of PUs. In our study on the care of terminally ill residents, 64 of 117 residents (54.7%) in the 2 proprietary facilities were admitted with or acquired a PU after admission; 52 of 64 residents (81.3%) died with PUs. One woman had 12 PUs. Thirty-eight of the 64 residents (59.4%) were admitted with at least 1 PU.⁸

A HEALTH-PROMOTING ENVIRONMENT

In 1985, Minkler⁹ noted that NHs, rather than promoting health, are a dependency-promoting environment. She emphasized the importance of resident autonomy and stated that a commitment to building a sense of community within the NH, and between residents and the outside world, was a critical component of health promotion for the institutionalized older persons.

Whereas the environment in the proprietary NHs promoted dependency, on the hospice unit, the staff provided a health-promoting environment even when residents were dying. The philosophy of the hospice was "to meet the physical, psychological, emotional, social, cultural, and spiritual needs of the residents and their families."¹⁰ When analyzing data from the hospice unit, we concluded that their philosophy is manifested in a culture of care, community, and compassion.¹⁰

Three times a week, the hospice-certified physician and nurses reviewed each resident's care. Every symptom, such as pain, fatigue, anorexia, fear, sleeplessness, and depression, was monitored and managed. Because their symptoms were so well managed, most of the

residents were active and independent until they were actively dying.

Pam, a 55-year-old woman, was admitted to the hospice unit with a diagnosis of metastatic breast cancer, which had metastasized to every bone in her body. It was so severe that her physicians in the acute care hospital said that she would have to remain in bed for the rest of her life. They said that if she got out of bed, she would fracture her bones. After assessing her needs, the hospice care physician said, "We need to restore her sense of control over some aspect of her life, while we help her deal with the emotional devastation of the impact of her illness." He believed that it was important for her to get out of bed.

Metastatic bone cancer is very painful; however, during the 6 months that we observed Pam's care, despite severe bone metastases, she was never in pain. Realizing that she needed to have some control over her life, the staff helped her into a wheelchair so that she could move about freely. Their concern for her autonomy took priority over the risk of bone fractures.

Pam went into a beautiful garden adjacent to the hospice unit every day, where there were trees, flowers, a fountain, and wind chimes. She loved spending time there. Whereas many residents in the proprietary facilities lost weight, Pam gained weight even though she was dying of cancer. One day, she remarked that she had to go shopping because none of her clothes fit any more. On several occasions, she left the facility, going to the shopping mall and a museum. The physician on the hospice unit escorted Pam to the annual staff appreciation dinner at a restaurant, a highlight during the last weeks of her life.

The hospice team created a therapeutic community in which staff, residents, families, and friends were an integral part. A community is defined as a group of mutually interacting individuals with common interests residing in the same area. Every day, delicious food was prepared on the unit. Residents, families, and staff participated in the food preparation. At mealtime, they gathered in a communal dining room, where

on holidays, birthdays, and other special events, there was a festive atmosphere.¹⁰

There were music, books, and comfortable chairs. On the first Friday of the month, they held a happy hour with special food and drink. Every 3 months, the communal room was converted to a chapel-like environment, where the staff, residents, and families gathered for a memorial service to remember those who had died.

A key element of hospice care was to help residents live their lives fully and meaningfully. We observed that when the staff met the residents' needs, the residents were able to and wanted to give to others.

Mr Wang, a 55-year-old man, was dying of gastric cancer. When admitted to the hospice unit, he was depressed and withdrawn. The social worker (SW) learned that in China Mr Wang had been an accomplished artist, so he bought some calligraphy pens, ink, and paper, and took these materials to Mr Wang. Mr Wang brushed him away. Then the SW tried another strategy. He bought a book on how to do calligraphy and sat down at Mr Wang's bedside and started to do calligraphy. Mr Wang immediately saw that the SW was not doing it correctly. He grabbed the pen to show him how to do it. From that moment on, Mr Wang began creating beautiful artwork. His work was so beautiful that during one of the happy hours, they invited guests to view it. When I arrived at the hospice, I could hardly believe my eyes. The communal room was filled to capacity with residents, families, friends, and staff. Moreover, Mr Wang, who had been depressed and withdrawn and had remained in bed, was nicely dressed and walking about proudly showing his art to visitors.

But, Mr Wang did something else that was even more remarkable. In the bed next to him was Mr Wu, a 39-year-old man with 3 small children. Mr Wu was dying of pancreatic cancer. His wife was working to provide for the family, but his mother came every day; she was grief-stricken.

When I interviewed the SW, he said, "I want to tell you about one of the most beautiful things I have ever seen. It was the day be-

fore Mr Wu died. His mother was at his bedside, looking very sad. Mr Wang opened the drawer of his bedside stand, took out one of his beautiful pieces of artwork, and gave it to Mr Wu's mother. You could see that he knew she was suffering, so he gave her a precious gift."

When residents were well cared for and their needs were met, they continued to grow even when they were dying. The smallest kindness shown to them was often met with a gift in return.

The hospice-certified nurse manager was a gentle, caring, and compassionate woman. "Most of the residents affect me individually," she said. "If I don't open my heart to my patients, if I don't do it from my heart, then the care isn't good. I really don't know what it is like to die. I'm learning from my patients all the time."^{10(p19)}

A man who was dying of cancer appeared tense and anxious. He was telephoning his sister frequently. Thinking that he might be afraid of dying, the nurse manager asked him to come to the nursing station where they could talk.

"I'm not afraid of dying," he told her. "I'm a religious man, but the nurses don't want to talk with me. I think they're afraid to talk with me because I'm jaundiced, and they think I'm contagious. And I'm feeling isolated." "Oh my dear," the nurse replied. "Let me tell you about jaundice." She described the various types of jaundice and explained that he was jaundiced because of metastases from the cancer that was blocking the flow of bile.

"It made all the difference in the world for this man," the nurse manager said. He no longer felt that staff was avoiding him because they thought he was contagious. She explained, "The most precious thing is our life, and when we think we are going to lose it, it is very frightening." She reassured him that they would be there to care for him. "He cried a lot," she said, "and I cried, too."

When I visited this man, he seemed at peace. One day when I came and took hold of his hand, he immediately noticed that my hands were cold. "Oh, let me warm your

hands for you," he said. He took my hands between his, held them, and blew on them to warm them with his breath. It was touching that even though he was dying, he reached out to give the gift of warmth to me. On the hospice unit, health promotion (physical and psychologic) is valued and continues until the patient dies.

NURSING HOMES: A DEPENDENCY-PROMOTING ENVIRONMENT

Whereas the hospice unit was a health-promoting environment, the proprietary NHs, on the whole, promoted dependency. *Health promotion* has been defined as "the course of action used to reach optimum levels of well-being."¹¹ In some cases, individual actions can and will be health promoting. For example, if one eats nutritious foods, refrains from smoking, and exercises regularly, hopefully, these actions will keep one healthy. However, individual actions alone cannot always promote health. Health promotion is influenced by technologic, economic, social, cultural, and political factors.¹²

In NHs, because of functional, physical, and cognitive limitations, the residents cannot take individual responsibility for their health. Many must depend on healthcare service providers for nearly every aspect of their care. Although health promotion occurs to some extent in NHs (eg, residents usually receive influenza immunizations) and NHs

have infection control policies, many health-promoting interventions that would assist residents to reach and maintain an optimum level of health and well-being are not developed and implemented. At a bare minimum, if NHs provided adequate nutritional care and regular exercise, it would help promote residents' health. Our data disclosed, however, that often the NH environment, rather than promoting health and well-being, contributed to illness and the functional decline of residents.

Most NHs are profit making and in some NH corporations there is a climate of "excessive profit taking," which contributes to an organizational structure in which there is inadequate staffing, a lack of staff education, and inadequate supervision. This, in turn, contributes to a clinical practice in which there is inadequate assistance with meals, lack of support for exercise and mobility, and inadequate symptom management. The clinical consequences are poor nutritional status, weight loss, PUs, and functional decline. The outcome for residents is an accelerated decline, health crises, and sometimes death (Figure 1).

NURSING HOMES: A PROFIT-MAKING INDUSTRY

The tendency is to place the blame for poor care on individual caregivers. However, there are many economic, structural, political, and systemwide issues that contribute to the lack of health promotion and, ultimately, a low quality of care in NHs. Our research disclosed

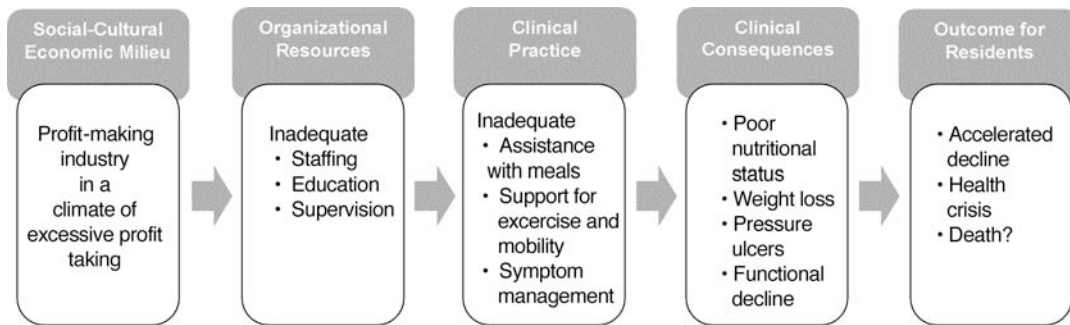


Figure 1. The nursing home environment: Promoting health or contributing to decline?

that inadequate staffing, lack of supervision, and inadequate education contributed to the lack of health promotion in the for-profit facilities. Many of the staff members were conscientious; they were concerned about the inadequate level of staffing, and they worked hard under difficult conditions to provide quality care. However, regulations require that only 1 registered nurse (RN) be on duty for 8 hours a day, and that a licensed nurse (an RN or an LVN) be on duty 24 hours a day. Given the complex needs of NH residents, 1 licensed staff cannot possibly provide the necessary care, supervise the unlicensed staff, and design, implement, and oversee health-promotion activities.

In our studies, typically, there was 1 licensed staff for 15 residents on the day shift, 1 for every 22 residents on the evening shift, and 1 for every 45 residents on the night shift. On the day shift, each NA had 9 to 10 residents to care for; in the evenings, they each had 15 residents; on the night shift, there was 1 NA for every 23 residents. However, when a staff member called in sick, which happened quite often, the staffing ratios increased significantly.⁴

Staffing should be increased, but there is also a need to increase the educational requirements of the staff. In California, regulations require that to be certified, NAs must have 50 hours of classroom instruction and 100 hours of supervised clinical training. An enormous amount of content must be taught, including communication and interpersonal skills, infection control, safety and emergency procedures, bathing, dressing, oral hygiene, elimination, prevention of PUs, nutrition, and death and dying.¹³ When interviewed, many of the NAs said that they had received little or no education to prepare them to care for people who were dying.

An increase in staffing will increase the cost of care, and some will argue that we cannot afford to spend more money on NH care; however, we must look at how our government dollars are being spent. For many years, it has troubled me greatly that American NHs are part of a profit-making industry, whereas in

many Western countries, they are not. I believe that in some situations, profit making takes priority over quality of care. Staff salaries are a major part of the cost of care. Thus, if NH corporations want to make more money for their stockholders, one way to save money is to cut the number of staff.

In the August 2007 issue, *McKnight's Long-Term Care* reported that the Carlyle Group was planning to purchase Manor Care, a \$6.3 billion dollar deal.¹⁴ On December 21, 2007, the Carlyle Group acquired Manor Care, and the CEO personally grossed between \$118 million and \$186 million from cashing in his company stock and exercising his stock options.¹⁵

On September 23, 2007, an article in *The New York Times* described how private equity firms, like the Carlyle Group, purchase NHs and immediately cut their costs by reducing the number of RNs. Staffing levels are often cut below the mandatory minimum.¹⁶ Regulators say that residents at NHs owned by private investment firms, on average, have fared worse than other NH residents in problems like depression, loss of mobility, and ability to bathe and dress.

The article in *The New York Times* created an outcry from the Service Employees International Union, the nation's largest and fastest growing union of healthcare service workers. They sent letters to 4 Congressional committees, urging them to hold hearings, exercise oversight, and consider legislative reforms related to private equity ownership of NHs. On November 15, 2007, members of the House Ways and Means Committee and the Senate Special Committee on Aging held hearings and proposed measures to require NHs to disclose ownership and regulators to release information about poorly managed homes.

When profit making takes priority over quality of care, it is difficult for the staff to provide quality care and engage in health promotion. Thus, it is not surprising that residents lose their ability to walk, are not fed, lose weight, and develop PUs.

NHs are a multibillion dollar industry. We live in an entrepreneurial society and profit

making is an integral part of our healthcare system. The article in *The New York Times* describing how NH corporations are making more money and providing less care made me think of the people in NHs who are hungry and thirsty because no one feeds them or gives them a drink of water. I see older people with tears streaming down their faces because of pain from a PU, and I wonder—Is this really the best that we can do for our elders?

Some proprietary NHs definitely provide good care, but as long as some NHs engage in excessive profit taking, many residents will not receive quality care. It is imperative that nurses and other healthcare service providers become involved in health policy to ensure that health promotion in NHs becomes a reality. In the midst of a profit-making climate, and especially when there is corporate greed, healthcare service professionals must be the voice for those who have no voice and advocates for those who have no advocates.

It is commendable that many NH staff (eg, RNs, LVNs, NAs, social workers, and others) and advocacy groups, such as the National Citizens Committee for Nursing Home Reform, spend countless hours in their efforts to improve the care of NH residents. It is frightening to imagine what care would be like today if it were not for the many caring NH staff and organizations dedicated to providing quality care. Many people in our society are unaware of the serious problems that

exist, and some families are reluctant to complain because they fear retaliation. When this occurs, NH residents become invisible; they are voiceless and forgotten.

The findings of these studies are not generalizable because the research was conducted in only 4 NHs. However, other studies that have focused on for-profit status in explaining the variation in the quality of care have found that proprietary NHs have significantly lower quality than nonprofit facilities.¹⁷⁻²¹ A recent study notes that a possible explanation is that “some proprietary homes take excessive profits to the detriment of care quality.”²²

Over the years, my thoughts have often gone back to a beautiful woman who always sat in the front lobby of an NH, always smiling. One day, however, she appeared sad. She told me that earlier she needed to go to the bathroom, but nobody came to help her, and she was incontinent. When her husband came, he changed her clothes and bed linens, but he was annoyed. “Do you think he will still love me?” she asked. She asked if I were married and told me that she and her husband had been married for over 50 years. “I hope that you will be as happy as we have been,” she said, “but we have lived too long. I’m too old to take care of him, and he’s too old to take care of me.” We have a professional, social, and ethical responsibility to care for older people who can no longer care for themselves. It is a grave responsibility.

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