

Residents' and Family Perspectives of Involuntary Healthcare Facility Closure and Relocation

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ABSTRACT

Older adults who receive care in a healthcare facility certified by the Centers for Medicare and Medicaid Services receive services mandated and regulated by state and federal policy to ensure that basic quality and safety standards are met. Termination of certification due to ongoing care deficiencies results in the involuntary relocation of residents receiving Medicare or Medicaid services to another healthcare facility. If a facility ultimately closes, all residents are displaced. Facility decertification happens infrequently, but when it does occur, it affects both residents and their families. Few studies have examined resident input and the role that family plays in the relocation process. The purpose of this study was to explore residents' and families' perceptions of the relocation process and its effect on residents' health and wellbeing. The study sample included 27 residents and 93 family members from two facilities that lost their certification. Semi-structured, audio-recorded interviews conducted with participants either in-person or by telephone focused on perceptions of relocation processes, relocation challenges and stressors, and physical and mental effects on residents. Interviews were transcribed verbatim and analyzed using an open coding process to identify common themes and patterns in the data. Four interrelated, overarching themes emerged from the analysis: 1) awareness of need to relocate; 2) notification of need to relocate; 3) involvement in relocation decisions; and 4) relocation stressors. Neither residents nor families were satisfied with the relocation process and offered multiple suggestions to guide policy and practice to improve their involuntary relocation experiences.

Keywords: older adults, long-term services and supports, nursing homes, qualitative methods

Perspectivas de los residentes y sus familias sobre el cierre y la reubicación involuntarios de los establecimientos de salud

RESUMEN

Los adultos mayores que reciben atención en un centro de atención médica certificado por los Centros de Servicios de Medicare y Medicaid reciben servicios exigidos y regulados por la política estatal y federal para garantizar que se cumplan los estándares bási-

cos de calidad y seguridad. La terminación de la certificación debido a deficiencias continuas en la atención da como resultado la reubicación involuntaria de los residentes que reciben servicios de Medicare o Medicaid a otro centro de atención médica. Si una instalación finalmente cierra, todos los residentes son desplazados. La descertificación de instalaciones ocurre con poca frecuencia, pero cuando ocurre, afecta tanto a los residentes como a sus familias. Pocos estudios han examinado los aportes de los residentes y el papel que desempeña la familia en el proceso de reubicación. El propósito de este estudio fue explorar las percepciones de los residentes y sus familias sobre el proceso de reubicación y su efecto en la salud y el bienestar de los residentes. La muestra del estudio incluyó a 27 residentes y 93 familiares de dos establecimientos que perdieron su certificación. Entrevistas semiestructuradas grabadas en audio realizadas con los participantes, ya sea en persona o por teléfono, centradas en las percepciones de los procesos de reubicación, los desafíos y factores estresantes de la reubicación, y los efectos físicos y mentales en los residentes. Las entrevistas se transcribieron palabra por palabra y se analizaron mediante un proceso de codificación abierta para identificar temas y patrones comunes en los datos. Del análisis surgieron cuatro temas generales interrelacionados: 1) conciencia de la necesidad de reubicarse; 2) notificación de necesidad de reubicación; 3) participación en las decisiones de reubicación; y 4) factores estresantes de reubicación. Ni los residentes ni las familias quedaron satisfechos con el proceso de reubicación y ofrecieron múltiples sugerencias para guiar las políticas y prácticas para mejorar sus experiencias de reubicación involuntaria.

Palabras clave: adultos mayores, servicios y apoyos a largo plazo, hogares de ancianos, métodos cualitativos

居民和家庭对非自愿医疗设施关闭及搬迁的看法

摘要

在联邦医疗保险和医疗补助服务中心认证的医疗机构接受护理的老年人，接受由州和联邦政策授权并监管的、用于确保满足基本医疗质量和安全标准的一系列服务。因持续存在的护理缺陷造成的认证终止会导致接受联邦医疗保险和医疗补助服务的居民非自愿搬迁到另一家医疗机构。如果医疗机构最终关闭，所有居民都会被迫迁移。医疗机构取消认证一事

很少发生，但一旦发生便会影响居民及其家人。很少有研究分析了居民的意见以及家庭在搬迁过程中发挥的作用。本研究旨在探究居民和家庭对搬迁过程的感知及其对居民健康和福祉的影响。研究样本包括27名居民和93名家庭成员，他们来自两个失去认证的医疗设施。与参与者面对面或通过电话进行的半结构化录音访谈聚焦于搬迁过程感知、搬迁挑战和压力源、以及对居民产生的身心影响。访谈被逐字转录并使用开放式编码进行分析，以确定数据中的共同主题和模式。分析发现了四个相互关联的重要主题：1) 对需要搬迁的认识；2) 需要搬迁的通知；3) 参与搬迁决策；4) 搬迁压力源。居民和家庭都对搬迁过程不满意，并提出了多项建议以指导政策和实践，以期改善其非自愿搬迁体验。

关键词：老年人，长期服务和支持，疗养院，定性方法

Older adults residing in a health-care facility certified by the Centers for Medicare and Medicaid Services (CMS) receive services mandated and regulated by state and federal policy to ensure that basic quality and safety standards are met. Federal and state agencies inspect facilities regularly; when health and fire safety standards are not met, the cited deficiencies require timely correction. In 1998, the “Special Focus Facility” (SFF) program was developed to monitor compliance history. After inspection, a minority of facilities have more deficiencies, more severe deficiencies, or a pattern of serious deficiencies that may designate them as an SFF. Anywhere from 5 to 30 facilities per state can be in the SFF program. According to CMS, “most of the nursing homes in the SFF program significantly improve their quality of care within 18-24 months after being selected, while about 10% tend to be

terminated from Medicare and Medicaid” (CMS.gov, 2021). Because facilities have ample opportunity to correct the deficiencies, thereby making termination of certification a rare event, providers often do not consider them as serious threats (Rudder, 2016). In turn, residents and families are told not worry and typically do not anticipate or plan for relocation.

Unless residents utilize another payer source, termination of certification results in the involuntary relocation of residents receiving Medicare or Medicaid services to another healthcare facility. If a facility ultimately closes, all residents, irrespective of payer source, are displaced. Facility decertification and the involuntary relocation of residents happen infrequently (Castle, 2005/2006; Li et al., 2010), as it is an action of last resort. However, when it occurs, it impacts both residents and their families. During the transition process,

residents' care needs should be of primary concern, yet few studies have examined resident input (Lee et al., 2002) or the role that family plays in the relocation process (Gaugler & Mitchell, 2021).

Federal Requirements for Facility Closure

CMS finalized its requirements for long-term healthcare facilities closure on March 19, 2013 (Department of Health and Human Services [DHHS], 2013a). Administrators are required to “provide written notification of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure or, if the Secretary terminates the facility’s participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate” (p.16795, DHHS, 2013a). Subsequent public comments regarding the rule suggested including more specific and explicit requirements. In response, CMS stated,

We appreciate the commenter’s suggestion; however, we do not believe it is necessary to include specific requirements for the plan in the regulation text. We want to allow each LTC facility the flexibility to develop a plan that would most effectively protect the residents’ health, safety, and well-being. (p.16798, DHHS, 2013a)

A subsequent rule was finalized in September 2016, which established “national emergency preparedness re-

quirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters” (p. 63860, DHHS, 2013b). To adequately meet the needs of residents during disasters and emergency situations, providers need to coordinate with federal, state, tribal, regional, and local emergency preparedness systems. DHHS maintained the need for flexibility so that regulations are neither too specific so that they become outdated over time nor too broad to be ineffective. Instead, principles set forth in the National Preparedness Cycle within the National Preparedness System guided development of the regulations (DHHS, 2013b).

Relocation Research

Understanding the effects of relocation on residents’ health and wellbeing has long-been a priority among researchers and practitioners alike (e.g., see Brownie et al., 2014; Davison et al., 2021; Pino et al., 1978). A review of literature identified psychological (e.g., autonomy and control) and social factors (e.g., relationships with staff, residents, families, and friends), as well as aspects of the built environment (e.g., private and public spaces; technology) that influence nursing home residents’ sense of home (Oswald & Wahl, 2005; Rijnaard et al., 2016). Other researchers have examined residents’ initial response to moving to assisted living facilities (O’Hora & Roberto, 2019) and care homes (O’Neill et al., 2022). For moves to both types of facilities, study authors offered recommendations to improve

the relocation experience, emphasizing strong communication between providers, residents, and families, and consideration of contextual factors as key for a positive transition and residents' wellbeing.

For persons living with Alzheimer's disease and related dementias (ADRD), a move to a healthcare facility is often a necessity, particularly in the later stages of life (Arrighi et al., 2010; Toot et al., 2017). The literature on the consequences of relocation for persons living with ADRD on their quality of life and their family caregivers presents inconsistent findings across studies: some residents benefited from the relocation, while others experienced no changes in quality of life (Moon et al., 2017). Ryman and colleagues (2019) found a detrimental effect for persons living with ADRD who relocated with respect to mortality and morbidity; however, the extent of participation and control (i.e., involvement in decision-making) modified adverse effects of relocation.

While there is ample research focused on older adults' initial placement in healthcare facilities, there is a dearth of contemporary literature exploring subsequent planned or involuntary relocation experiences of older residents. Murphy and colleagues (2013) explored residents' perceptions of a planned relocation from one long-term care setting to another. Three themes emerged, emphasizing the importance of 1) involvement in decisions and preparation before relocation, 2) desirability of the relocation (i.e., residents' feelings and emotions), and 3) care continuity in relation to staff, fam-

ily relationships, and relationships with other residents. The authors advocated for taking a person-centered approach to identify residents' unique needs and concerns, thereby increasing the likelihood of a positive experience with relocation.

A scoping review of involuntary relocation (Weaver et al., 2020) concluded that residents experienced immediate but minimal long-term health problems; of the 28 articles identified about involuntary relocation of residents published between 1971 and 2018, four explicitly examined residents' perception of the move, two of which also included family's perceptions of the move; one additional article included the family's perspective. Findings indicated that involuntary relocation result in immediate but minimal disruptions to health, even among this highly vulnerable population; intrinsic characteristics (e.g., functional or cognitive ability; social connections), as well as extrinsic factors (e.g., preparation and communication; staff involvement) affect functional, psychological, and emotional health outcomes of residents who experience involuntary relocation (Weaver et al., 2020).

Viewed collectively, findings across relocation studies suggest the importance of preparedness, involvement in decision-making, and inclusion of family members when experiencing initial (or additional) relocation to long-term healthcare facilities. When relocation occurs, particularly when involuntarily, information about residents' and families' involvement and response remains sparse. Thus, the pur-

pose of this study was to explore residents' and family members' viewpoints concerning the relocation process and effects of relocation on the health and wellbeing of residents. We analyzed the experiences of residents and their family caregivers following a healthcare facility decertification that triggered an involuntary relocation. Recognizing the need for a person-centered approach that illuminates the voices of residents as well as their families, our primary research question is: What are residents' and family members' perceptions of the relocation process? Based on their experiences, we discuss the need to amend policy to benefit and prioritize residents and their families during involuntary relocation.

Methods

We collected resident and family perception data as part of a larger mixed-method investigation of involuntary relocation of healthcare facility residents. The study sample came from two facilities, one in a rural area and one in an urban area of Virginia that lost their Medicare and State Medicaid certification due to ongoing care deficiencies in 2013 and 2015, respectively. The rural facility was independently owned; its decertification necessitated the relocation of 53 residents. The urban facility was part of a national corporation; its decertification required relocation of 132 residents. Decertification of both facilities and subsequent resident relocations occurred within a 2-year period. Because data collection procedures were similar

across facilities, we combined and analyzed the data collectively.

Procedures

Contact information for 99 residents and 191 family members was provided directly from the Virginia Department of Medical Assistance Services (DMAS) to study authors using secure information transfer protocols following the policies and procedures of the DMAS and the Virginia Tech Institutional Review Board (#15-135). All participants provided informed consent prior to being interviewed. A research team member (including Weaver, Brossoie, and Teaster) conducted in-person interviews with the residents and either in-person or telephone interviews with families. Interviews were recorded and transcribed for the purpose of analysis. In appreciation of their time, the research team transferred \$10 into the resident's facility fund accounts, and family members received a \$10 gift card to a local retailer.

Participants

The study sample was comprised of 27 residents and 93 family members identified as responsible for monitoring a resident's care (i.e., relatives, guardians, power of attorneys). Non-participating residents were unable to be interviewed because they had cognitive impairments, were geographically inaccessible, or had died. Among the non-participating family members, 66 were lost to contact (e.g., invalid contact information, unable to contact after five attempts), and 32 family members declined an interview.

Residents interviewed ranged in age from 37 to 93, 33% identified as female, and the majority were White. Family members primarily identified as female (69%) and were either an adult child (28%) or other family member (26%); just (8%) was a spouse/partner of the resident. To preserve participant confidentiality, no other demographic or health characteristics were collected about individual study participants. However, aggregate-level (de-identified) Minimum Data Set (MDS; CMS, gov, n.d.a.) health assessment data (available from the second author) for all residents at the time of the relocation suggests that their health profiles were typical of most nursing home residents. The most prevalent diseases/disorders among the residents were heart/circulation, gastrointestinal, metabolic, neurological, musculoskeletal (e.g., pain), and psychiatric (e.g., depression, anxiety) disorders.

Interviews

Findings from the review of the scholarly literature (Weaver et al., 2020) informed the interview questions. The order of the interview questions was consistent across residents and families, with follow up questions based on the participant's role in the relocation process. Interview questions represented the following domains: general perceptions of relocation process, pre-relocation communications, relocation challenges and stressors, resident quality of life, scope of participation during relocation process, and recommendation for future relocations.

Analysis

Initially, we used an open coding process (Charmaz, 2006) to develop primary codes and secondary codes, which were applied to all interviews to generate common themes within and across the interviews (See Weaver et al., 2021 for detailed description of the initial coding process). We used the constant comparative method in which each coded response was verified by at least one other author to ensure codes were applied consistently and appropriately (Strauss & Corbin, 1990). The intensive coding approach yielded 100% agreement in the development and application of the coding scheme, which enhanced the rigor of the analysis and dependability of the findings. Data were managed using Atlas.ti (ver.7.0) software.

For the current analysis, two authors (Weaver and Roberto) revisited the initial findings to address our research question. In our second coding iteration, we gleaned nuances and commonalities across resident and family perceptions. We conducted a thematic analysis of the data (Braun & Clarke, 2012) by separating, sorting, and synthesizing the initial coding categories. Four interrelated, overarching themes, each with multiple sub-themes, emerged from the analysis of the resident and family member interviews. We used a range of participants' quotes are used to illustrate experiences and perceptions.

Results

Awareness of Need to Relocate

For many residents and families, the need to relocate was not explicitly clear, although there were signs and suspicions that something was amiss. As participants reflected on their awareness of needing to relocate, they noted changes in staffing and temporary arrangements for relocation within facilities.

Change of Staffing

Several residents commented on improper behaviors of staff and observed poor quality of care for several years preceding decertification. One resident described the nurses and CNAs as “not coming to work on time, having inappropriate conversations that [don't] have anything to do with healthcare, [and] messing up appointments and medical records.” Residents recounted that service delivery was poor and regarded the nurses and frontline staff as “very unprofessional.” They recalled that their residential facility had been “in shambles” for several years. When a new administrator was hired after the long-time administrator and director of nursing were fired, one resident believed that “it was too late to correct the problem[s]” contributing to the facility's decertification.

Similarly, most family members reported sensing that something was awry. They had observed changes and disarray in staff and services at the facility. Gossip circulated among staff and in the community, but staff continually denied rumors about licensing prob-

lems or closure until the time to relocate residents was imminent.

We kept asking them, “What's going on?” We were scared that it was going to get shut down. Rumors were going around. They kept telling us, “No, we're not going to be shut down. Nobody's going to be losing their jobs. Don't worry about it.” They had meetings with the residents and the staff telling them, “We were not going to get shut down” and then a week after, they came and told the residents that it was getting shut down, that they were losing their license, and that all the residents had to ship off somewhere else. It was abrupt. It was too late by the time they told us.

Other families were not surprised by the news that CMS had decertified the facility. One family member recalled, “There [was] a buzz going around since last January about it.” Another family member suggested that staff also sensed impending change. “She [a staff member] didn't want to tell me because she wasn't positive that they were going to make everybody get out of [facility] or what they were going to do.”

In retrospect, families interpreted the lack of communication as a means to calm family concerns during a time of uncertainty. However, families did not view it favorably.

I went and talked to the social worker. She completely denied that they were going to be shutting down and everything. I told

her, “Please let me know, I’ve got to make arrangements. I’m an only child, there’s no one else to help. I work, and all that,” and she said none of that was going to happen. About a week later it was on the news, it was going to happen.

Temporary Arrangement

In hindsight, residents noted additional clues about the forthcoming relocation. For instance, one resident recalled how residents were relocated to new rooms on different floors under the guise of remodeling rooms for short-term residents needing rehabilitation services; however, the new rooms and new residents never materialized.

They had cleared that floor, the floor that I was on, and then they started transitioning people from upstairs out of the facility. So, by the time that they had the meeting with us . . . upstairs was empty.

Similarly, the reason given one resident for moving was initially presented as temporary and within the facility due to remodeling. “But then the next thing I know they were moving me out!” Residents also noticed that when other residents were admitted to the hospital they were never readmitted to the facility.

Notification of Need to Relocate

Residents and family members rarely indicated that they received notice from the facilities about the need for relocation. It was unclear from most of our in-

terviews with residents if they were ever told or understood why they had to move. Family members learned about the impending relocation through unofficial channels and indirect statements from staff as well as their own observations that something seemed to be not right within the facilities. Often, families learned the fate of the home of their loved ones through the media.

Unofficial Notification

Only one resident reported receiving a tip from a staff member that he should start looking for a new place to live.

I knew from all the people being there, strangers being there, that something was up. I made friends with some of the nurses, and they told me, “Go ahead and tell your sister to start looking for you a place because this is not going to last.” And so that’s what I did. I was pretty lucky with finding this place [new health-care facility].

Several family members received a heads-up from staff or members of the community in which the facilities were located. One family member recounted, “Well, I just found out really on the QT. One of the staff who looked after mom was concerned that things were not going well.” Another family found out inadvertently when she “walked into the facility and heard people talking about it.” She was told about the relocation only when she spoke to office staff about moving her mother, a decision she had made before knowing anything about

the relocation plans. Word about the problems experienced by the facilities appeared to seep out to the community, as one family member indicated that a person she knew who lived in the area asked her, "Is your brother not at this nursing home?" and then proceeded to tell her "all these horrible things."

Indirect Notification

In some instances, family members reported that the residents called them to say they were in the process of moving. One family member recalled a conversation with her brother:

He called me. He said, "Look baby, this is what's going on. They're moving us. And they ain't gave us no notice, no nothing. We all gotta pack up and get outta here. They're taking us to places." He wasn't very happy about it.

When families heard about the closing for the first time through local media, they promptly called the facilities for more information.

I was absolutely not told. I found out about it on the news . . . I saw it on the news, and I did call, and I found out that they lost their license. And they told me that all the residents had to be moved . . . by a certain time.

Even after the news story broke, many families reported that staff told them that the changes would not affect their family member. One family member recalled an all-too-common exchange.

My brother had seen on the news that they were closing. So, we called—or he had contacted them and they said no, our mom would be fine, and we wouldn't have to deal with anything. It was just going to affect other patients.

Direct Notification

What and when residents were told about the relocation was unclear. As one family member explained:

He [resident] was upset. By the time I got up there, he told me, "I was mad!" And I said, "I'm sure you were." Just being caught by surprise. I found out he probably had the same amount of notice [that family member had] and having no time to really even grasp what was going on. I think that was the most difficult for him. Not having any of us talk to him to be able to explain it to him, him not knowing if we knew where he was going.

In general, residents only seemed to understand that the facility could not keep them anymore. One resident commented that some of the other residents thought they were being moved because of something they had done.

One of the men was crying, and he told the driver of the van who was taking him up there [new facility], "If you will take me back to [decertified facility], I promise I'll be good."

Residents who understood the necessity of the move tried to make some good come out of a bad situation. One resident's daughter acknowledged her mother's unhappiness with the move but explained, "There ain't nothing we can do about it." The resident agreed and tried to remain positive, concluding the move "was nobody's fault. It couldn't be helped."

When families were asked how the facilities notified them about the relocation, responses were mixed. A few recalled receiving a letter about the impending closure that "let everybody know at that time that they were shutting down and they would help people relocate, but pretty much we had to do it on our own." Other family members did not receive a letter, with one indicating "They said that I was supposedly given a letter, but I assure you if I would have received a letter that they were closing the facility, I would have known that."

At one facility, families were invited to attend a meeting during which the facility's health services staff and administrators reviewed the decertification findings and addressed attendees' concerns. One family member recalled,

A meeting was called, and I attended. At that point, [the facility] was saying that they realized that we were probably going to have to move our family members, that they had done everything they could to keep it open, but they had lost their assistance from Medicaid, Medicare, everything.

At the other facility, family members reported being notified after the resident move was arranged or in progress.

I was on my way up there [to visit her], and I got a call. And they said, "I'm moving your mother to [new facility] within 20 minutes." I said, "Twenty minutes? You didn't tell me you were moving my mother. You didn't say anything to me." Usually they'd call, but nothing.

I got this phone call late in the afternoon [from] this lady saying, "Hi, I just want to let you know that we're going to have to move [resident] to [city, state]." My words to her were, "Like hell you will." And she said, "I guess you've been reading the newspaper," and I said, "I read the newspaper every day," and she said, "Do you already know?" I said, "Know what?" And she said, "We have lost our accreditation," and she said, "We need to move rather quickly..."

A few families were given time to plan for the move, even though most were not afforded that luxury. One family member reported being satisfied with her 48-hour notice because she had a good working relationship with the social worker and had confidence that she would relocate the resident with the resident's best interest in mind.

They called me 48 hours ahead of time, and they sent a letter saying, "This is going to be the day

that she moves,” and [asked] was that day good for me, my schedule, and this is the timeframe and everything.

Lack of Notification

Some family members were concerned that residents were not told or misled about the need to move and were relocated without being prepared for it. One resident reportedly went for medical treatment only to be transferred to his new home after the appointment, without ever returning to the facility.

They shipped him from dialysis, they didn't give him a chance to go back and get his things, they didn't give him a chance to go say goodbye to anybody.

Families consistently denied receiving any formal communication, such as a letter or phone call, from the facilities about the need to relocate residents, and most did not recall receiving any notice at all. Communication with facility staff was described as “hopeless” and “ridiculous.” One family member described how she was at the facility earlier the same day that the news broke in the media, yet no one told her about it when she was there. She recalled her conversation with staff:

I was there Tuesday. So why didn't you tell me on Tuesday that 'y'all were closing'? I mean. I'm sure you knew on Tuesday that you were closing, because I found out on the news that night.

Involvement in Relocation Decisions

Residents' level of involvement in relocation decisions included no choice, limited choice, or informed choice. Families varied in how much they were involved in the relocation process. Some families took responsibility for finding a placement for residents, whereas other families were not engaged. Involvement was dependent on how much choice residents and families perceived they had in selecting a new healthcare facility for their relative.

No Choice

Residents expressed frustrations about how staff assumed they were unable to comprehend the situation and excluded them from decision-making. For example, one resident recalled her move to a new facility and explained that she never was given any information from staff or the people who transported her.

They [staff] told me that morning, “You're going to go away.” I said, “For what?” “Going away where?” They said, “Come on, you've got to go.” I said, “Go where?” Finally, I said, “Okay.” So, I went to my room and got my clothes together and then they came . . . This guy went in my room and got my bags and stuff and put them in the car. He said, “You're moving away from here.” I said, “Where am I going?” . . . “I'm not going with somebody if I don't know where I'm going. I am not going anywhere.”

He said, "Don't be afraid. Go on, baby. Go on. Go on." Then he said, "Come on. I'll tell you when we get there." I remember seeing a sign that said [name of facility], so we turned and pulled up to the front. He said, "Okay. There's your home." I said, "I'm not home." He said, "No, this is where you'll be."

Another resident came back from a doctor's appointment only to be escorted to a new facility without warning.

They didn't care. Really, they didn't. Unless you were somebody that knew your own mind and could talk for yourself, they really didn't care too much [about involving you in any decision-making]. They were just there for a job, not for the patients.

Overwhelmingly, family members did not feel like they had a choice in where to relocate residents and expressed frustrations similar to those of the residents. About one-third of family members appeared to neither understand that they had a choice in selecting a new facility nor be involved in the decision-making process. One family member recounted, "[staff] knew that place [new facility], and they knew there were beds available there, so I had no choice. After calling around, I realized that was the only place she could go to at the time."

The following experience shared by one family member was repeated throughout the interviews. "She [staff]

just said, 'He's going to this facility in this town.' She didn't give us any option even to discuss it. She said, "This is what we decided; this is where he's going."

Limited Choice

While some residents perceived limited choice in the decision-making process, the timeline for selecting a new placement and moving to it was quick, much quicker than anyone would have liked. For example, one resident noted, "First, they said that we didn't have to move. Then, all of a sudden, we had to leave and go to different facilities, and they wanted you to pack up and get ready to leave."

Some residents perceived being pressured by the staff to move to a particular facility, accept the arrangement, and trust that they had arranged the move in their best interest.

I was kind of pressured into accepting this relocation . . . They tried to make it sound like everything's in place being that I require certain needs. And when I got here, I found out it wasn't—it couldn't have been farther from the truth. They tried to make it sound like this place was almost full to capacity, and they had really just one space, and if I didn't accept it right then that it would be given away. Like I said, I found out that wasn't the case at all.

Choices were constrained by time and the ability to find an available bed even among family members who were aware of healthcare facility op-

tions and actively engaged in the relocation process. As a result, they had to make immediate decisions without the benefit of time to consider alternatives.

I didn't know what I was doing in picking a place. You knew so many people were going to be flooding the market, so to speak. I really wanted to get in one place. I wanted to make a decision quickly before there weren't any more beds. I knew there wasn't going to be a whole lot of places for her to go.

It was the bed space that was available, and if I didn't pick that, she might go somewhere 5 hours, 6 hours away . . . I had no choice. I had to take it. I had to take it and that was that.

Many families were highly critical of the discharging staff and their apparent disrespect for the inclusion of residents and family members in the relocation process.

The social worker, she was kind of helpful, but she wasn't really helpful. Like, if you were to drop the ball and say, "Okay, you just find something," she would have just sent you anywhere. Like if you didn't voice your opinion, she was just going to do what she wanted to do. I don't think she saw the need of the families, the specific need of a family.

Another family member recalled expressing her frustration to a staff member and demanding answers without a successful outcome.

They [facility] already found somewhere to place him, and I'm like, "You can't do that. You can't just place him somewhere without consulting me and let me know what was going on . . . How can you do that?"

Informed Choice

Only a few residents perceived they had an informed choice in their relocation experience. Residents able to communicate their needs often turned to their professional allies for support in finding a place to relocate.

Well, my situation's different because I'm able to articulate what my care should be. I work with my Ombudsman in my care plan meeting. She suggested that I come here. This place is pretty cool. I haven't really had a lot of problems.

Two residents who enjoyed a caring and supportive friendship resisted moving until they found a new facility that would accept both of them. Although the new location meant family were further away, they were glad they could remain together.

My friend and me have been together for a while, and there were places they would have sent me, but they wouldn't accept her. I told them I didn't want go anywhere unless they would help her also. This place would accept both of us - so that's why we're here.

Only a few families felt like they had a choice, albeit limited.

I had the choice to send her either to facility A or facility B . . . And of course, in facility B, I would never be able to get up there. That's too much driving for me because I have my own health issues. And so I considered, too, for her to go to facility A, and it was a good decision to move her to facility A because it is only 45 minutes to an hour to get there, and I can get there reasonably well.

Still, some families appreciated that facility staff coordinated and oversaw the actual move.

They did all the leg work as far as getting her moved so I have to give them credit for that because they found somewhere for her to go although there was nowhere for her to go nearby . . . I told them I really wouldn't be able to do a whole lot physically. I could make some phone calls, if necessary, but they assured me they would do their best to find a good spot for her. And I feel like they did.

Family members also recognized difficulties that the relocation placed on staff and appreciated the efforts. For example, one shared that "despite no notification, despite my obvious concerns about how it transpired, they did coordinate the move. I know there's not a lot of options when they reach that point." Another family member indicated that "they did a good job with being able to come up with as much information that

they needed to transfer the patients out in such a short time."

Relocation Stressors

Although not all residents and family members reported that the transition to the new facility was stressful, the ambiguity associated with the relocation appeared to contribute to heightened stress among most residents and their families. Regardless of how or when the relocation occurred, residents reported being worried about their transition and where they were going. They commonly reported general distress over "not knowing what you're getting into." One resident admitted that he "tried not to let on, but constantly worried about the entire situation." Other stressors included moving further away from family, moving residents and their belongings, and residents' loss of friendships and sense of community.

Increased Distance from Family

For many residents, the move away from the region meant fewer visits from family and friends, which contributed to dissatisfaction with their new location. One resident noted, "The thing I don't like is my wife can't come up that often." They also perceived opportunities for community outings when family members were able to visit and accessibility to healthcare specialists as limited.

Well, there's nothing here. [My daughter] will come up here, like, twice a month, checking me out, but there's nothing [to do] here. . . And then, well, I kept all

my doctors in [previous area] because I said, "With this weird disease I have, I'm not starting over." So, they haul me down to [previous area] when I need checkup. I'm like, I'm not starting over.

Family members also shared concerns they heard from the residents about the long-distance moves.

He was concerned because he really wants to stay in the [previous] area, and he's so far out of there. He's very concerned because in [previous area], he knows people that can come and do things for him [like run errands] . . . For them to move him some 90 miles or so outside of there, he is very unhappy about that.

Families were worried about how frequently they would be able to visit the residents at their new facilities. One family member explained, "He's still an hour and a half away from where I live, and I don't do a lot of driving that far away – especially in areas I am not familiar with." Another family member reported not being able to visit because there was no bus service to the facility. A third family member, who relied on someone else to drive, expressed frustration over the travel challenge: "Well, the hardest part is I can't visit him much because I don't drive. And the only time I can go is when my son takes me." For other families, even a move nearby was an inconvenience: "She's actually a lot further from me than she'd like to be or than I would like her to be. It's not out of town or anything, but it is a little far."

The longer distances also made it more difficult for family members to monitor the residents' care, "I would like for him to be closer to the city so I can look after him more . . . I'm not driving and to get to him I have to get someone to take me." Only a few families reported that residents were placed in a facility closer than the decertified healthcare facility. They credited the staff for keeping their location in mind.

Moving Residents and their Belongings

Families discussed the actual process of moving residents and their belongings, including physical assistance with packing resident belongings and the relocation itself. Families appreciated receiving assistance. "...all the arrangements were done for her. The girls at the facility had already packed up most of her things when I went out to pack them up." Conversely, family members were frustrated when they were expected to be responsible for the move, despite short notice.

We were off packing—actually packing up all of my husband's belongings because we were told, "He has to get out now." His brother had a large van, and we loaded a lot of his stuff into the van, but in the meantime, my daughter-in-law and my brother-in-law got on the phone and started calling nursing homes all over town to find out if they had any beds . . . I pretty much feel that all of the work—all of the phone work and leg work was

done by his family, and we didn't receive any help or support from the nursing home itself.

The staff was basically, I'm sorry to say, was useless. They didn't provide any help in packing. All they did was bring the stuff down to their room and set it there, and it was left up to the residents to get help, either from family or friends to get it, I guess, dispersed where it needed to be.

Even when staff did help prepare for the move, family members noted that most haphazardly focused on mechanics of the move and not the residents.

Oh, they had packed up all of her belongings and put them in boxes and put the boxes on her bed in front of her. But they had not bothered to give her breakfast, dress her, and clean her up from the evening before—from the nighttime. She was just sitting there in her bathrobe, looking extremely frightened and distraught.

Loss of Friendships and Sense of Community

Residents talked a lot about the losses they experienced, including friendships with other residents and staff, loss of their sense of place in the community, and loss of health. Residents often viewed the staff as family and good friends, which made it difficult for residents to see staff upset about losing their jobs. "Oh, there were so many

tears that week before we moved. You could just be going down the hall, see another employee just burst into tears."

Residents felt a strong connection and commitment to the community of residents and staff—the facility was their home. It was hard to see others leave and be left. Two residents suggested that not only was it hard to leave the facility, but also it was hard to leave the area.

I didn't want to move. I cried. I did that all week. I was born and raised in [county], but I moved to [location of decertified facility]. I am used to [location of decertified facility]. I don't like [nearby city]. I didn't want to move. I liked it at that place, and I didn't want to move. But we had to.

Although some residents reported being able to stay in touch via telephone, they shared a sense of loss over friendships with former residents and staff. Several mentioned how they missed the comradery with other residents; for one resident, the new facility had yet to fill that void in his social life. "These people, they don't know too much about [card games]." Another resident captured a sentiment shared by many,

It's very hard leaving a place that you've been at for a while; it's like leaving home. You're leaving your friends and everything. People that worked there, real good people that you got to know through the years and stuff. Everybody was crying and everything.

Moving alone to a new facility was difficult for residents. One resident recalled a time when another relocated resident recognized their face at the new facility. "He came like two or three days after I did. We were never friends in [decertified facility], but he saw me, his eyes got big and lit up. He was like someplace, somebody he recognized. Pitiful, isn't it?"

Discussion

Upon moving to a residential healthcare facility, most older adults establish a sense of personal comfort and some level of competence and control (Golant, 2011). When the need to make a change to their living environment is necessary, as in the case of involuntary relocation, older adults may struggle with the immediate stress associated with leaving a place that they identify as home (Oswald & Wahl, 2005) and feel that they belong (Oswald & Wahl, 2013). Although the discomfort for residents and their families associated with involuntary relocation should not be ignored or diminished (Capezuti et al., 2006; Oswald & Rowles, 2007), other serious concerns for residents, as well as stressors and hardships for their families, emerged from our data. Specific to the focus of this study were the facility responses to decertification. Most notably, facilities failed to support residents' autonomy and well-being during the relocation process. Little evidence from the residents emerged that their preferences were sought, much less valued, which contrasted with the

person-centered individualized care promised upon admission (CFR Title 42, Public Health § 483.21).

The lack of resident input denies residents the opportunity to make decisions about how and where they want to live, which is integral to their ability to age (Scheidt et al., 1999), age in place (Löfqvist et al., 2013), and transition into new home environments (Oswald et al., 2002). Denial and devaluation of their autonomy raises multiple questions about how and to what end individuals can expect to be involved in how they live their lives when faced with declining competencies and increasing care needs. Future studies and community dialogues should explore how the rights of vulnerable persons can be preserved to ensure that they continue to direct how and where they live.

From an implementation standpoint, neither residents nor families were satisfied with the involuntary relocation process. Their shared experiences suggest that, to hold a facility accountable, relocation requires planning prior to the relocation, a detailed action plan for seeing the residents and families through the relocation, and a strategy for follow-up to ensure that the quality care of residents is maintained. Unfortunately, facilities that experience closures are typically the worst of the worst facilities. A rule that requires them to comply with good practice, when they are in complete chaos, is unlikely to be effective. CMS decertification and subsequent closure is rare but likely occurs after a facility has been poorly run for a long time (Li et al., 2010).

When facilities agree to provide services funded by Medicare and Medicaid, they are contractually obligated to comply with standards and regulations—established by CMS to deliver quality healthcare, safety, accessibility, and affordable healthcare. Moreover, a facility agrees to communicate with residents and their families and include them in making decisions about their care. As one check on service provision, qualified health professionals are hired by each state to regularly survey facilities to determine if they are meeting required standards of care and facility operations. Yet stark inconsistencies in standards of care and enforcement penalties exist across states (Harrington et al., 2004).

Allowing flexibility for each healthcare facility seems appropriate and accommodating. Residents' health, safety, and wellbeing are a priority during an impending closure or involuntary relocation. However, once regulators determine that services a facility provides are inadequate and are thus found non-compliant, it is critical to consider whether that facility has the capacity to enact a plan that protects residents' health, safety, and wellbeing.

Policy and Practice Recommendations

Residents and family members in our study offered suggestions related to CMS policy for decertified facilities tasked with relocating residents. Below, we discuss recommendations in terms of the CMS guidelines.

Establish Timely, Specified Notification to Residents, Families, and the Larger Community

With stipulations, CMS requires that administrators “provide written notification of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure...” (p.16795, DHHS, 2013a). Decertified facilities have a responsibility and a duty to engage in thorough, timely, and reliable communication with residents and families to deliver high-quality “effective, safe, efficient, patient-centered, equitable, and timely care” (CMS.gov, n.d.b). We suggest that it is time for the 2013 CMS policy to stipulate a defined timeline for communication to residents, family members, facility staff, and the broader community about the relocation process, including but not limited sharing information about why the facility is closing, when it is closing, and the process for closing. Our suggestions are bolstered by recommendations proffered by the residents and family members in our study:

1. Provide thorough, timely, and accurate information to residents and their families. Notify and involve families in the early stages of the relocation process; rely on multiple methods of communication when reaching out to residents and families about the relocation process, including an initial phone call, face-to-face conversations during on-site visits, and written notification (i.e., letter, website).

2. Remain transparent with all parties about the timeline for relocating residents; identify a point-person for communicating information about the relocation to residents, families, and receiving facilities.
 3. Explain the current situation to residents at an appropriate level of understanding (i.e., consider their cognitive abilities). Provide residents with individual counseling to prepare them mentally and physically for the transition to their new residence.
 4. Leverage the expertise of local agencies. For example, the regional long-term care ombudsman can provide insights into the unique needs of residents and facilitate communication between residents, families, facilities, and state agencies.
- the relocation process. Sanctions should be leveraged upon facilities without an established relocation plan. Proactive planning is consonant with the CMS goal of “flexibility [for each facility] to develop a plan for relocation.” Further, CMS could encourage state-level entities to offer incentives to staff/administrators who contribute to a successful relocation experience and require additional staffing to support care coordination during transitions. CMS should also mandate that decertified facilities involve residents and their families and the long-term care ombudsman early in the process and to the extent possible in relocation decision-making processes. Recommendations from residents and families in our studied further support these proposed changes to policy:

1. Engage residents and families and the long-term care ombudsman in the decision-making process with at least 30-days’ notice to make an informed decisions about their new care arrangements.
2. Involve each resident and their family and relocation staff to identify healthcare needs that affect placement options.
3. Provide residents and families with physical support for moving residents and their belongings to new facilities.

Expand Emergency Preparedness Requirements to Incorporate Facility Relocation

The CMS rule establishing “national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters” (p. 63860, DHHS, 2013b) is another mechanism that should be utilized pertinent to facility closures and consequent relocations. We propose that CMS require that facilities develop and maintain a “relocation plan” analogous to mandated emergency preparedness plans. An established relocation plan can minimize disruptions in care and facilitate

Consider How Operations and Ownership of Facilities Affect Nursing Home Relocation

The scholarly literature (e.g., Bowblis,

2011; Castle et al., 2010; Fashaw et al., 2020) suggests that nursing home owners may sell their property and/or structurally reorganize in response to the regulatory demands made of them. Importantly, when new regulations, such as those offered above are proposed, it is important to understand that their promulgation is influenced by political will and lobbying. For example, Former President Trump's administration relaxed nursing home regulations, which likely affected conduct within the facilities as well as their ownership and oversight. Also important is that the administrator and staff activities within the nursing facility also contribute to maintaining a quality environment (Amirkanyan et al., 2018; Li et al., 2019).

Facilities are required by federal law to acknowledge and act upon grievances and recommendations from residents and families (Long Term Care Community Coalition, 2021). To improve the delivery of aging services, the voices of older adults and their families, as well as the wider community in which the facility is situated, must be included (Martin et al., 2019). We urge that facilities, state-level entities, and federal policy makers consider our recommendations for policy, recommendations supported by research involving residents and families.

Limitations

This study is not without its limitations. First, the location and ownership of the facilities were different. This led to some residents relocating long distances from their previous healthcare

facility, which prohibited their participation in the study. With communication through technology becoming more commonplace (i.e., videoconferencing), future investigations will be better positioned to reach study participants regardless of their location (Archibald et al., 2019). Second, the timing of interviews differed. Inquiry into the relocation of residents from the rural facility was retrospective, while interviews with residents and families from the urban facility occurred soon after with the relocation. While concurrent inquiry is ideal, involuntary relocations are contentious, and as we learned, often happen swiftly with little advanced notice. As researchers, we cannot manipulate naturally occurring events, but the commonality of findings across sites gives us confidence that residents and family members at both facilities shared similar experiences and challenges.

Developing mutually beneficial, collaborative partnerships with state and local agencies will help position both researchers and agencies to conduct ongoing research on resident and family experiences with planned or anticipated transitions to long-term care (Gaugler et al., 2021) to quickly respond to less common involuntary transitions, and to gather data to inform policies that ultimately affect the health and well-being of vulnerable older adults and their families (Rudder, 2016). Finally, the resident sample was limited to higher functioning residents, thus, the voice of residents with cognitive and other impairments was heard only through the interviews with the family members. Implementing inno-

vative and ethically sound data collection with persons with limited capacity (e.g., Kelley et al. 2019; Phillipson et al., 2018; Sturge et al., 2021) will help future researcher gain insights from the persons most effected by relocation,

the residents themselves. Data collected and interpreted will also provide a too-often absent evidence base for making, implementing, and evaluating relevant policies and practices.

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Conflicts of Interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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