The Organizational Cultures of Nursing Homes: Influences on Responses to External Regulatory Controls

Lois Grau and Edward Wellin

This article is a qualitative study of two skilled nursing facilities. The research was designed to investigate how the homes coped with the demands of government regulation for state licensure and Medicaid/Medicare certification. Regulatory responses were found to be tightly associated with the organizational cultures of the two homes. In one home, residents and staff members represented the same ethnic and social class group. Relations among and between staff members, residents, and residents' family members tended to be informal, with the result that the home had little concern that families would complain to external regulatory bodies. The second home was characterized by sociocultural heterogeneity between residents and staff. Tension between these two groups resulted in family complaints which, in turn, triggered defensive strategies designed to protect the home from regulatory interventions.

Nursing homes in the U.S. are among the most tightly regulated components of the health care system. State licensure rules and regulations, as well as Medicaid/Medicare requirements for certification, specify most aspects of nursing home operations.

QUALITATIVE HEALTH RESEARCH, Vol. 2 No. 1, February 1992 42-60

In addition to formal regulatory intervention at governmental levels, nursing homes are subject to other less predictable and formalized control mechanisms. For example, the presence of family visitors has been found to directly benefit residents and may indirectly do so by influencing the quality of care they receive (Bowers, 1988; Dobrof, 1981; Harel, 1981; Miller & Harris, 1965; York & Calsyn, 1977).

Typically, the effects of regulatory strategies are measured in terms of how well or poorly nursing homes perform vis-à-vis established regulatory standards. Little attention has been paid to how nursing homes themselves perceive and respond to the regulatory environment in which they exist. Anecdotal reports from nursing home administrators and staff members suggest that while regulatory controls are necessary, the current regulatory system overly relies on "paper compliance," with the result that excessive staff time is devoted to documentation at the cost of direct resident care.

The present study was designed to explore this problem through study of two skilled nursing facilities. Like other studies with interest in the internal dynamics and operations of nursing homes (e.g., Gubrium, 1975; Stannard, 1973; Tellis-Nayak & Tellis-Nayak, 1989), the nursing home was viewed as an organizational system with government regulations and family visitors acting as inputs into the larger organization. Although it was assumed that the effects of these inputs on what goes on in the nursing home would not be simple matters of stimulus-response, it was anticipated that the two homes' responses to regulatory mechanisms would be fairly similar. This, however, was found not to be the case. The social composition, social structure, and social dynamics of the two facilities were found to shape the process of work and interpersonal relations within each home. These factors, in turn, generated distinct social constructions of the regulatory system by the administrators of the two homes. Hence early in the study,

Authors' Note: Correspondence or requests for reprints should be addressed to Lois Grau, Director, Nerken Center for Geriatric Research, Parker Jewish Geriatric Institute, New Hyde Park, NY 10042.

attention was focused on the complex interplay and sociocultural context of organizational factors which influenced regulatory-related attitudes and behaviors.

That is to say, focus was shifted from a comparison of regulatory responses to an attempt to understand the ways in which the organizational cultures of the two homes mediated these responses. Organizational culture has been defined as the fairly stable set of taken-for-granted assumptions, shared beliefs, meanings, and values that form a type of backdrop for action within an organization (Smircich, 1985). Although organizations can develop a single pervasive culture (Deal & Kennedy, 1982; Peters & Waterman, 1982), distinct subcultures may develop among separate groups within the organization (Gregory, 1983; Lawrence & Lorsch, 1967; Savage, 1982). The nature of an organization's culture and the extent to which subcultures exist is a function of the organization's ecological context (e.g., physical setting, historical forces, and social context), patterns of interaction among organizational members, and collective understandings of objects, events, and activities (Van Maanen & Barley, 1985).

Because relatively little is known about the organizational culture of nursing homes and its role in influencing regulatory related attitudes and behavior, an ethnographic study of two skilled care nursing facilities was undertaken. This approach provided the opportunity to explore both the formal and informal organizational characteristics and dynamics of the homes in an attempt to understand the respective perceptions and responses to the environing regulatory milieu.

RESEARCH SITES

Two skilled nursing facilities, "Monticello" and "Homehaven" (both pseudonyms), were selected for study on the basis of their reputations among local advocacy groups and health professionals as being high-quality nursing homes. Both were located in a major metropolitan area in the Midwest. The two homes

were similar in the characteristics typically used to describe nursing homes—both were proprietary, were locally owned and operated, charged fairly similar fees, and did not differ greatly in size (Monticello has 150 beds, Homehaven somewhat fewer). Like many nursing homes, each home actively sought private-pay, as against Medicaid-supported, residents. However, approximately a third of Monticello's and half of Homehaven's resident populations qualified for Medicaid. This was the result of the high costs of nursing home care and eventual need of most residents to "spend down" to reach Medicaid eligibility levels in order to finance nursing home care.

While similar in the characteristics just noted, the two homes differed in what proved to be important ways. Monticello was located in an upper-middle-class suburb adjacent to a large midwestern urban city. The facility attracted the majority of its residents from the surrounding geographic areas. Residents were middle and upper middle class and represented Protestant, Catholic, and Jewish faiths. Monticello's professional staff also were drawn from the surrounding suburbs. However, nurse aides, the major providers of "hands on" care to residents, were predominantly Black or members of other minority groups, most of whom lived miles away in inner-city neighborhoods of the adjacent urban center.

Homehaven, on the other hand, was situated in a densely populated part of the city characterized by Polish and Catholic neighborhoods and strong ethnic traditions. The home was known as a "local" facility which drew not only most of its residents but professional staff and nurse aides as well from the surrounding area. As a result, those who lived and worked in the home were predominantly of Polish descent and members of the working class, with husbands engaged in skilled or semiskilled occupations.

Although both homes had good reputations, Monticello was known as a relatively elite facility. This was the result of the home's graceful colonial exterior and elegant internal decor as well as its reputation for providing a wide range of social and therapeutic programs to residents. The home was also known

for its efforts to cater to the expectations of its residents, as evidenced, for example, by the medicine cabinet in the self-care unit which contained a large variety of liquor bottles replete with prescription labels and medication cards.

In comparison, Homehaven, inside and out, was unpretentious and plain. Although clean and neat, its interior was hospital-like with decorations limited to an occasional potted plant or plastic floral arrangement. Recreational activities were frequent at Homehaven but were typically limited to hand crafts, birthday parties, and musical entertainment supplied by a volunteer accordionist. Most social interaction within the home consisted of informal exchanges among and between staff, residents, and their family visitors.

DATA COLLECTION METHODS

Data were collected by quantitative and qualitative methods over a 6-month period. Standardized interviews were conducted with all administrative personnel, social workers, recreational therapists, registered nurses, and licensed practical nurses (total $n = 48$) and from a random sample of nursing aides (total $n = 45$) employed at each home. In addition to sociodemographic information, respondents were queried as to their work histories, daily work routines and work priorities, experience with regulatory surveys, knowledge of regulatory strategies, and attitudes toward residents and their families. Information on the sociodemographic and health characteristics of residents was collected from medical records. Many other documents (staff schedules, Medicaid data-reporting forms, patient care policy manuals, and social service records) were reviewed to learn about the formal operational policies and practices of the two homes.

Qualitative methods included informal interviews in each home with the staff, residents, and residents' families. Ongoing contact of this type led to the identification of key informants who provided general background information about such

things as the organizational structures, division of labor, and distribution of authority and responsibility within the homes. They also served as sources of information from which insights were derived and as a means of verifying relationships that emerged from other data sources.

Data were also collected via participant observation of formal events such as patient care meetings, recreational activities, and daily life in the two homes. The senior author also undertook participant observation at each home in the role of nurse aide during day, evening, and night shifts.

FORMAL ORGANIZATIONAL RESPONSES TO REGULATORY REQUIREMENTS

Initially, it appeared that Monticello and Homehaven responded to the demands of regulatory compliance in similar ways. Both facilities relied heavily on documentation to demonstrate regulatory compliance with patient care and staffing standards. The bulk of this responsibility fell to the nursing staffs at each home. Nurses at Monticello spent approximately 50% of their time on paperwork, those at Homehaven around 30%. Paperwork and the nurses' responsibility for telephoning physicians to obtain required medical order renewals were chronic bones of contention among nurses at both homes. Most nurses complained that paperwork tasks detracted from the provision of direct patient care.

As the study progressed, it became clear that Monticello was far more concerned about, and put much more effort into, formal compliance strategies than did Homehaven. For example, Monticello instituted its own internal reviews to monitor documentation and employed two full-time medical record assistants to identify omissions or errors in paperwork. The senior medical record assistant was viewed as an in-house expert with respect to documentary requirements and, as such, regularly attended policy-making meetings.

The administration's concern for maintaining regulatory compliance was also reflected by Monticello's frequent in-service meetings which focused on regulation-related matters. Nurse aides were routinely trained in charting, and nurses were informed as to the precise way in which physician orders and nursing notes should be phrased.

At Homehaven, medical record review was limited to the night nurses' ad hoc reviews of resident medication records. The purpose was to identify omissions in charting, which when found were simply completed by the night nurse. Required charting on the nurses' notes was undertaken as a matter of routine without concern for the appropriateness of specific wording. In contrast to Monticello, documentation-related matters did not appear on the agenda of in-service education meetings nor were they the focus of memoranda.

The homes also varied in how they perceived regulatory agencies. At Monticello, concern with regulatory matters permeated the activities of the administration and nursing staff. The annual inspection by state personnel was viewed as an important event, and much preinspection readying of records and the physical plant occurred. However, there was an even higher level of concern about potential intervention from two sources: the state's regulatory/legal agencies and its ombudsman program.

At Homehaven, regulatory interest was limited to "passing" the annual state inspection. Keeping up paperwork was seen as mandatory, but the home's patient care policies and practices and its paperwork appeared to be oriented more to "keeping the record straight" than to regulatory concerns. So certain was the nursing staff of the quality of care they provided that they had little fear of the consequences of resident or family complaints. For example, when asked what she would do if a family member threatened to telephone the state regulatory agency to lodge a complaint, the nurse stated, "I'd dial the number for them." This is not to say that the administration and nursing staff were totally indifferent to regulatory intervention. Some "clean up" activities occurred prior to the anticipated annual

visit of the survey team, but these were less intense and more short-lived than the preinspection tumult at Monticello.

IMPACT OF REGULATORY ATTITUDES ON PATIENT CARE PRACTICES

The homes also differed in their interpretations of certain patient care regulatory standards. For example, at Monticello, patient safety concerns ranked high. Medical orders for restraints were obtained for all residents who were physically frail, in fear that independent ambulation might result in falls. Residents who were confused or who refused to wait for assistance to ambulate were also restrained. When one resident's daughter complained about the use of restraints for her mother because, although frail, she was capable of walking with a cane, the administration held firm, stating that if this practice was unacceptable they would assist in arranging a transfer to another facility. This was in sharp contrast to the general deference of the administration to the wishes of residents and their families.

Monticello was equally cautious when an accident or other untoward event occurred. Incident reports and physician notification were required should any event, however minor, occur. "Difficult" residents (discussed later) had their charts flagged to indicate that both a family member and the director of nursing be notified immediately, day or night, should any incident occur.

At Homehaven, on the other hand, both confused and physically frail residents were encouraged to ambulate about their units, based on the nurses' philosophy that physical independence should be encouraged. Hence restraints were reserved for stroke or other patients who required the physical support of a vest or gerichair to sit. Nor were incident reports taken as seriously as at Monticello. Reports and medical notification were undertaken only in the event of a medication error or injury.

FACTORS ASSOCIATED WITH REGULATORY RESPONSES

Early in the fieldwork, the authors attributed differences between the homes' attitudes and responses to official regulation to differences in their administrative styles and organizational structures. Monticello was a relatively complex organization characterized by centralized decision making and a sharp division of labor within and across departments. Homehaven was a far simpler and less formalized place, in which decision making tended to be shared and tasks and responsibilities often overlapped within and across departments. Although important, these differences in the degree of formalization of the homes were found to contribute to but not to be the primary cause of their respective regulatory strategies and related resident care practices.

What was found to be most important was the nature of relationships between staff and residents and residents' families at each home. Somewhat unexpectedly, Monticello's administration, in contrast to that at Homehaven, had been confronted with frequent and wide-ranging complaints from residents and more often, their families. In addition, some families had taken their complaints outside the nursing home to the state regulatory agency, the ombudsman program, or the courts. Most of these complaints were judged by the appropriate authorities to be groundless, but a number placed the home in what the administrator described as "no win" situations. For example, the home was sued by a resident's son for patient neglect because of his mother's broken hip. The situation was as follows: The resident in question was prepared for the night, and the bedside rails were placed in their upright position. However, restraints were not used at the request of the resident and because the nurse assessed the patient as being alert. This judgment was in her jurisdiction because the medical order called for restraints only when necessary (i.e., when the resident was confused and agitated). However, during the night, the resident successfully scaled the side-rails and fell to the floor. Monticello settled out-of-court because the home's lawyer believed that

however well-informed the nurse's judgment was at the time it was made, it turned out to be wrong. Had restraints been used, the accident probably would not have occurred.

In addition, the home had recently dealt with family complaints to the state of inadequate notification prior to the transfer of two residents. The situations were complex but had in common Monticello's inability to cope with the psychiatric (suicidal) condition of one resident and the abusive behavior of another resident's son. Although the home was not charged for either violation, the time and costs of the investigations were significant.

Homehaven families had few complaints. The complaints which were expressed tended to be minor, having to do with things such as a missing wheelchair, the location of a favorite nightgown, and the like. All of these concerns were taken by families to the nursing staff who resolved or explained the matter to the families' satisfaction.

One serious event did occur during fieldwork at Homehaven which exemplifies the difference between Homehaven and Monticello families. A confused male resident fell while walking down the hall and fractured his hip. However, neither the resident's family nor the administration raised the issue of the home's liability. The incident was viewed and treated as an unfortunate accident.

Monticello's rigid regulatory compliance strategies and conservative interpretation of patient safety standards were logical responses to its encounters with state regulatory, advocacy, and legal bodies. The fact that family complaints could occur at any time and be lodged with one of a number of external agents accounted for the home's day-in and day-out concern with compliance. Compliance strategies were, in this sense, protective. Stringent documentation and rigidly adhered-to patient safety practices functioned to prevent untoward patient-care-related events as well as to provide evidence of appropriate care should such an event occur.

The concern for preventing family complaints was exemplified by the identification of a group of residents who were

labeled "difficult" and given special treatment. These residents were assigned "special" aides, veteran workers who cared for fewer residents than their counterparts. This service was provided at no additional cost to residents. However, observations of these residents suggested they differed little from other residents in their care requirements or behavior. What distinguished them was their families. Each had one or more family members who visited frequently and who were known among the staff for their constant surveillance and frequent criticisms of patient care.

During the course of fieldwork, Homehaven had no experience of regulatory intervention outside of the routine annual state survey. Nor could informants recall any such intervention in the past. As a result, the administration and staff members considered government regulation as little more than a necessary inconvenience. Although they resented the paperwork involved in what they called "paper compliance," most Homehaven nurses believed that some type of regulation was necessary to deal with what, in their view, was the presence of "bad" nursing homes in the area. The state ombudsman program and the courts were seen as distant realities. The idea that they should enter into life at Homehaven was, to the nurses, farfetched.

THE SOCIAL ECOLOGY OF THE HOMES

Monticello's experience of family-initiated regulatory and legal interventions and the home's cautious and conservative response to regulatory requirements could be explained on the basis of its inability to provide high-quality care. This was not, however, the case. Monticello offered rich and varied recreational and therapeutic services to residents and with the exception of patient safety practices, attempted to individualize care according to the wishes and needs of residents and their families. Moreover, nurses and other professionals were observed to provide technically correct and concerned care to residents.

The home's experience with family complaints was a result of its social composition and organizational culture. The home viewed itself as a prestigious facility and to maintain this reputation, intentionally recruited residents from affluent socioeconomic levels. Although similar in this regard, residents differed in religious affiliation (57% were Protestant, 32% Catholic, 29% Jewish, and 13% members of other religious groups) and heritage. As a result, residents' cultural traditions and interests varied. Monticello's repertoire of activities was in large measure a response to this diversity. For example, the home had music, travel, gourmet, and other clubs, as well as comprehensive recreational and physical and occupational therapy programs. It provided Protestant, Catholic, and Jewish religious services each week and celebrated major religious holidays. However, relations between various groups of residents were not always smooth. For example, conflicts occurred between roommates of differing backgrounds and between cliques of residents. Events such as the case of a Protestant resident who mistakenly joined in the Jewish Passover seder and was angrily accused by a confused Jewish resident of trying to get "a free meal" or the dispute among residents about the relative prominence of Christmas and Chanukah decorations were not uncommon.

These internal tensions were magnified by families who, although most viewed Monticello as a good or excellent nursing home, tended to scrutinize and question patient care practices. "Difficult" families and some others were particularly hard for staff to deal with. For example, one family member insisted that one of the authors (working as a nurse aide) rearrange a resident's drawer three times until it was done "correctly." Although these families directed the work of the aides, they took their complaints to supervisory personnel or to administration. The aides typically were treated by these family members as servants, people with specific responsibilities but little or no authority.

Because most aides were poorly educated minority-group members, they had little understanding of, for example, Jewish

traditions or affluent life-styles. Most aides reported tense relationships with some residents or their families. Although social distance between individuals is often bridged with time, this was seldom the case at Monticello because of the high turnover of aides—over 100% the previous year. Moreover, two thirds of the nurse aides who were interviewed were currently seeking other jobs.

The social composition of Homehaven differed sharply from that at Monticello, in that approximately 80% of residents were of Polish descent and three fourths were Catholic (all other residents were Protestants). Most residents had previously lived in the local neighborhood and many were members of the same Catholic parish. As a result, residents tended to have shared interests, favoring such activities as hand crafts, bingo, and musical entertainment. Although occasional disputes occurred between residents, these tended to be individual matters rather than the consequences of group membership, as was often the case at Monticello.

Homehaven families played a quite different role from their Monticello counterparts. About half of the residents had family members—most often daughters—who visited frequently. These relatives tended to participate in the provision of care rather than, as at Monticello, attempting to control it. This is most likely the result of the fact that one third of the residents had previously lived with a family member (as against 4% at Monticello), and many others had lived in side-by-side duplexes adjacent to an adult child (an arrangement characteristic of the housing stock of the local Polish neighborhoods). Families simply continued, in modified form, earlier patterns of care.

The nurse aides at Homehaven also differed from those at Monticello. Fully every aide who was interviewed stated that she selected work at Homehaven because of her desire to care for older people. Most likened residents to their own parents or grandparents and found caring for them to be a logical extension of their roles as wives and mothers. The median length of employment among the aides was four years, and one third had

been employed at Homehaven for 6 or more years. None were currently exploring other job opportunities.

Relations between the nursing staff and families at Homehaven tended to be informal. This was particularly so for frequent family visitors. Family members often found they had something in common with staff members—common acquaintances or membership in the same local church. As a result, family-staff relationships were personalized. This was enhanced by the relatively simple organizational structure of the home and its relatively informal division of labor among the nurs- ing staff. Business relating to patient care tended to be conducted on a face-to-face basis on the clinical units or over the telephone rather than in formal meetings or "behind closed doors" as at Monticello. As a result, information tended to be shared directly or passed on informally. In addition, nurse aides tended to work as a team with each other and with the nurses. This team approach and their long job tenure provided them the knowledge and authority to deal with many patient-related problems and concerns. As a result, families turned to whoever was available—and this most likely was the aides—for information or assistance.

DISCUSSION

Although Monticello and Homehaven were selected for study on the basis of their structural similarities, these served as poor indicators of the homes' internal characteristics and operations. Each home was found to have a distinct organizational culture which sharply influenced their responses to both formal governmental regulations and the presence of family members. Monticello is best characterized by the presence of multiple, and at times conflicting, subcultures. The relatively high organizational complexity of the home carved vertical and horizontal niches that served as loci for the development of distinct subcultures based on occupational role and status. This was partic-

ularly the case for the nurse aides who were distinguished from professional staff by their low occupational status as well as from other staff, residents, and family members on the basis of ethnicity.

The organizational culture of Homehaven was more uniform. The relatively loose and, at times, overlapping division of labor and responsibility encouraged shared job-related knowledge and understandings. Shared social class membership and ethnic identity among staff members, residents, and their families softened the boundary which characterizes typical provider-client relationships. In addition, staff members, residents, and family members brought into the home shared understandings about local community institutions and traditions.

The notion that leadership—in the case of nursing homes, their administrations—generates the values, understandings, and behavioral norms that become part of an organization's culture fails to recognize the power of other actors in the culture creation process (Martin, Sitkin, & Boehm, 1985). Monticello's administration was successful in portraying the facility as an elite home which caters to the needs of middle- and upper-middle-class residents and their families. However, this understanding had little salience or meaning to the nurse aides who spent the most time with, and provided the vast majority of care to, residents. This and the social distance between the nurse aides and the home's clientele unconsciously undermined the major ethos of the administrative subculture. Homehaven's administration portrayed its facility as a warm and friendly place in which traditional cultural values are maintained. Unlike at Monticello, this value orientation was shared by professional and nonprofessional staff members, thus supporting a more common organizational culture.

In the present study, the organizational cultures of Monticello and Homehaven were found to be unexpectedly important in accounting for their attitudes toward and responses to regulatory requirements. Although the presence of a relatively small number of "difficult" families triggered Monticello's cautious

regulatory-related practices, the conditions for family complaints and threats, and the home's response to them, were the result of diverse social values and expectations. The social distance and mistrust between some family members and nurse aides led families to take their concerns to higher authorities within the home and in the case of "difficult" families, to outside regulatory/control agencies. Having experienced the time, cost, and threat to its reputation which resulted from nonroutine investigations by the state regulatory agency and from private litigation, the administration employed various policies and procedures designed to demonstrate the home's innocence in the case of similar future events. Homehaven, on the other hand, had no felt need for such procedures because of its lack of experience of nonroutine regulatory or legal interventions. The two homes were similar, however, in that both viewed their regulatory-related attitudes and behaviors as rational and appropriate responses to the regulatory system. Hence each constructed the regulatory system into quite different social realities. Monticello did not attribute family members' recourse to outside agencies to the fact that the home purposefully attracted residents and families with high and diverse expectations for care. Nor did the administration recognize that the source of many such problems lay at the, so to speak, bottom of the organization: tense and distrustful relationships between family members and nurse aides. As a result, no attempt was made to assist aides in dealing with difficult families or to provide these families with counseling and support. Instead, the home dealt with potential regulatory/legal problems in exclusively regulatory terms.

Nor was Homehaven aware of how shared ethnic and social-class membership mediated a smoother course for human relationships within the home. The fact that residents and staff came from similar backgrounds minimized social distance and promoted the personalization of relationships. This was complemented by the long job tenure of most staff and the tendency for tasks and responsibilities to overlap between the nurses and

the nurse aides. As a result, families found Homehaven to be a familiar microcosm of the larger world in which they lived.

Although there is a growing recognition of the importance of the nurse aide role with respect to the quality of care and quality of life of nursing home residents (Holbur, 1982; Waxman, Carner, & Berkenstock, 1984; Tellis-Nayak & Tellis-Nayak, 1989), further consideration needs to be given to its importance in shaping families' attitudes toward nursing home care. Conversely, the effects of the behavior of families on nurse aides' job satisfaction and, subsequently, on the quality of care they provide also requires attention.

Clearly, in that Monticello and Homehaven each represents a distinct case of sociocultural heterogeneity and homophyly, their study provides insight into the importance of sociocultural factors in shaping human relationships within the nursing home. The importance of person-environment congruity in nursing homes has been recognized (Coe, 1965; Harel, 1981; Kahana, Liang, & Felton, 1980; Lieberman, 1974), but the role that sociocultural factors play in human relationships and the social milieu of the nursing home have received limited attention. This requires study of human relations both within "ethnic" nursing homes and within more culturally diverse facilities. At the same time, it is important that nursing homes themselves become sensitive to the sociocultural conditions that foster discord and harmony between residents, residents' families, and staff members.

When nursing homes are viewed as human service organizations, the complexity of their behavior emerges, as well as the importance of human relationships in accounting for it. The significance of cultural, social-structural, and sociodemographic characteristics in shaping the nursing home's climate and patient care philosophy is a matter not often addressed, but it is one of importance to those who live and work in nursing homes as well as to those responsible for regulating the nursing home industry.

REFERENCES

Bowers, B. (1988). Family perceptions of care in a nursing home. *Gerontologist, 28*, 361-368.

Coe, R. (1965). Self-conception and institutionalization. In A. M. Rose & W. A. Peterson (Eds.), *Older people and their social world* (pp. 225-244). Philadelphia: Davis.

Deal, T. E., & Kennedy, A. A. (1982). *Corporate cultures*. Reading, MA: Addison-Wesley.

Dobrof, R. (1981). Guide to practice. In R. Dobrof & E. Litwak (Eds.), *Maintenance of family ties of long-term care patients: Theory and guide to practice* (DHHS Publication No. ADM 81-400, pp. 1-71). Washington, DC: U.S. Government Printing Office.

Gregory, K. L. (1983). Native-view paradigms: Multiple cultures and culture conflicts in organizations. *Administrative Science Quarterly, 28*, 359-376.

Gubrium, J. F. (1975). *Living and dying at Murray Manor*. New York: St. Martin.

Harel, Z. (1981). Quality of care, congruence and well-being among institutionalized aged. *Gerontologist, 21*, 523-531.

Holbur, B. T. (1982). *Turnover among nursing personnel in nursing homes*. Ann Arbor: University of Michigan Press.

Kahana, E., Liang, S., & Felton, B. (1980). Alternative models of person-environment fit: Prediction of morale in three homes for the aged. *Journal of Gerontology, 35*, 584-595.

Lawrence, P. R., & Lorsch, J. W. (1967). Differentiation and integration in complex organizations. *Administrative Science Quarterly, 12*, 1-47.

Lieberman, M. (1974). Relocation research and social policy. *Gerontologist, 14*, 494-501.

Martin, J., Sitkin, S. B., & Boehm, M. (1985). Founders and the elusiveness of a cultural legacy. In P. J. Frost, L. F. Moore, M. R. Louis, C. C. Lundberg, & J. Martin (Eds.), *Organizational culture* (pp. 99-124). Beverly Hills, CA: Sage.

Miller, M. B., & Harris, A. (1965). Social factors and family conflicts in a nursing home population. *Journal of American Geriatrics Society, 13*, 845-851.

Peters, T., & Waterman, R. H. (1982). *In search of excellence*. New York: Harper & Row.

Savage, G. T. (1982, November). *Organizations as conflicting small group cultures*. Paper presented at the annual meeting of the Speech Communication Association, Louisville, KY.

Smircich, L. (1985). Is the concept of culture a paradigm for understanding organizations and ourselves? In P. J. Frost, L. F. Moore, M. R. Louis, C. C. Lundberg, & J. Martin (Eds.), *Organizational culture* (pp. 5-72). Beverly Hills, CA: Sage.

Stannard, C. I. (1973). Old folks and dirty work: The social conditions for patient abuse in a nursing home. *Social Problems, 20*, 329-342.

Tellis-Nayak, V., & Tellis-Nayak, M. (1989). Quality of care and the burden of two cultures: When the world of the nurse's aide enters the world of the nursing home. *Gerontologist, 29*, 307-313.

Van Maanen, J., & Barley, S. R. (1985). Cultural organization: Fragments of a theory. In P. J. Frost, L. F. Moore, M. R. Louis, C. C. Lundberg, & J. Martin (Eds.), *Organizational culture* (pp. 31-53). Beverly Hills, CA: Sage.

Waxman, H. M., Carner, E. A., & Berkenstock, G. (1984). Job turnover and job satisfaction among nursing home aides. *Gerontologist, 24*, 503-509.

York, J. L., & Calsyn, R. J. (1977). Family involvement in nursing homes. *Gerontologist, 17*, 500-505.

Lois Grau is the director of the Nerken Center for Geriatric Research at the Parker Jewish Geriatric Institute in New Hyde Park, NY. Edward Wellin is a professor in the Department of Anthropology at the University of Wisconsin, Milwaukee campus.