

**Richard A. Courtney, CELA**  
**Certified Elder Law Attorney**  
**4400 Old Canton Road, Suite 220**  
**Jackson, Mississippi 39211**  
**601-987-3000 or 1-866-ELDERLAW**  
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## **10 Things to Know About Assisted Living**

(From an October 20, 2008 article by Jane Gross in the New York Times – [www.nytimes.com](http://www.nytimes.com).)

Dr. Cheryl Woodson is a solo-practice geriatrician in Chicago Heights, Ill., who has found that she can no longer afford to accept new Medicare patients. She is also a daughter who cared for her own mother with Alzheimer's disease for a decade. Here are some candid observations and advice from Dr. Woodson's book, "To Survive Caregiving," pertaining to caring for a loved one in assisted living.

1. Assisted living, a popular solution for elderly people who cannot live independently, is a "myth," Dr. Woodson said, "a place for people who don't exist." Families often believe these facilities will meet all of their loved ones' needs, enabling caregivers to focus on jobs and family, only to find this isn't the case. Before long, the elderly resident will require more than "meals you don't have to cook, grass you don't have to cut and socialization," Dr. Woodson said. At that point the elderly resident is in trouble, since assisted living facilities are not permitted by law to provide medical care and consider it to be the family's responsibility.

2. Squaring a family's expectations with those legal limits would require a thorough, first-hand assessment of the elderly person's physical and cognitive health before admission to an assisted living facility. That rarely happens. New residents are admitted based on a report from their current physicians, who may not be qualified to diagnose the early signs of dementia and impending immobility or may sugarcoat the situation in order to help a desperate family. "They just need a little help," the usual rationale for accepting elderly prospects into assisted living, is ridiculous on its face, Dr. Woodson said. "If they just needed a little help, they'd still be in the community."

3. Instead, without verifying the physician's report or the family's representations, these facilities may admit residents who already need help with simple tasks like dressing or eating, or will in the very near future, and then charge extra for these services. Some do this to fill empty beds; others give residency a shot as a kindness to desperate families, Dr. Woodson said. But when the resident declines, as all of them will unless they die suddenly, more and more a la carte services mean a bigger and bigger monthly bill, or more and more work for family members who expected the opposite.

4. Coordinating all the services that the assisted living facility doesn't provide generally falls to one sibling, Dr. Woodson noted, who then becomes overwhelmed, sacrificing more than should be expected. The solution is hiring a geriatric care manager — “They should be called rent-a-daughters,” Dr. Woodson said — adding further to the expense, until the resident and family can no longer afford this kind of accommodation and are forced to consider a nursing home.

5. Most families balk at the prospect of transferring an aging parent to a nursing home because they like the aesthetics of assisted living — the carpeted floors, overstuffed chairs and crystal chandeliers. But without round-the-clock care, many residents are “as alone at night as if they were in their own homes,” Dr. Woodson said. Other families are unwilling to break a promise to Mom or Dad never to put them in a nursing home. The spirit of that promise — to give a parent the best possible care — is what matters, Dr. Woodson said, “and sometimes that means not doing it yourself.” An aging parent's condition may eventually require three shifts of nurses and aides, not a family member trying to take care of everything 24/7.

6. The doctors who see residents at assisted living facilities are essentially freelancers, not employees, since their fees are paid by Medicare and they also may maintain private practices. So rather than hang around the facility expecting them to answer your questions on the fly, Dr. Woodson suggested calling and arranging to see them “by appointment, not by ambush.” This consultation will not be covered by Medicare unless it coincides with a medical procedure for the resident. Still, it is essential in order to stay on top of an elderly person's medications, some of which may be unnecessary and even dangerous, and to make decisions about which medical care improves the quality of life and which is pointless and wasteful.

7. If a parent lives in an assisted living facility, families should closely monitor the monthly pharmacy bill, less for cost than for content. Is Xanax being prescribed for anxiety? There are numerous other remedies available without the potentially dangerous side effects. What about muscle relaxants for arthritic pain? They increase confusion in the elderly and add to the risk of falls; instead, ask for pain medication and/or a heating pad. If the assisted living facility offers to have prescriptions filled and delivered by a local pharmacy — a huge convenience for family members — be sure it's a pharmacy that insists upon periodic blood work or other tests for drugs that are supposed to be closely monitored.

8. The goal of medical care for the elderly, in Dr. Woodson's view and the view of every geriatrician I've ever interviewed, is to make day-to-day life more comfortable, not to cure illness or extend longevity. Examples? A joint replacement to relieve pain and improve mobility makes sense only if the patient has the cognitive ability to complete physical therapy. Otherwise, he or she will never walk again and would be better off avoiding surgery and simply being kept comfortable. Similarly, anyone who would refuse cancer treatment because of advanced age probably doesn't need a mammogram, Pap smear or colonoscopy. “Why draw a map to someplace we know we're not going?” Dr. Woodson asked.

9. Apply similar standards to immunizations and vaccinations. If someone is so ill or disabled that death would be welcome, refuse the vaccine for pneumonia, long known as “the old person’s friend.” But never say no to the shingles vaccine, which can prevent an excruciating rash. “Even if someone was only going to live five more minutes, that’s the one thing I’d suggest,” Dr. Woodson says. “It’s a quality-of-life issue.”

10. Do not assume that the presenting symptom of Alzheimer’s disease will be forgetting words, losing things or other obvious examples of short-term memory loss. Often the first thing a family member will notice is an empty checking account, Dr. Woodson said, because a normally cautious and frugal person has been tricked by a get-rich-quick scheme or other scam. And like missing money, look out for pills missing from those seven-day dispensers that help people with multiple medications keep track of what they’re taking and when. Family members may find the dispensers empty and worry about overdose, Dr. Woodson noted, but often the missing pills will turn up under couch cushions or scattered elsewhere around the house. Take this as a cue that it may be time for a cognitive assessment.

**[NOTE:** Our firm has many clients who have received excellent care in a number of assisted living facilities. We have a geriatric care manager who can assist with assessment and monitoring of care for older clients in such arrangements.]