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Elder Crimes of the Law Abiding: Backwards Dresses, Covered Up Messes, and Nursing Homes

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ABSTRACT
This article uses data from 75 biographies, autobiographies, and research monographs on nursing homes to explore physical neglect and abuse. Linked to crimes of the law abiding concepts, it implies employees see maltreatment as "normal." It extends lines of research examining bureaucratic forces and their influence on nursing homes. It also provides a history of elder care in the UK and US and a review of structural ritualization theory. Findings concentrate on how rituals involving hierarchical structure, work efficiency, documentation, and rules adversely influence care homes. This includes physical maltreatment involving employee neglect of personal needs of residents, failing to provide medical help, bodily harm, and not maintaining quality living spaces.

KEYWORDS
Nursing home abuse; elder abuse; crimes of the law abiding; organizational deviance; structural ritualization theory

INTRODUCTION

One in three US nursing home residents experience elder abuse, and in the UK, 44 percent of senior maltreatment cases occur in care homes (BBC, 2013; Castle, Ferguson-Rome, and Teresi, 2013). Recently, New Yorker Cherrylee Young punched a resident causing him to fall on a piece of metal, which killed him (NBC, 2014). Karen Pedley of Carharrack, Cornwall, set a 96-year-old resident on fire (BBC, 2016). These cases are atypical. Most institutional abuse involves taken-for-granted work rituals that facilitate "crimes of everyday life" (Karstedt and Farrall, 2006:1011). Around 40 percent of nursing home employees have observed pushing, grabbing, shoving, kicking, and inappropriate feeding (Hillier and Barrow, 2015). Add other cases employees know of, and the number is 93 percent (Payne and Gainey, 2005).

Weber (1921/1968) predicted organizational dominance a century ago. He expressed concern with bureaucracy's impersonal interaction, rules, documentation, and hierarchy. Modern research reflects his trepidation (Griffin and Spillane, 2016; Linstead, Marechal, and Griffin, 2014; Ritzer, 2015; Vaughn, 1999). Everyday crimes of the law abiding relate (Karstedt and Farrall, 2006). These are morally dubious actions not always formally illegal, committed by people in traditionally reputable careers. Nursing home maltreatment applies. It is widespread, underreported, and often fails to carry deviant status within the walls of facilities (Miller, 2017). This article uses data from 75 biographies, autobiographies, and research monographs to explore law abiding crime in care homes. It gives a brief history of elder care in the UK and US, followed by a review of structural ritualization theory (SRT). Findings concentrate on how bureaucratic dynamics worsen care in nursing homes and specifically how they influence a standard that physical maltreatment is an accepted, typical part of organizational life.

A History of Elder Care and Nursing Homes

Aspects of elder care in the UK and US are similar (Kosberg and Garcia, 2013). Five percent of people over the age of 65 reside in care homes in the UK (Baldock, 2003) and seven percent in the US (Heffernan, 2003). This analysis primarily reflects experiences in these countries, so a history of elder care in them is relevant. Moreover, research implies that before scholars can comprehend crimes of the law abiding, it is necessary to understand preceding history (Karstedt and Farrall, 2006).

Local poor laws were the first to dictate elder care in the UK (Baldock, 2003). US Colonial policy was similar. Families provided care, but the aged also lived on local poor farms (Heffernan, 2003). The mid-1900s saw change. In the UK, public childcare facilities replaced workhouses, and workhouses became old folk's homes (Doyal and Pennell, 1979). After the mid-1940s, the National Health Service emerged and more government funds, along with formal health care trends, birthed care homes (Baldock, 2003). In the US, the 1935 Social Security Act provided qualified elderly up to $30 per month. Regulations prohibited institutionalized elderly from receiving money (Canterbury, 1938), but many lived with and paid nurses for services. This shift fueled normlessness and uncertainties about institutionalized care. The perceived credibility of the medical industry eased fears (Heffernan, 2003).

Mistreatment stories leaked in the 1960s. Government oversight increased, but lobby groups manipulated regulations. In the US, elder care expenditures increased to $1.3 billion by 1965 (Giacalone, 2001). Citizens push back when market shifts create unfair treatment (Karstedt and Farrall, 2006). In the UK, advocates helped to establish new laws for single resident rooms and central heating, but there was little impact (Lievesley, Crosby, and Bowman, 2012). In the US during the 1980s, new intricate rules and associated costs hurt small facilities. Large homes became the norm (Johnson and Grant, 1985). In the UK, more provisions to for-profits helped them soon comprise an 85 percent share of the industry (Lievesley et al., 2012). Again, reformers demanded change. The US passed the Omnibus Budget Reconciliation Act (OBRA) in 1987 (Filinson, 1995). It stipulated residents be free of corporal punishment, overmedication, and physical restraints (Riekse and Holstege, 1996). State inspection arms emerged (Ulsperger, 2002). UK advocates wanted similar legislation (Hughes, Lapane, and Mor, 1999). It did not come. The Department of Health did establish the Commission for Social Care Inspection. The Care Quality Commission replaced it in 2009 (Lievesley et al., 2012). In the US, oversight now occurs through states via the federal Centers for Medicare and Medicaid Services (Heffernan, 2003). Agencies in both countries focus on staffing, service compliance, and provide facility ratings reports (CQC, 2017; Nursing Home Compare, 2017).

Ombudsman programs in the US have volunteers visit residents. They provide information to Adult Protective Services or law enforcement. Interestingly, many ombudsmen do not believe a majority of resident maltreatment necessitates prosecution (Payne and Berg, 2003). Regardless, what about those providing hands on care? How can they know about maltreatment and not report it? How can they engage in it and view it as acceptable? Law abiding criminals navigate "moral mazes" of ambiguity (Karstedt and Farrall 2006:1013). The shifting nature of elder care has turned the aged into objects of profit, but it has also increased employee dependence on bureaucratic logics that normalize maltreatment.

Structural Ritualization Theory

Structural ritualization theory (SRT) focuses on taken-for-granted rituals (Knottnerus, 2011). Ritualized symbolic practices (RSPs) provide groundwork. These are regular social

and personal actions with symbolic meaning. They can involve non-criminal and criminal practices (Knottnerus, 1997).

Repetitiveness, salience, homologousness, and resources are pertinent. Repetitiveness is "relative frequency with which a RSP is performed" (Knottnerus, 1997:262). Consider variation by setting - home versus work setting or that some rituals occur multiple times per day. Salience is the "degree to which a RSP is perceived to be central to an act, action sequence, or bundle of interrelated acts" (Knottnerus, 1997:262). Homologousness is "perceived similarity among different RSPs" (Knottnerus, 1997:263). Different RSPs exist, but if similar they fortify each other. Resources are "materials needed to engage in RSPs which are available to actors" (Knottnerus, 1997:264). With certain resources, higher likelihood of RSP involvement exists. Resources involve time, clothing, money, or any other physical items, but also traits like intellect or physical ability (Knottnerus, 2011). Rank concerns "standing of a RSP in terms of its dominance" (Knottnerus, 1997:266). High rank, and a bigger impact, exists when a RSP has repetition, is important, similar to other RSPs, and actors have resources to engage in it (Knottnerus, 2011). Consider Enron.

As a corporation, Enron created an "invisible foundation" of moral standards (Karstedt and Farrall, 2006:1013). In reality, rituals involving risk, personal gratification, excessive pride, and the use of fictional imagery, along with unethical actions, characterized it. These RSPs happened often, were similar, and overlapped. Acknowledging intelligence as a key resource, employees regularly lied to customers. They received monetary benefits for it and tricked themselves into believing failure was impossible. Framing their actions in terms of fictional anti-heroes helped them normalize illicit behavior (Knottnerus et al., 2006).

Besides Enron research, a number of SRT studies exist (see Liang, Knottnerus, and Long, 2016; Sen and Knottnerus, 2016; Ulsperger, Knottnerus, and Ulsperger, 2017; Ulsperger et al., 2015). They have potential to help us better understand bureaucracy (see Edwards and Knottnerus, 2007; Guan and Knottnerus, 2006; Minton and Knottnerus, 2008; Sell et al., 2000). They help us better understand leadership and unnecessary death (Knottnerus, 2023; Ulsperger 2022). They can also help our understanding of crime-related behavior.

Lanier and DeVall (2017) believe certain RSPs elevate success in drug treatment programs. Ricciardelli and Memarpour (2016) argue prison inmates create RSPs to manage objectification (see also Bottoms, 1999). Correctional officers do too. Pressured to follow bureaucratic standards, they self objectify and subsequently engage in policy violations to manage work stress (Memarpour and Ricciardelli, 2015). Ulsperger and Knottnerus (2009; 2011) suggest elder care employees participate in emotional and verbal abuse due to bureaucracy. This article adds to these studies with a "crimes of the law abiding" perspective.

RESEARCH METHODS

Studying organizational criminal behavior is problematic. Distrust of outsiders and observation effects alter behavior. In turn, qualitative researchers analyze documents reflecting actor experiences with techniques such as literary ethnography (Copes, 2012). A literary ethnography involves systematic, intensive reading of literary texts for a composite portrait of social phenomena. It involves six stages. Researchers identify a scope of multiple sources, read and interpret them, identify themes, classify themes, develop applicable analytic constructs, and finally reread sources for confirmation (Van de Poel-Knottnerus and Knottnerus, 1994). Researchers can examine novels, short stories, plays, fictionalized autobiographies, biographies, autobiographies, memoirs, and diaries. Analysis

of meeting records and community reports is possible. Logbooks and conversation records are other options (see Lowenthal, 1989).

Content analysis parallels exist, but there are differences. Literary ethnography has required steps and emphasizes sources such as biographies. Moreover, content analysis is a broad label for communication examination. Literary ethnographies focus on written works (Hodder, 1994). Literary ethnographies are also different from meta-analysis ethnographies, which start with a focus on specific issues (Noblit and Hare, 1988). Literary ethnographies start with documents generally related to a topic, and subsequently streamline focus. They are also distinct because they move beyond surface level quantification and provide multiple interpretations of reality (Reid, 2016).

Analyzing Bureaucracy

Building on previous literature (see Ulsperger and Knottnerus, 2011), we found autobiographies, biographies, and research monographs ranging from 1963 to 2017 *(n* = 75). Fifty six percent came before the year 2000, and 44 percent after (see Appendix). Sources included works like Shield's (1988) *Uneasy Endings* and Diamond's (1995) *Making Gray Gold*. More recent materials like Sheard's (2016) *Caring* proved beneficial. We analyzed UK sources like Kayser-Jones' (1981) classic *Old, Alone, and Neglected*, with contemporary works like 'It Makes Me Feel that I'm Still Relevant' (Hall et al., 2012).

After initially adjusting to the materials by reading samples, discussions occurred on coding. Each researcher then deeply read sources independently while coding content. Considering Weber's (1921/1968) work and SRT, we grouped and applied the themes loosely at first. Each researcher made typed notes. This provided the ability to easily back up files and search for themes. This led to broad themes involving general social dynamics, work patterns, and maltreatment. We then coded specific themes to subdivisions with the aforementioned constructs of bureaucracy and SRT – see Table 1.

Bureaucratic RSPs were any aspect of the social environment and its processes involving staff separation and hierarchy, rules, documentation, and efficiency. Staff separation and hierarchy involved ritual dividing lines between employees. Rituals of rules involved references to official regulation on completing tasks. Documentation concerned recording aspects of care home life in written form. Efficiency involved demands for effective quickness. We used an open subdivision of "other" for late emerging themes. To rank bureaucratic RSPs, we focused on repetitiveness and salience. We used paragraphs and larger grammatical recording units, like book chapter portions. With our enumeration, each unit represented a RSP. We counted occurrences of RSPs to measure frequency. Not all units carried the same weight, so we also considered stated intensity to gauge salience.

Table 1. Bureaucratic RSPs

Subdivision	Number	Percent
Staff Separation and Hierarchy	974	36.1
Rules	647	23.9
Documentation	575	21.3
Efficiency	326	12.1
Other	177	6.6
Total	2,699	100

Analyzing Physical Abuse and Neglect

Abuse and neglect themes surfaced. For an analytic construct, we used Ulsperger and Knottnerus' (2011) and Castle et al.'s (2013) synthesis of nursing home maltreatment. We

grouped the themes and methodically tracked them - see Table 2. We included any act of personal negligence, medical dereliction, bodily harm, or environmental negligence.

Personal negligence concerned staff not providing resident upkeep, including clothing and personal hygiene. Medical dereliction involved not delivering medicine and services. This included using pharmaceuticals primarily to control a resident. Bodily harm incorporated actual physical abuse by staff toward residents and excessive restraint use. Environmental negligence related to employees not maintaining living areas, recreational rooms, kitchens, and facility grounds. We again tracked an "other" subdivision.

Table 2. Physical Maltreatment RSPs

Subdivision	Number	Percent
Personal Negligence	242	29.0
Medical Dereliction	208	24.9
Bodily Harm	132	15.8
Environmental Negligence	122	14.6
Other	131	15.7
Total	835	100

Intercoder Reliability

Again, early on researchers read large samples and collectively discussed categorization. We started with three researchers reading and interpreting sources. We then decided to have two researchers identify and classify themes, which gave the ability to develop a Cohen's kappa for agreement levels (Armstrong et al., 1997; McHugh, 2012). This value is easy to acquire when classifying objective, nominal data. However, literary ethnography focuses on latent, complex meaning. This was not conducive to Cohen's kappa (see Paul and Birzer, 2017). Avoiding circuitousness, we shifted to percentage agreement (Lombard, Snyder-Duch, and Bracken, 2002). Two researchers continued to read and code until an acceptable average of agreement existed. With disagreements, discussions with the third researcher produced case placement. We checked for intercoder reliability again during the final contextual confirmation. This involved rereading data samples for inconsistencies. To aid in trustworthiness, we discussed findings with others interested in nursing home issues, including resident's family members. This ensured the findings gelled with non-scholarly perceptions (for more see Ulsperger, 2009).

Limitations

An inability to test causal relationships quantitatively existed. In addition, we relied on prerecorded information and did not have the ability to follow up with people. The researchers' interpretive process may not reflect the totality of circumstances. As implied earlier, focusing on themes and constructs, some predefined, can also bias findings (Berg and Lune, 2017).

RESULTS AND DISCUSSION

Bureaucratization

We found 2,699 references to bureaucracy. Sources discuss RSPs of staff separation and hierarchy 974 times (36.1 percent), rule-based RSPs 647 times (23.9 percent), and documentation 575 times (21.3 percent). They reference efficiency rituals 326 times (12.1 percent). The "other" subdivision has 177 references (6.6 percent).

RSPs of staff separation have high repetitiveness and salience. Shield (1988) and McLean (2007) describe hierarchy reflecting administrative, medical, social services, and

nursing. Nurses, busy with charting, rarely have resident contact. Aides do hands-on work (Gaffney, 2012), but also have boundaries. With one source, residents looked forward to coffee. The activity director served it. Avoiding the area where the activity director served it, some residents stayed in their rooms and asked aides to bring them coffee. Aides, believing it was not their responsibility, would not serve it (Kayser-Jones, 1981). Similarly, prescribing medications is a physician's duty while nurses administer them. Aides sometimes question the drugs given, but nurses often dismiss concerns believing aides lack adequate knowledge (Dwyer et al., 2010). An aide notes in one source that she knows residents are getting the wrong drugs, but "if you've got no training you cannot interfere" (Hantikainen and Kappeli, 2000:1201).

We found a lower frequency of rule-related RSPs compared to staff separation. The quantity discovered still reflects a substantial amount and reveals salience. In one source, an aide indicates the abundance of rules leads to goal displacement arguing that rules become more important than providing benevolent care (Gass, 2004). In one source, residents even complain about "too many rules, regulations and routines" (Brandburg et al., 2013). In another, a resident states with so many regulations, "I feel so strangled here" (Howsden, 1981:144). Moreover, more rules always emerge. Foner (1994:68) points out, "A seemingly endless onslaught of new rules affected even the smallest details of work life. One day aides could wear jewelry to work; the next, after a memo went out, only watches, engagement and wedding rings."

Rules not part of official policy are a result of wider organizational regulations (Bresser and Millonig, 2003). This occurs for a variety of reasons, including practicality. Karstedt and Farrall (2006:1017) argue, "Too many rules and regulations decrease the legitimacy of norms and moral obligations, and create incentives for all to circumvent such obligations. To get things done citizens revert to illegal practices to cut red tape, which they deem justified…" In nursing homes, employees have unofficial decrees (Sandvoll, Kristofffersen, and Hauge, 2012). Gass (2004:57-58) points out that to move a resident a three employee requirement exists, but:

> We are routinely in violation of what we are told we must do… To get three aides together I must search for my partner, if I have one that day, and then walk a hundred feet or so over to another hall to recruit a willing and available aide. Now multiply this by the number of times each day that Bud may need to be toileted, changed, or bathed… While all of this is happening, someone on my hall is sitting in excrement, clamoring for a bath, or fighting against a bath…. You can see why I cheat.

With Sheard (2016:11), an aide discusses a resident call light going off above a DON and an administrator:

> It is a rule of the facility that you cannot leave the food cart unattended. At the same time, the resident needed to go to the bathroom… The administrator asked me if I saw the call light going off. I turned to him and said yes, but I can't leave the food cart unattended… When you are in orientation, what you hear is not what they really put into practice.

Informal rules can carry a menacing tone. An aide comments on an employee giving a scalding bath in one source. The problem was that the person should have known that "crazy patients are not punished for cursing aides," with hot baths, only ones with suitable mental capacity (Stannard, 1973:338).

The amount of RSPs related to documentation is similar to the rules subdivision, so substantial repetitiveness exists. With salience, employees state, "there is so much of it there is little time left to do anything else" (Farmer, 1996:20). Diamond (1995: 160) elaborates:

> Staff continually cursed at being overwhelmed with paperwork… They were a formality with force – made of forms, and forming the contours of the job, both in doing the prescribed work and in certifying that it had been done. Sometimes they formed the way we spoke. A nursing assistant once approached a charge nurse about a resident who had been at the home for two months and was crying out loudly in her room. "Is there anything I can do for her?" asked the nursing assistant. "Oh," said the nurse, immersed in the medications checklist, "don't worry about it, it's nothing physical, just emotional."

Consider top-level workers. In one source, an aide points out "Sometimes the doctors come in and write in the chart, but they don't go see the patient" (Kayser-Jones, 2002:15). A resident with decades of experience in nursing homes comments "required assessments and paperwork" are more important than residents (Gaffney, 2012:73). Documentation dehumanizes and creates an objectification that increases victimization (see Sgarzi and McDevitt, 2003). Gass (2004: 34) states:

> Harold is still in his right mind, but… we make all his choices for him… We count his heartbeats… We monitor and measure all sorts of body parts – the kinds of things state inspectors can check easily – but we cannot measure the man. So despite our best intentions, we leave Harold the person off the charts… We can make him do whatever we want. He's at our mercy.

Efficiency-based RSPs carry less quantitative weight than other subdivisions. This implies less influence, but many sources highlight their significant impact. Stress emerges for employees due to time (Nakrem, 2015). If low staff numbers exist, doing quick work is problematic, especially with reduced breaks for not completing assignments or refusals to pay overtime (Vinsnes et al., 2012). Staff feel they cannot "be in several places at the same time" (Hantikainen and Kappeli, 2000:1202). Fontana (1978:130) elaborates:

> There was usually a minimal number of aides on the ward, and in order to meet
> Administrative demands the aides would accomplish their daily assignments as quickly as possible… In the rushed meal hour, food was shoved down open mouths or splattered on closed mouths as the aides carried on without missing a beat. The aides broke the rules concerning good care, but it mattered little to them since the goal of efficiency was seemingly more important.

Employees sometimes prefer residents who are on feeding tubes due to the disruptions feeding creates (McLean, 2007; Pasman et al., 2003). Foner (1994:60) states:

> [Ms. James] had no tolerance for patients' resistance, which slowed her down… I overheard her explain, indeed justify, her approach… "Schmidt eats for me, but if anyone hears me they're gonna get me for patient abuse…" She once told a resident,
>
> "You eat… if you don't eat, I'm gonna…"

Themes of ritualized meetings surfaced late in the project. We classified them into an "other" subdivision. References imply that formal engagements involving facility staff and/or family members during work hours overload already busy schedules.

Physical Maltreatment

We found 835 references to physical maltreatment. Sources discuss RSPs of personal negligence 242 times (29.0 percent). They mention medical dereliction 208 times (24.9 percent), and bodily harm 132 times (15.8 percent). They reference RSPs of environmental negligence 122 times (14.6 percent). The "other" subdivision has 131 references (15.7 percent). RSPs of abuse and neglect stood alone in the sources, but as reflected with the subsequent information, they had connections to bureaucracy.

Personal negligence RSPs are highly repetitive. Sources also point to their centrality. Busy aides fail to clean or clothe residents. Laird (1979) details her disappointment when

an aide put a dress on a resident backwards. This could have been a mistake. However, Kayser-Jones (1981:46) explains:

> Mrs. White… had to wear a bathrobe tied backwards around her waist to simulate a skirt… Robes often are put on this way, staff informed me, to decrease the amount of work involved in changing an incontinent patient and to decrease the amount of laundry. If robes are put on backwards and not tucked under, they are not soiled when patients are incontinent.

Oosterveld-Vlug et al. (2013) discuss staff leaving residents partially naked for quickness (see also Duncan and Morgan, 1994).

Decent physical appearance of residents is a sign of well-being and poor hygienic care, along with neglected clothing, is routine (Gubrium, 1975; Vinsnes et al. 2012). Circling back to informal rules, Shield explains that if a resident is too demanding with personal needs, "In subtle and not so subtle ways, staff members neglect… doing things" (1988:159). Personal negligence can transition into medical dereliction. Gass (2004:26) describes finding residents lying in "soupy diarrhea." Acid from feces making burning patches into their skin. Mclean (2007) discusses a physician recommended bonnet to keep water out of a resident's ears. Aides kept it off. It slowed bathing. She also describes aides having personal conversations while feeding. "Inattentive to the fact she was spitting it out" the aide continued to "stuff food into her mouth" (McLean, 2007:194).

A lower frequency of RSPs involving medical dereliction exists, however the quantity is notable since it is slightly lower than RSPs of personal negligence. Moreover, medical dereliction appears a centralized practice. Kayser-Jones (1981:76) explains a nurse suggested glasses and a hearing aid for a resident and the doctor rejected her stating, "Oh well, she's old…" Nurses are at fault too. One admitted to Lopez (2007) that she did not give required medications to a suffering resident merely because a daughter did not want her to have them. Alternatively, providing too much is also problematic. Overmedication occurs with residents who engage in bothersome screaming related to psychological problems (Bourbonnais and Ducharme, 2010). These vocalizations inadvertently create medical abandonment for residents yelling legitimately. Gaffney (2012) discusses an insect in her bed biting her repeatedly. After extended yelling, staff came and explained they thought it was someone yelling for help who did not need it.

Nurses also medicate disruptive residents when aides recommend it. Gubrium (1975: 148-149) explains residents "Do not necessarily enter the Manor with physician's orders for tranquilizers. However, when aides define them as troublemakers, they get tranquilizers shortly after" and if "the nurses forget to sedate… concerned aides repeatedly remind them." Fontana (1978:128) explains the attribution of overmedication to other causes:

> The goal of the [facility]… was to provide a smooth-running schedule and flow of work, minimizing disturbances and avoiding trouble… Therefore if Maria, a wiry old patient, fell heavily to the ground after having been pumped full of Thorazine, the incident was dismissed as the result of an obfuscated mind and deteriorated body.

Bodily harm RSPs have lower frequency. However, examples of it are powerful. McLean (2007: 183) discusses administrator glorification of an aide:

> [The DON] felt that [aides] who took considerable amount of time to relate with those under their care were trying to avoid real work. That is why she preferred Rose... Rose managed the residents who got in the way of completing her care tasks by yelling, pushing, or holding down their hands so tightly that they became bruised. Such exercises of power over defenseless, failing elders damaged both bodies and spirits and raise the specter of immorality to which bioethicists have alerted us.

This type of aide is referenced as "real rough" in an interview with Tappan (2016:4). Sources also suggest that staff tie residents down for personal safety, but also when they disrupt schedules or need to save on expenses (Hantikaine, 2001; Henry, 1963). Paterniti (2000:106) explains:

> Out of frustration and a perceived need to keep Scott restrained, aides frequently tied a square knot in [his] nylon vest restraint… Some even remarked, "If you're a mechanic, let's see you get yourself out of this one!" On one occasion, an aide locked Scott, tied to a chair, in the janitors' closet. The aide entertained himself by keeping records of how long it took Scott to work his way out of the restraints…

When he was working as an aide, a resident told Diamond (1995) she did not need restraints. An LPN responded it was necessary because she did not have the money to pay additional aides.

More direct bodily harm examples exist. In a conversation with Tisdale (1987: 09), an employee says "Some are kind, some are cruel… They kick me, I kick them." Stannard (1973) explains, hierarchy keeps residents far removed from administrative workers. They may hear about physical harm, but they seldom actually see criminal forms of maltreatment firsthand. This creates a barrier to the normality of abuse. It also generates situations where employees sometimes let residents fight amongst themselves for amusement. An aide tells Sheard (2016: 40) that she was watching residents in a recreation area when a woman started hitting another. The aide says she just let them fight until things got so out of control someone called the police. Interestingly, family members do not always feel they can intervene without consequence. Kayser-Jones (2002:14) explains:

> A 93-year-old woman was admitted to the nursing home with ovarian cancer. The daughter found bruises on her mother's arms. At first, she did not want to ask the nurses about them because she feared retaliation. Later, she decided to report it… Now, she said: "They [i.e., nurses] don't talk to me; they never crack a smile; they never come in to say hello."

RSPs of environmental negligence appear in the sources at a similar percentage as bodily harm. Carrying a lower rank, references in the data did not emphasize environmental negligence, but did mention it in passing. Henry (1963) contends, in addition to violating health codes, it sends a message to residents that they are not worthy. Gubrium (1993:170) notes a state surveyor's comment, "I think that cleanliness is a problem. I think here roaches are a problem… This place has probably got as good roaches as I have ever run into…" Nakrem (2015:515) comments on areas that do not simply smell like urine, but "contaminated urine." Vinsnes et al. (2012:248) discuss "dirty floors" and "soiled chairs." This does not have to be the norm. Comparing nursing homes she lived in, Gaffney (2012) argues in some facilities, barrels of soiled laundry left around contribute to repugnant smells. In others, unpleasant smells are rare because employees take the time to store dirty linens in designated areas.

The "other" category of physical maltreatment includes limited supplies and inappropriate architecture. Examples involve unlawful behavior connected to facility safety. We do not believe they are applicable to the current analysis as RSPs. However, they are worthy of future study.

CONCLUSION

Not every nursing home employee engages in "law abiding" crime, but many accept abuse and neglect as a normal part of care (Hillier and Barrow, 2015; Payne and Gainey, 2005). This is concerning since more citizens need long-term care services now than ever (Lueddeke, 2016). As revealed with policy decisions during the COVID-19 pandemic, it is

also problematic when governmental leaders push for policies that elevate the likelihood of geriatric deaths in total institutions (King, 2021). SRT shows that care home employees operate in a milieu where bureaucratic rituals saturate daily life and inadvertently promote poor care. The highest-ranking aspect of bureaucratization involves staff separation and hierarchy, then rules, documentation, and efficiency. With hierarchy, employees perform duties only when they are their precise responsibility. Administrators and frontline workers develop different norms. Lower level employees sometimes accept neglect and abuse, and even view it as an appropriate punishment for work disruptions. Administrators may see maltreatment as wrong but avoid dealing with it because it does not cross their everyday paths. Cohesion created by staff separation leads aides to cover up maltreatment carried out by one of their own. Rule-based RSPs put burdens on workers, but they ignore rules of care and even create their own for practical purposes, even if they lead to unethical treatment. Documentation promotes victimization through objectification. It turns personal acts into statistical measurements. Moreover, demands for efficiency create an environment where fast labor trumps quality care. Bureaucratization relates to physical maltreatment. Physical neglect RSPs rank highest, then medical dereliction, bodily harm, and environmental negligence. Employees fail to provide physical upkeep of residents for many reasons, including efficiency. Staff members administer medical care inappropriately due to hierarchical disagreements or desires to control workflow. Similar bodily harm themes exist. Finally, employees fail to maintain living environments, possibly due to bureaucratic constraints.

Future research should revisit our source data. Reanalyzing RSPs by country would be interesting. Reanalysis of bureaucracy and maltreatment by year, employee gender, resident gender, race, and size of facility would also be good. A deeper analysis from an interactionist perspective would be fruitful, as would pre versus post COVID-19 pandemic examinations. What do employees think about avoiding labels associated with poor care? Can we find out more about what is happening with people in power who are distributing care labels? Moreover, if bureaucracy is truly producing crimes in nursing homes, what can we do to stop it?

Culture change models imply we can limit maltreatment with alternative RSPs involving staff empowerment and person-centered activities (see Berridge, Tyler, and Miller, 2016). However, some believe alternative RSPs do little to impede depersonalization (see Kao, 2013). Perhaps Weber (1921/1968) was right. Once bureaucratization takes hold, there is limited ability to stop the negative consequences. From a law abiding crime perspective, Karstedt and Farrall (2006:1029) believe people "hit back" when widespread victimization occurs. Research confirms this has occurred with care home maltreatment (see Ulsperger, 2002). However, stories about illicit behavior in nursing homes are becoming less common (Miller, Livingstone, and Ronneberg, 2016). It is possible people working in these institutions have normalized horrific acts against the aged, but now the general citizenry has as well.

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Appendix: Literary Sources

Source	Author	Year
Rosemont	J. Henry	1963
The Tower Nursing Home	J. Henry	1963
Muni San	J. Henry	1963
Old Folks and Dirty Work	C. Stannard	1973
Living and Dying at Murray Manor	J. Gubrium	1975
The Last Frontier	A. Fontana	1977
The Internal Order of a Home for the Jewish Elderly	Watson/Maxwell	1977
Ripping off the Elderly	A. Fontana	1978
Limbo	C. Laird	1979
Nursing Home Life	C. Bennett	1980
Nursing Home Housekeepers	J. Henderson	1981
Work and the Helpless Self	J. Howsden	1981
Old, Alone, and Neglected	J. Kayser-Jones	1981
The Reluctant Consumer	M. Vesperi	1983
It's OK Mom	J. Retsinas	1986
Goffman Revisited	M. Richard	1986
Harvest Moon	S. Tisdale	1987
Family Perceptions of Care in a Nursing Home	B. Bowers	1988
Social Networks, Social Support, and Elderly Institutions	B. Powers	1988
Self Perceived Health of Elderly Institutionalized People	B. Powers	1988
Uneasy Endings	R. Shield	1988
Anatomy of a Nursing Home	M. O'Brien	1989
Borders of Time	Crandall/Crandall	1990
The Ends of Time	J. Savishinsky	1991
Making Gray Gold	T. Diamond	1992
The Erosion of Autonomy in Long-term Care	Lidz et al.	1992
Speaking of Life	J. Gubrium	1993
Sharing the Caring	Duncan/Morgan	1994
The Caregiving Dilemma	N. Foner	1994
The Hidden Injuries of Bureaucracy	N. Foner	1995
Relatives as Trouble	N. Foner	1995
The Culture of Care in a Nursing Home	J. Henderson	1995
The Head Nurse as a Key Informant	McLean/Perkinson	1995
From the Inside Out	B. Powers	1995
In and Out of Bounds	J. Savishinsky	1995
Ethics in the Nursing Home	R. Shield	1995
A Nursing Home and Its Organizational Climate	B. Farmer	1996
Life at Lake Home	C. Wellin	1996
Television in the Nursing Home	W. Hajjar	1998
Expanding the Discourse of Care	Caron et al.	1999
Maudie	R. Metz	1999
A Qualitative Examination of the Similarities…	Payne et al.	1999
Using Restraint with Nursing Home Residents	Hantikainen/Kappeli	2000
The Micropolitics of Identity in Adverse Circumstance	D. Paterniti	2000
Emotional Labor as Cultural Performance	J. Sass	2000
Nursing Staff Perceptions of the Behaviour…	V. Hantikainen	2001
The Experience of Dying	J. Kayser-Jones	2002
Feeding Nursing Home Patients with Severe Dementia	Pasman et al.	2003
Nobody's Home	T. Gass	2004
Moving Forward Together	Aveyard/Davies	2006

The Nursing Home as Home	Hauge/Heggen	2007
Suffering and Dying Nursing Home Residents	R. Lopez	2007
The Person in Dementia	A. McLean A	2007
Three Nursing Home Residents Speak…	Dwyer et al.	2008
Preservation of Self in the Nursing Home	M. Ryvicker	2009
Comfort Measures	Waldrop/Kirkendall	2009
The Meanings of Screams…	Bourbonnais/Ducharme	2010
Nursing Home Residents' Views on Dying and Death	Dwyer et al.	2010
Life Stories and Biography	Kellett et al.	2010
I Hate Having Nobody Here	Cahill/Diaz-Ponce	2011
Residents' Experiences of Interpersonal…	Nakrem et al.	2011
Resident Strategies for Making a Life in a Nursing Home	Brandburg et al.	2012
Making Myself at Home in a Nursing Home	S. Gaffney	2012
It Makes Me Feel that I'm Still Relevant	Hall et al.	2012
New Quality Regulations…	Sandvoll et al.	2012
Quality of Care…	Vinsnes et al.	2012
Resident Strategies for Making a Life…	Brandburg et al.	2013
When Frost Happens	Kao	2013
Changes in the Personal Dignity of Nursing Home…	Oosterveld-Vlug et al.	2013
Nursing Home Staff's Views on Residents' Dignity	Oosterveld-Vlug et al.	2013
Quality of Life in Nursing Homes	Schenk et al.	2013
Understanding Organizational and Cultural Premises…	S. Nakrem	2015
Caring	T. Sheard	2016
They Know Me Here	R. Tappan	2016
This is My Life Now	S. Wood	2017

Note: Full referencing for all sources in this appendix is available by contacting the authors.