


Sexual Expression, Policies, and Practices in Skilled Nursing Settings Serving Older Adults: An Updated Assessment in the State of Kansas

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Abstract

Doll assessed sexual expressions, policies, and practices in Skilled Nursing Facilities (SNFs) in the state of Kansas. This study provided an updated and expanded assessment. A mixed-methods survey was distributed to administrators of all SNFs in the state of Kansas. Among 60 administrations, 84% reported any sexual expression among residents in their community within the past year and 55% reported expressions involving an individual with cognitive impairment. In response to sexual expressions, 70% of administrators believe staff would treat residents with dignity and respect and about 40% anticipated staff discomfort. About 40% of administrators reported having a policy related to sexual expression. Attitudes and responses of staff and administrators appear to be shifting in a sex-positive direction. While policies related to sexuality are more common than a decade ago, there is room for additional uptake, standardization, and infusion of person-centered language and practices.

Keywords

sexuality, intimacy, long-term care, healthcare administration, healthcare training

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Within the U.S., societal ageism informs the social exclusion of older adults, including exclusion from discussions around sexuality and sexual needs (Lichtenberg, 2014; Syme et al., 2016). Although many older adults remain sexually interested and active in later life, it is largely assumed that sexuality becomes irrelevant as individuals age (Lester et al., 2016), particularly among those receiving institutional care (Cornelison & Doll, 2012). Within this context, sexuality and intimacy in long-term care are at times considered problems to be dealt with rather than reasonable expectations of desiring and consenting adults (Lichtenberg, 2014). Additionally, issues related to mental or physical capacity to participate in sexual activity dominate the practice discourse, supporting a rhetoric of paternalistic protection or control (Syme et al., 2016).

Within skilled-nursing facilities (SNFs) in particular, where issues of liability and federal mandates necessarily inform policy and practice development, balancing the protection and self-determination of residents can be an ongoing struggle. Additionally, staff discomfort and avoidance around addressing issues about sexuality often lead to three practice approaches: (1) strict policies limiting or

completely outlawing any intimate activity (Bentrott & Margrett, 2017), (2) paternalistic policies that supposedly “protect” seniors or invoke traditional values of modesty without attention to self-determination (Lichtenberg, 2014), or (3) a complete silence around the issue in both policy and conversation with residents and their families (Lester et al., 2016). A 2016 survey found that in a national U.S. sample of SNF administrators, 63.4% reported having no policy in place to address sexual or intimate behavior despite a high prevalence of sexual activity among residents (reported in 71.2% of SNFs; Lester et al., 2016). The assumed asexuality of older people allows for common practices in long-term care to include paternalistic redirection of resident’s sexual desires, the absence of privacy, or requiring the approval of a family member to allow sexual activity even for cognitively intact residents,

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all of which may be damaging to the dignity and self-determination of the resident (Lester et al., 2016). These practices may also effectively eliminate any possibility of intimate, loving, and sexual encounters that residents often desire despite the fact that sexual and intimate connections provide irreplaceable physical and mental health benefits (Hillman, 2012; Miles & Parker, 1999) such as decreased stress, depression and anxiety, and improved immune function and self-esteem (Levin, 2007).

Even where restrictive policies are absent, societal ageism and the assumptions and values of staff may interfere with sexual expression. Among residents of SNF's, individuals who are not sexually active report being deterred by staff members' negative attitudes toward sex, feelings of guilt, and feeling undesirable (Langer, 2009). Facility administrators may avoid engaging in direct conversations around sexual activity or needs (Lester et al., 2016) while staff often receive little training in negotiating opportunities for privacy and intimacy (Zeiss & Kasl-Godley, 2001) and express discomfort when discussing sexuality with residents (Mahieu et al., 2011). Additionally, the boundaries of acceptable sexual behaviors are often left to the discretion of facilities and subject to the values of staff, which typically uphold long-term, monogamous, heterosexual couplings of married individuals as the only acceptable context for sexual engagement among older adults (Bentrott & Margrett, 2017; Cornelison & Doll, 2012).

Only recently have facilities begun to incorporate sexual needs into their intake assessments, trained staff on sexuality in later life, or provided interventions into creating safe and positive environments for promoting sexual wellness among residents (Lester et al., 2016; Syme et al., 2020). Despite recent advances toward more sexual permissiveness informed by a person-centered care perspective (Syme et al., 2020), relationships, or behaviors that are deemed non-normative continue to be less supported, such as encounters involving individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ; Cornelison & Doll, 2012). For instance, in a study of 218 long-term care staff, participants were more likely to respond negatively to hypothetical same-sex sexual vignettes when compared to heterosexual vignettes (Hinrichs & Vacha-Haase, 2010).

Another realm of behavior that raises unique concerns includes sexual acts or relationships involving individuals living with dementia, which tend to raise important issues around consent and protection (Bauer et al., 2014; Lennox & Davidson, 2013; Makimoto et al., 2015; Syme et al., 2017; Victor & Guidry-Grimes, 2019). This area of discussion brings several complications to the fore, as the surrounding literature requires attention to issues of consent, liability, resident rights, permission of responsible parties, and facility policies (Bauer, 2014; Syme et al., 2017). Researchers tend to agree that there is a need for standardized policies in this area, with some arguing for person-focused approaches, such as allowing residents to engage in sexual acts without restrictions from staff and

family members in support of self-determination while also providing protections from non-consensual sexual acts (Lennox & Davidson, 2013; Victor & Guidry-Grimes, 2019).

In order to assess the context of sexual policies and practices in SNFs, Doll (2013) completed a survey of administrators in the state of Kansas to investigate the scope of sexual expression in SNFs, attitudinal and behavioral responses to these expressions among staff and families, and the presence or lack of policies related to sexual expression among residents. Among 91 participating facilities, 85% reported some sexual expression among residents in the past year with the most common behaviors including sexual acts of masturbation, intercourse, or groping and sexual talk (i.e., using sexually explicit language). Staff's most common reactions to sexual expression among residents were to ask a supervisor for instructions (reported by 68.9%), try to respectfully support the resident (51.1%), follow the facility policy (41.1%), respond with disgust (32.2%), ignoring the issue (27.8%), or to panic (20%). While over 40% reported that staff would follow the facility policy in response to sexual expressions, only 26% of administrators stated that there was a policy related to sexual expression in place. When asked to state the content of these policies, a majority of respondents cited the residents' right to privacy, but policies were rarely related specifically to issues of sexuality. While the findings indicate areas of need in terms of greater staff awareness around issues related to sexuality and policy development, we have yet to see if such steps have been taken or whether attitudes, practices, and policies have changed in the past decade. There is also room to build greater specificity into this assessment to gain greater insight into ongoing areas of needed attention.

The purpose of the present study was to provide an updated assessment of sexual expressions, staff reactions, practices, and policies in place related to sexuality in SNFs in the state of Kansas. This study also builds on the original study to gain greater detail around staff responses and attitudes toward sexual expression among LGBTQ residents and those living with dementia.

Methods

Sampling and Data Collection

Study procedures were reviewed and approved by the the University of Kansas Human Subjects Division. To recruit study participants, a full list of long-term care facilities in Kansas was developed including the contact information of one administrator from each facility. Survey invitations were circulated via email to administrators from all 364 long-term care facilities in June of 2020. For those facilities for which email addresses could not be identified, hard copies were mailed with a prepaid return envelope. A second survey invitation was emailed to those who had not yet completed a survey after 2 weeks. For those who did not complete an

electronic survey after two attempts, a hard copy was mailed to the facility after an additional 2 weeks. Of 364 distributed surveys, 60 were returned (51 online and 9 hard copies) for a response rate of 16.5%. Surveys took approximately 10 to 15 minutes to complete and all participants were eligible to enter a drawing to receive 1 of 6 \$100 gift cards.

Measures

Survey questionnaires consisted of items in five substantive categories, (1) type and frequency of sexual expression; (2) attitudes of administrators toward residents' sexual expression; (3) staff responses and practices related to sexual expression among residents; (4) current policies in place related to sexual expression; and (5) topics addressed in prior staff trainings related to sexuality. The survey included 48 close-ended items and 26 open-ended items, including offering space for open-ended comments following each subsection of the survey ($n=7$). Many items were adopted directly from the first survey (Doll, 2013) with slight variations in wording for clarity or expansion to response categories. We also added to the original survey by expanding measures assessing: staff attitudes toward residents' sexual behaviors (including among residents living with dementia and LGBTQ identities), staff practices, areas of prior staff training and needed future training, and demographic characteristics of participating administrators in addition to characteristics of facilities. Additions and revisions to the survey were informed by conversations with the Primary Investigator of the study by Doll (2013) based on lessons learned from the original assessment. The survey was also originally designed prior to the onset of the COVID-19 pandemic. Due to the onset of the pandemic, the initial set of questions on sexual expressions and their frequency were adapted to reflect expressions during the year of February 2019 to February 2020 as opposed to their original wording which referenced "the past year." This adjustment was made as the pandemic likely limited sexual expression among residents due to their being isolated from one another, therefore reflecting atypical rates of sexual expression and contact. No other questions were adapted due to the pandemic onset.

Sexual expression and behaviors. Participants were asked to indicate whether the following sexual expressions had occurred in their facility in the year of February 2019 to February 2020: (1) sexual talk; (2) individual sexual acts; (3) interactional sexual acts; (4) sexual relationships; (5) implied sexual acts; (6) any sexual expression including an individual living with cognitive impairment or dementia; and (7) substantiated or false allegations of sexual abuse perpetrated by a resident or staff member toward another resident or staff member. While incidences of sexual abuse are not considered to be appropriate expressions of sexuality, these allegations were included in the survey as prior incidences of

reported abuse may inform administrators' perspectives on sexual expression and concerns over issues of liability. Participants also reported the frequency of any type of reported sexual expressions which occurred in the same time period, ranging from "more than once a week" to "less than every 3 months."

Attitudes of administrators. In order to measure administrator attitudes toward residents' sexual expression, three items were included from the Ageing Sexuality Knowledge and Attitudes Scale (ASKAS) developed by White (1982) asking to what extent participants agreed with the provided statements, such as, "Older people generally have little interest in sexuality or sexual expression." Also included were four items from the Staff Attitudes about Intimacy and Dementia (SAID) Survey (Kuhn, 2002), which asked to what extent administrators agreed with statements such as, "Competent and consenting residents are entitled to sexual expression." All seven items were assessed using a 4-point Likert scale (1=strongly agree and 4=strongly disagree).

Staff responses and practices. Participants were asked to select staffs' typical responses to residents' sexual expression from a provided scale which included both practices and emotional reactions, including: inform a supervisor, ask for supervisor suggestions/directions, follow the facility policy, ignore the issue, try to support residents in their situation, treating residents, and their situation with respect, disgust, embarrassment, panic, and discomfort. While many of these options were listed in the prior survey, we included items to differentiate between treating residents with respect versus supporting their needs and to the more extreme emotional reactions of disgust and panic, we added the reactions of embarrassment and discomfort. Administrators were also asked if they believed their staff would respond differently in cases of sexual expression among LGBTQ residents and residents experiencing cognitive impairment or dementia. In both instances, they were asked to explain their answer in an open-ended text box. Participants were also asked to report typical reactions and actions of residents' family members or other responsible parties, including: supportive of administrator/staff actions, unsupportive of administrator/staff actions, anger, disgust, indifference, supportive of the resident's sexual desires, or unsupportive of the resident's sexual desires.

Policies around sexual expression. Participants were asked whether they had a policy addressing sexual expression in their facility (yes/no). If they had a policy, participants were asked to provide the wording of the policy and to identify who was involved in developing the policy including: administration, social workers, direct care staff, residents, residents' families or other responsible parties, long-term care ombudsmen, department on aging, or a consultant. Participants who reported having a policy were also asked

if the policy addressed issues related to: residents' rights, assessment of residents' sexual desires, documentation of residents' sexual desires, consent, cognitive impairment, confidentiality, appropriate staff actions, staff training, and documentation of sexual needs in ongoing care planning. If administrators reported that they did not have a policy, they were asked if they had considered forming one and who would be involved in its development, including the same options as for those who did have a current policy.

Participants were asked to report how often staff had been trained in: sexuality and/or sexual health among older adults, impacts of cognitive impairment or dementia on sexual expression, identifying possible signs of sexual abuse, and approaches to the provision of privacy. Possible responses included: never, once, and more than once. They were then asked to report any additional areas of needed training.

Characteristics of facility and administrator. Lastly, participants reported the characteristics of facilities including the number of current residents, the average age of residents, the percentage of residents who were women, Medicaid funded, LGBQ-identified, transgender-identified, individuals of color, cognitively impaired, and aging alone (without significant family or friends to inform their care). They were asked if their facility was affiliated with a chain, religiously affiliated, or located in a rural location and whether it was for profit, non-profit, or government owned. Participants were asked to provide their demographic information including age (from a list of age ranges), ethnic identity, racial background, gender identity, whether they identified as transgender, sexual orientation, and years worked in their current position (options included 1–5, 6–10, 11–15, and 16+ years).

Data Analysis

Descriptive statistics were analyzed using SPSS data analysis software (Version 25). Open-ended questions were examined for common responses, patterns in responses, and notable mentions or exclusions to supplement the quantitative analysis.

Results

Sample Characteristics

The final sample included 60 SNF administrators. Of the included facilities, 24 (48.0%) were affiliated with a chain, 9 (18.8%) were religiously affiliated, and 34 (70.8%) were located in a rural area. About half of the facilities were for-profit (45.5%). Their number of residents ranged from 21 to 156 with 57 residents on average. Of the administrators sampled, 75.0% were non-Hispanic White individuals and 61.7% were female. About 40.0% of individuals had been in their current position for 1 to 5 years ($n=24$), 13.3% for 6 to 10 ($n=8$), 6.7% for 11 to 15 ($n=4$), and 23.3% for 16 or more ($n=14$). Residents'

Table 1. Characteristics of Residents in Surveyed Facilities.

Characteristics	M (SD) or %
Resident age	75.4 (17.6)
Percentage of residents	
Medicaid funded	63.2 (18.7)
LGB-identified	1.5 (5.5)
Women	66.8 (15.5)
Racial/ethnic minority	13.0 (20.7)
Cognitively impaired/living with dementia	49.9 (23.6)
Aging alone	16.0 (17.5)

average age was 75.4 ($SD=17.6$) and the majority were women (66.8%) and received Medicaid funding (63.2%), and half were cognitively impaired or living with dementia (49.9%). See Table 1 for additional resident characteristics.

Sexual Expression and Behaviors

In regard to sexual behaviors, 50 (84%) administrators reported the occurrence of any sexual expression in their facility within the past year. The most common forms of behavior reported included sexual talk ($n=39$, 67.2%) and individual sexual acts ($n=37$, 62.7%), which were more common than implied sexual acts ($n=27$, 45.8%), interactional sexual acts ($n=20$, 34.5%), sexual relationships ($n=16$, 27.1%), and substantiated or false allegations of sexual abuse perpetrated by a resident or staff member toward another resident or staff member ($n=15$, 25.4%). Over half reported sexual expressions that included a resident living with some stage of cognitive impairment ($n=32$, 55.2%). In terms of frequency of any sexual act, almost half reported that sexual expressions occurred less than every 3 months ($n=28$, 48.3%), 11 (18.0%) reported that acts occurred once every 2 to 3 months, and 20 (33.3%) reported that acts occurred once a month or more.

Staff and Family Responses and Attitudes

Staff responses to sexual expressions among residents can be found in Figure 1. When made aware of sexual expressions among residents, administrators anticipated that their staff's most common responses would be to inform a supervisor ($n=46$, 76.7%), ask for suggestions or instructions from a supervisor ($n=43$, 71.7%), and to treat the resident(s) with dignity and respect ($n=42$, 70.0%). About half anticipated that staff would follow the facility policy regarding sexual expression ($n=33$, 55.0%) or try to support the resident's needs ($n=31$, 51.0%) and only 4 (6.7%) believed staff would ignore the issue. Of emotional reactions among staff, the most anticipated response was discomfort reported by 25 administrators (41.7%), followed by embarrassment ($n=21$, 35.0%), panic ($n=8$, 13.3%), and disgust ($n=2$, 3.3%). When asked how family commonly responded to

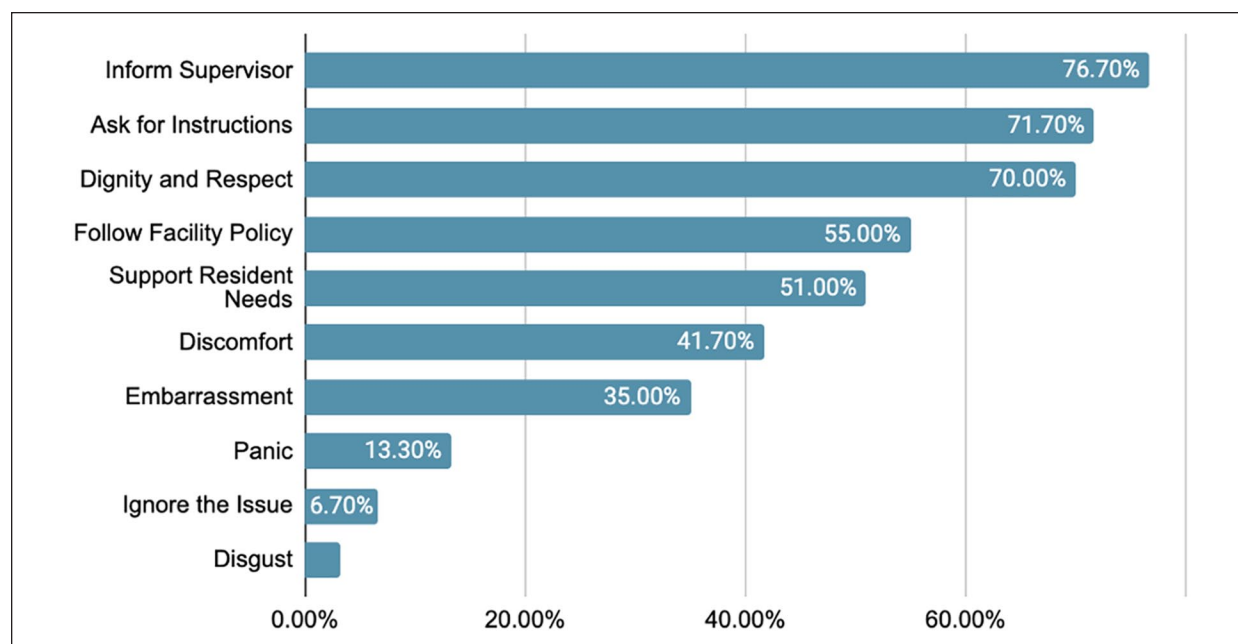


Figure 1. Staff responses to resident sexual behaviors.

residents' sexual expressions, administrators reported negative emotional responses of indifference ($n=23$, 15.0%), anger ($n=13$, 8.5%), and disgust ($n=12$, 7.8%). In terms of actions, 36 (23.5%) reported that families were supportive of staff or administrator's actions while 11 (7.2%) were not and 27 (17.7%) reported that families were supportive of the resident's sexual desire while 31 (20.3%) were not.

Residents With Cognitive Impairment and LGBTQ Identities

When asked if staff would respond differently in cases involving residents living with cognitive impairment, 44 (72.1%) said "yes" and 13 (22.8%) said "no," with almost all citing issues with consent or competency, stating that staff would "view this as non-consensual." Several also cited the need to "protect" residents or "prevent them from being taken advantage of" and two cited strict regulations and serious punishments when sexual activity has occurred in such settings in the past.

When asked if staff would respond differently in cases where a resident identified as LGBTQ, 19 (34.6%) said "yes" and 36 (65.5%) said "no." When asked to explain their answer, those who indicated that staff would not respond differently stated the need to "treat each individual the same, regardless of sexual orientation" and cited increasing diversity among staff as increasing comfort with diverse resident identities: "we have a very diverse staff who are from every walk of life so these identities are not out of the ordinary." Among those who believed their staff would respond differently to an LGBTQ-identified residents' sexual expression, most cited potential discomfort among staff due to a lack

of exposure to LGBTQ identities in general, such as one administrator who stated, "We currently do not have any residents who are open about being LGBTQ+. I think there would be increased panic, discomfort, disgust. They might not treat the resident with the same respect and dignity." Another stated, "We are in a rural small community and honestly there is little acceptance of anything different than the norm." One respondent disagreed with the inclusion of the survey question, stating, "Staff would respond differently because they are not used to being around it as much. I really do not appreciate this agenda-based question." Facilities in a rural or less populated area were slightly more likely to say that staff would respond differently to expressions of an LGBTQ resident than the overall sample (38.2% compared to 34.6%, respectively) while those affiliated with a chain were somewhat less likely to say that staff would respond differently (29.2%).

Administrator Attitudes

In terms of administrator attitudes, in response to the statement that "older people generally have little sexual interest," a large majority disagreed ($n=33$, 56.9%) or strongly disagreed ($n=12$, 20.7%). The majority agreed ($n=30$, 51.7%) or strongly agreed ($n=19$, 32.8%) that it was the responsibility of administrators and staff to support sexual expression. In situations involving individuals with cognitive impairment, 93.1% of administrators believed that competent and consenting residents were entitled sexual expression while 63.4% agreed or strongly agreed that residents living with cognitive impairment "cannot make sound decisions regarding sex." When asked if "staff should

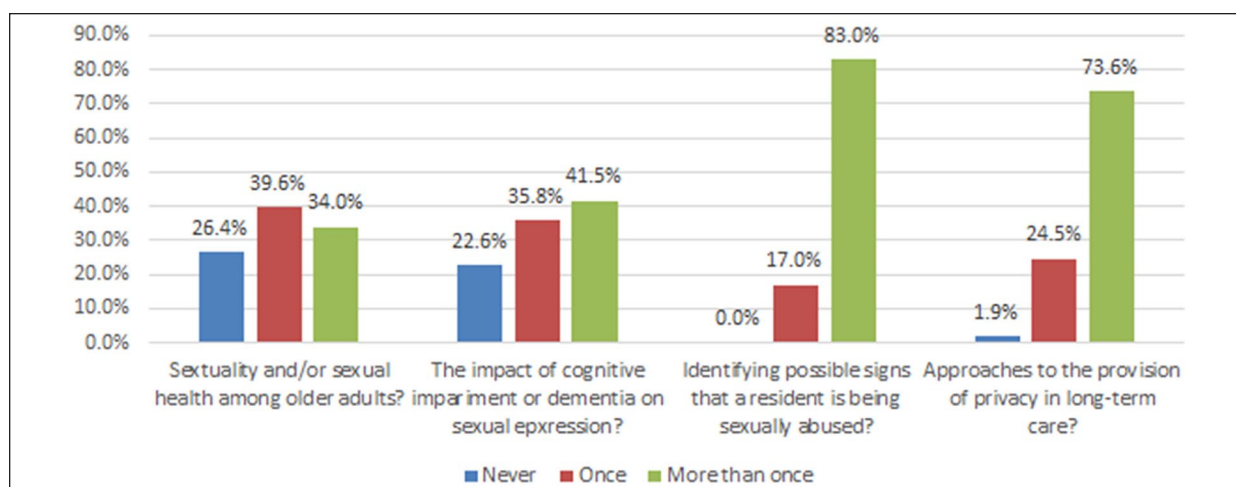


Figure 2. Past training efforts in surveyed facilities.

provide a private place so as to allow a male and female resident to engage in sexual activity even if both of them are mildly impaired due to dementia,” results were relatively more mixed with 31 (55.3%) agreeing ($n=26$, 46.4%) or strongly agreeing ($n=5$, 8.9%), and 25 (44.3%) saying they disagreed ($n=23$, 41.1%) or strongly disagreed ($n=2$, 3.6%). There was greater consensus around the item, “A couple, with one spouse or partner living at home and one with dementia residing in a care community, is entitled to be sexually intimate even if the person living with dementia appears unable to give consent.” In this case, the majority disagreed ($n=29$, 53.7%) or strongly disagreed ($n=10$, 18.5%).

Facility Policies and Training

When asked whether their facility had a policy regarding sexual expression, 22 (40.0%) said they did. Facilities that were somewhat less likely to have a policy were those located in a rural or less populated area ($n=11$ out of 34, 32.3%), those affiliated with a chain ($n=8$ out of 26, 30.1%), and religiously affiliated facilities ($n=2$ out of 9, 22.2%).

When asked to provide the wording of the policy, the majority offered brief summaries including coverage of issues related to consent and privacy, such as: “Mutual consent must be present. We are to provide privacy to the best of our ability and we will perform any assistance within the scope of our regular duties.” Several also added attention to non-discrimination policies regarding sexual orientation and a few addressed the right of couples to share rooms if desired by both individuals. One religiously affiliated facility’s policy limited sexual conduct to married couples: “Our policy is related to married couples only as we are a Christian and a church-related facility. The policy is discussed with residents prior to admission so that those with other beliefs can choose to go elsewhere.”

Of those involved in developing an existing policy, the stakeholders most commonly included were administrators ($n=17$), social workers ($n=12$), and direct care staff ($n=10$), followed by residents ($n=5$), residents’ families ($n=5$), a consultant ($n=5$), long-term care ombudsman ($n=4$), and the Department on Aging ($n=4$). Policies most commonly addressed resident rights (100%), followed by staff actions, documentation of ongoing care planning, and issues related to cognitive impairment and consent (94.7%), confidentiality (89.5%), staff training (84.2%), and assessment and documentation of sexual desire (79.0%). Among those who did not have a policy in place, 19 (59.4%) reported that they had considered developing one.

Figure 2 summarizes past staff training efforts, with the most common topics of training related to sexuality being identification of signs of sexual abuse and issues pertaining to provision of privacy, with 100% and 98.1% reporting that these trainings had been offered once (16.9% and 24.5%) or more than once (83.0% and 73.4%), respectively. Rates of training around sexuality or sexual health and the intersection of sexuality and cognitive impairment fell to 73.6% and 77.4% having been offered once (39.6% and 35.9%) or more than once (34.0% and 41.5%), respectively. In terms of needed areas of future training, administrators suggested the need for training around the intersection of sexuality and resident rights, “regulatory guidance” around sexuality, and added training for families in addition to staff.

Discussion

While sexuality continues to be an underdiscussed topic in SNFs, the findings of this survey provide an updated assessment on sexuality-related expressions and policies, staff and family responses and training, and administrator attitudes. Overall, findings indicate that attitudes and emotional responses of staff have shifted in a more

sex-positive and supportive direction and policies are more common; however, staff actions remain more similar to those reported in 2013, the majority of facilities do not have specific policies in place, and those that exist are varied in their coverage. Staff training around sexuality are also focused more so on issues related to liability than the broader experience of sexual expression and there is evidence to suggest that sexual expressions of LGBTQ residents will provoke different, and at times discriminatory responses.

Compared to the last state-wide report in Kansas which was completed in 2013, the rate of reported sexual behaviors among residents was similar, with 84% of administrators reporting any sexual behaviors or expressions in their facility within the past year compared to 85% in the prior assessment (Doll, 2013). However, individual sexual behaviors were reported less frequently, such as sexual talk which was reported by 67% of facilities, down from 85%, and implied sexual acts which were reported by 46%, down from 60%. Although the topic of sexuality has gained more attention in recent years, the rhetoric around the topic has come to be quite focused on issues related to liability and consent. If this framing of sexuality is impacting the ways in which administrators and staff discuss sexual expression with residents in SNFs, it is possible that sexual behaviors have been deterred by such discourse over the past decade.

In contrast, there is reason to believe that attitudes around sexuality have become more supportive of sexual expression among both administrators and staff. Anticipated emotional reactions among staff in response to resident sexual behavior included disgust, which was reported by almost one-third of administrators (32.2%) or panic, which was reported by one-fifth of participants (20.0%) in 2008. In contrast, the percentage of administrators anticipating disgust among their staff in 2020 fell to just over 3% and 13.3% anticipated responses of panic. These more extreme negative emotional reactions may have been largely replaced by those of embarrassment and discomfort which were reported by a little over one-third of participants in 2020, although data on these less extreme reactions were not collected in the prior survey.

In terms of behavioral responses among staff, while just over half (51.1%) reported that they would try to respectfully help a resident seeking sexual expression in 2008, this measure was broken out into two distinct outcomes in the following survey. In 2020, 70.0% of staff were anticipated to treat the resident with dignity and respect, but this support fell to only half (51.0%) who were anticipated to take action to support the residents' needs. This finding indicates that while attitudes and emotional responses may have shifted in a more positive and supportive direction, staff remain less inclined to act in support of these resident desires. It is also possible that staff wish to support residents, but are unsure of next steps to take, as indicated by continued high rates of administrators anticipating that staff will ask for

direction or instructions. Findings also indicate that staff are likely to follow a facility policy in more than half of cases, which is a higher percentage than those which report having a policy. One new area of findings that this survey contributes to the prior assessment are those items indicating administrator attitudes around sexuality, which may offer more nuanced interpretation of the reported patterns in staff actions. Although the vast majority of administrators agreed that it was the responsibility of staff and administrators to support residents' sexual needs, these two findings indicate that there may be a mismatch between attitudinal and behavioral support. This is also reflected in the fact that the most disagreement among administrator attitudes was evident in perceptions of whether staff were responsible for providing access to privacy for sexual connection between two residents with minor cognitive impairment.

Another way to interpret this disagreement is through the lens of heightened sensitivity to sexual expression involving residents with cognitive impairment. The vast majority of participants believed that staff would treat individuals with cognitive impairment differently than those who were cognitively intact, often citing the need to protect these individuals and ensure consent. Trainings have also focused more so on regulatory and liability-related issues, where 100% of staff have been trained in identifying signs of sexual abuse and nearly all have been trained one or more times on provision of privacy. Such coverage in training and interpretations of administrators on issues related to consent indicate that the need to protect such residents is a commonly held belief and one which is federally-mandated, as reflected by reports of strict regulations and punishments in cases where residents have not been adequately protected. The commonly held perception of vulnerability is certainly warranted in this case and is likely informed by both federal mandates and widely publicized cases that have attended to such issues of consent and cognition over the past decade (Syme et al., 2017).

In addition to residents living with cognitive impairment and dementia, there is prior empirical evidence to suggest that LGBTQ-identified residents are also a vulnerable population in skilled nursing settings. In the case of LGBTQ individuals, however, vulnerability takes the form of the potential for facing discriminatory practices, which may result in ineffective or harmful healthcare services (SAGE & HRC, 2020). Older LGBTQ individuals have also reported a fear of discrimination in such settings, which may cause an individual not to disclose their sexual orientation or gender identity (Putney et al., 2018; Sullivan, 2014). The findings of this study are consistent with prior literature (Cornelison & Doll, 2012; Hinrichs & Vacha-Haase, 2010; Putney et al., 2018) indicating more negative attitudes toward and discomfort surrounding sexual expressions among LGBTQ-identified residents. There is also potential for discriminatory practices, as evidenced by comments suggesting that staff may be less likely to treat LGBTQ residents with respect or dignity.

Overall, there is reason for optimism in terms of development toward more sexually positive and supportive policies and practices. However, there also remains room for continued improvement. While attitudes toward sexual expression appear to be better aligned with person-centered care practices, the continued focus on issues surrounding liability and consent appear to dominate training provision. Successfully balancing the self-determination of residents with the federal mandate to protect residents may require more nuanced and comprehensive policies and trainings that address sexual expression in a broader way, as opposed to focusing solely on the provision of privacy and identifying sexual abuse. Additionally, while attitudes are changing, there remains ambiguity in terms of how ready administrators and staff might be to take action to support sexual expression. Findings indicate a concerning potential for discriminatory practices targeting LGBTQ residents as well as a continued discomfort around sexuality-related issues specific to this population. Trainings specific to LGBTQ cultural awareness may positively impact staff attitudes in this regard. As the findings indicate, hiring LGBTQ staff may also prove to be an effective strategy in terms of foster greater awareness of such identities among the staff at large and better supporting the needs of LGBTQ residents.

This study has notable limitations which may impact the generalizability of findings. First, the context of the pandemic may have resulted in a smaller sample as administrators were likely overwhelmed during this time, in which case findings are limited in terms of generalizability. Additionally, while efforts were made to reword the opening questions appropriately to reflect the year prior to the pandemic, the findings may reflect the limits of the administrator's accurate retrospective recall, which may be reflected in the reduced reports of sexual behaviors among residents, likely to be extremely limited during the early stages of the pandemic due to quarantine mandates. Due to the limited sample size, we were also not able to assess differences across facility types or administrator characteristics with sufficient power. Finally, facility characteristics were similar across the prior survey and the follow up assessment, although there were slightly more chain-affiliated facilities and fewer for-profit facilities included in the follow up. However, resident and administrator characteristics were not included in the first survey, which limits our ability to assess differences in respondent demographics which may inform differences in findings.

Future developments in this area of research might include assessing how similar practices and policies are employed in less regulated environments, such as assisted living and adult family homes. While the literature base examining the perspectives of LGBTQ SNF residents is growing, there remains ample opportunity for exploring experiences related to sexual expression

specifically, as well as developing interventions to reduce potential for discriminatory practices and policies. The recent development of the Long-Term Care Equality Index (SAGE & HRC, 2020) offers one potential tool that facility administrators can use to assess and improve sensitivity to the unique needs of this population through development and refinement of existing policies and standard practices. Given that policies and attitudes have shifted in a more sex-positive direction but daily staff actions have not followed suit, exploring barriers to translating policy into practice through implementation studies would also offer useful information regarding the best strategies for shaping organizational change efforts. Additional information on the current policies in place and how they translate into daily practices in a more nuanced and complex ways would also offer meaningful evidence to support and direct the development of more standardized and person-centered policies and more in-depth staff training around sexual expression in these facilities in the future.

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Ethical Approval

Study procedures approved by University of Kansas Human Subjects Division (#STUDY00144546).

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