The assisted living (AL) environment plays an important role in supporting residents' life satisfaction and helping them to age in place. Guided by ecological theory, the AL environment is multidimensional and has many interrelated components including staffing (e.g. direct care workers, nursing, activity staff), services provided (e.g. medical, mental health, pharmacy), amenities offered at the setting (e.g. beauty salon, computer room, exercise facilities), and built environment features (e.g. walkability). Moreover, evidence suggests that aspects of the AL environment can enhance or detract from the physical function, well-being, social engagement, and behavioral outcomes among residents. The purpose of this study was to develop and test an integrative AL environment measurement model that includes indicators of staffing, services, amenities, and the built environment. Baseline data was used from a study testing the Dissemination and Implementation of Function Focused Care in AL. A total of 54 AL facilities across three states were included in the sample. Settings ranged in size from 31 to 164 beds with an average size of 82.2 (SD=26.2) beds and the majority were for profit facilities (n=41, 74.5%). Structural equation modeling was used to test the proposed model. Results showed that the model fit the data (chi-squared/df=1.86, p<.05; CFI=.858, RMSEA=.126). Having an integrative AL environment measurement model will advance future research that explores the impact of the environment on resident outcomes. In addition, findings from this study can inform interventions and programs designed to modify AL environments to optimize residents' ability to age in place.

REASONS FOR RELOCATING TO ASSISTED LIVING: THE PUSH, THE PULL, AND DECISIONAL CONTROL

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Using the push-pull framework, this study describes reasons for relocation and self-reported decisional control in the move to assisted living (AL). A sample of 202 residents of 21 ALs responded to a semi-structured questionnaire regarding their relocation. Participants most commonly relocated from a private local residence (n = 80, 40%), hospital/rehab facility (n = 27, 13%), or private long-distance residence (n = 24, 12%). The most frequently reported pull reasons to relocate to an AL were: "security and safety" (n = 46), "closer to family or friends" (n = 43), and "appearance of the facility" (n = 40). The most frequently reported push reasons to relocate from a previous residence were: "health problems" (n = 94), "others planned the move" (n = 87), and "fear of an accident" (n = 53). On average, participants who moved from other ALs reported the most decisional control in the move (M = 3.94, SD = 1.47), while participants from hospitals/rehab facilities reported the lowest control (M = 2.48, SD = 1.42). On average, participants who relocated from other ALs reported the most pull factors (M = 2.67, SD = 1.15), while participants from independent living communities reported the most push factors (M = 2.53, SD = 1.46). Results suggest that current residents commonly cite safety as both a push and pull reason for relocating to their AL. In addition, reasons for relocation and decisional control varied based on previous residence, which may be useful for identifying AL residents at risk for relocation stress.

SESSION 3275 (POSTER)

CANCER & BIOBEHAVIORAL HEALTH

HEALTH EXPERIENCES RESEARCH ON CANCER-RELATED FATIGUE AMONG OLDER ADULTS

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Among older cancer patients, cancer-related fatigue is a common chronic problem that may result in functional dependence and decreased quality of life. Currently, there exists no standard of care for managing fatigue among cancer patients, pressing the need for further research and the development of novel interventions. Our research followed the validated DIPEx (Database of Patient Experiences) methodology, which utilizes in-depth, narrative interviews to create a rich and broad archival resource of patient stories to highlight commonalities and differences in illness experiences. We interviewed 9 older women (aged 60+ years) who have been diagnosed with and treated for breast cancer (Stage I-IV (IV only if clinically-stable). Interviews were audio and/or video-recorded and transcribed for analysis of emergent themes using MAXQDA qualitative software. Four primary themes have emerged from the data: (1) fatigue is a distressing side effect of treatment for which patients do not feel adequately prepared; (2) information about fatigue and how to deal with it is not systematically provided within the oncology setting; (3) patients develop their own systems for managing fatigue and general energy levels (e.g., limiting activities, using blocks of time strategically, etc.); and (4) social support for fatigue varies. Education about cancer-related fatigue and its management represents an unmet need among older breast cancer survivors. The development and implementation of both clinician training initiatives and patient-facing educational and engagement interventions represent important next steps in supporting the care needs of cancer patients and survivors.

CHANGES IN RELIGIOUSNESS AMONG OLDER ADULTS FOLLOWING CANCER DIAGNOSIS

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This study aims to identify the changes in individuals' religious beliefs after receiving a cancer diagnosis. Open-ended religious development interviews were completed with 278 older adults (aged 55 to 102) in the northeast United States. Of these 278, 16 of the interviewees had received a cancer diagnosis within the previous two years. These older adults who report a cancer diagnosis describe few changes in their overall religiousness. On the contrary, these individuals describe longstanding, generally consistent patterns of religiousness that began early in life, most often related to their family