

## Article

# The Impact of the COVID-19 Pandemic on the Immobilized Lifestyle of Institutionalized Older Persons: An Empirical Study

Claudiu Coman <sup>1</sup>, Carmen Bărbat <sup>2</sup>, Cosmin Goian <sup>2</sup>, Maria Cristina Bularca <sup>1</sup>, Felicia Andrioni <sup>3</sup>, Lavinia Popp <sup>4</sup>, Adrian Netedu <sup>5</sup>, Mihai Burlacu <sup>1</sup>, Dănuț Bălăuță <sup>2</sup>, Nicolae Talpă <sup>6,\*</sup> and Bogdan Popa <sup>6</sup>

- <sup>1</sup> Department of Social Sciences and Communication, Faculty of Sociology and Communication, Transilvania University of Braşov, 500036 Braşov, Romania; claudiu.coman@unitbv.ro (C.C.); cristina.bularca@unitbv.ro (M.C.B.); mihai.burlacu@unitbv.ro (M.B.)
- <sup>2</sup> Department of Social Work, Faculty of Sociology and Psychology, West University of Timisoara, 300223 Timisoara, Romania; carmen.barbat@gmail.com (C.B.); cosmin.goian@e-uvt.ro (C.G.); danut.balauta@e-uvt.ro (D.B.)
- <sup>3</sup> Department of Socio-Humanities Sciences, Faculty of Sciences, University of Petrosani, 332006 Petrosani, Romania; felicia\_andrioni@yahoo.com
- <sup>4</sup> Department of Social Work, Faculty of Sociology and Social Work, University Babes-Bolyai, 400604 Cluj-Napoca, Romania; lavinia.popp@ubbcluj.ro
- <sup>5</sup> Department of Sociology and Social Work, Faculty of Philosophy and Socio-Political Sciences, Alexandru Ioan Cuza University of Iasi, 700309 Iasi, Romania; netedu\_adrian@yahoo.com
- <sup>6</sup> Department of Forest Engineering, Faculty of Silviculture and Forest Engineering, Transilvania University of Braşov, 500123 Braşov, Romania; popa.bogdan@unitbv.ro
- \* Correspondence: nicolae.talpa@unitbv.ro

**Abstract:** Our study aimed to examine how care centers for older persons acted and adapted during the COVID-19 pandemic period by considering the opinions of the beneficiaries, employees, and managers of such centers. The research was conducted between February and June 2022, and we used a mixed-methods approach. For the quantitative research, we applied a questionnaire to 430 institutionalized older persons from Timis County, Romania. For the qualitative analysis, we conducted interviews with 31 institutionalized older persons, 7 employees, and 4 managers. Most institutionalized older persons were mainly satisfied with their lives in the care centers. The main difficulties they faced were the impossibility of being close to loved ones and the difficulty of adapting to the living conditions within the center. Additionally, the older persons were satisfied with their interactions with the staff of the care centers. The conducted research provides a view of the lifestyle of older persons in care centers during the pandemic. It highlights their struggles and can be used as a reference point for further improvement of the lifestyle of older persons within care centers.

**Keywords:** COVID-19; pandemic; immobility; care centers; nursing homes; nursing staff; older persons; struggles



**Citation:** Coman, C.; Bărbat, C.; Goian, C.; Bularca, M.C.; Andrioni, F.; Popp, L.; Netedu, A.; Burlacu, M.; Bălăuță, D.; Talpă, N.; et al. The Impact of the COVID-19 Pandemic on the Immobilized Lifestyle of Institutionalized Older Persons: An Empirical Study. *Societies* **2024**, *14*, 91. <https://doi.org/10.3390/soc14060091>

Academic Editor: Eugène Loos

Received: 14 February 2024

Revised: 12 June 2024

Accepted: 14 June 2024

Published: 17 June 2024



**Copyright:** © 2024 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

## 1. Introduction

The decision to institutionalize an older person is based on several factors, including their advanced age, the lack or small number of children, the deterioration or inaccessibility of their home, cognitive disorders, or the absence of a spouse [1]. Although older persons avoid institutionalization, preferring as much as possible to live in the community in their own home, the transition to a care center becomes an option when their health worsens, physical and cognitive impairments appear, and the need for palliative and specialized care arises. Additionally, there are situations where family members cannot take care of the person in need, especially if they are also older or have other obligations that prevent them from being involved [2].

For older persons, the house is more than just a residence because they feel deeply connected to it, they feel safe, have familiar objects and a community with common

principles and values. This helps them find resources and resist risks more easily. This is also why older persons want to stay at home as much as possible and even spend their last years there [3]. Regarding the advantages, residential centers for older persons offer a safe and hygienic environment, medical care, food, and protection from possible abuse at home. On the other hand, the disadvantages include social exclusion, excessive sadness, the impossibility of establishing solid social relationships, and the diminishment or even loss of communication skills [4].

The older person's transition to a care center causes other family members to redefine their roles, as their control and involvement in care are diminished with this move. In addition to the reduction of burdens, they may also feel a sense of guilt caused by the decision to institutionalize the older person. Despite this, they can still monitor the care received by the older person, provide feedback to the staff, contribute effectively to their care, and maintain the beneficiary's connection to the outside world [2]. At the same time, this transition also brings several changes for the beneficiary, especially in their style and quality of life. Institutionalization can therefore increase the degree of vulnerability of older persons who are prone to experience, in addition to loneliness, functional impairments or depression [1].

Although the COVID-19 pandemic affected all socio-demographic groups, scientific evidence has shown that advanced age is a risk factor associated with a higher lethality of the virus [5]. Not only did the direct contact with the virus make them more vulnerable but also the indirect effects of social isolation, embodied in loneliness, limited access to medical services, limited social relationships, and reduced accessibility to community life [6]. Due to the comorbidities and frailty that characterize them, institutionalized older persons represented one of the most vulnerable populations to the morbidity and mortality of the SARS-CoV-2 virus [2]. Thus, the health issues that the older persons already had before the pandemic might have influenced the way they were affected by the virus. In the context in which, due to these pre-existing health issues, the diagnosis of COVID-19 might have been harder to reach in the case of older persons, the healthcare system needed to develop quick and efficient methods to deal with the pandemic and offer older persons appropriate medical treatment. In this regard, many researchers have tried to develop devices to aid healthcare workers in diagnosing patients. For example, one of the devices proposed by researchers is a biosensor that could identify the virus in "clinical samples, without any pre-treatment or labeling" [7]. Furthermore, while highlighting the challenges of diagnosing the COVID-19 virus, other researchers have emphasized the importance of early detection of the virus and the importance of using imaging methods in the process of diagnosis [8]. Considering that care centers are semi-closed environments designed for communal living, maintaining distancing or isolation is challenging and often impossible, resulting in the potential for the virus to spread easily [1].

Among the measures adopted by care centers for older persons to limit the spread of the SARS-CoV-2 virus were the prohibition of group activities, the limitation of movements outside the premises, isolation in their rooms [9], the efficient distribution of residents in space (avoiding overcrowding), establishing hygiene measures, cleaning and disinfecting spaces and devices, control policies and management of infected people [5], canceling all social activities, and restricting all visits [10]. Thus, the staff of care centers for older persons became solely responsible for the transmission of the virus to the residents [11]. Once all the measures to prevent the spread of the virus were put in place, social interactions with other residents, staff, and family members, as well as informal care from relatives, were limited [12].

Thus, due to physical isolation and the impossibility of using common residential spaces, the institutionalized older persons experienced physical, psychological, and cognitive consequences, exacerbating a pre-existing problem, namely loneliness. The resulting clinical effects included weight loss, the appearance of depressive symptoms, deterioration of cognitive functions, and insomnia, as well as increased frailty due to the lack of mobility [5]. Although adults naturally become frailer and less mobile as they age, the excessive

sedentariness caused by the COVID-19 restrictions has drastically accelerated this decline. Additionally, these restrictions created a barrier to leisure activities for residents. Even though occupational engagement plays an important role in care centers for older persons by promoting psychosocial well-being and dignity, residents were forced to spend passive time in their rooms, with reduced opportunities for occupational stimulation [12].

Beneficiaries' families have tried to adopt various support strategies embodied in various forms of remote care: delivering essential items to older persons, staying connected through technology, visiting outside with social distancing, or visiting behind a glass partition. All of these are ineffective for residents with cognitive impairments or those with vision and hearing impairments [2]. Even if they could not fully compensate for physical visits, alternative ways of contacting the family, such as phone calls, video calls, emails, or letters, positively influenced the emotional well-being of residents [9]. Even though video calling may be inappropriate for older persons with dementia, for instance, this form of digital contact has been found to reduce agitation and anxiety in these residents [12]. Crespo-Martín et al. [13] reinforce this idea, noting that the frequency of communication is directly proportional to resident satisfaction. Thus, social support, embodied in the present situation through telephone or video calls, lessened the negative effects of isolation on mental health. Moreover, the support they received helped them feel listened to and protected.

Thus, to support the residents, employees helped them use technology, namely electronic devices, to keep in touch with their families. The digital gap between generations has made communication very difficult, exacerbating feelings of isolation and loneliness [1]. Also, the reduced staff and their overload during the COVID-19 pandemic constituted a barrier to alternative means of communication. As a result, in most cases, digital contact between the residents and their families ceased after the restrictions were lifted [9].

Despite the dramatic consequences of COVID-19 and the restrictions imposed, older persons were much more self-confident compared to other age groups, based on their vast life experience. Having experienced stressful events and similar crises in the past, they have developed skills that increased their resilience. Thus, while other age groups perceived the pandemic as an element of novelty, older persons demonstrated greater adaptability [14].

According to Crespo-Martín et al. [13], care center residents paid particular attention to spirituality during the COVID-19 pandemic. Religiosity and spirituality helped older persons to remain calm and confident, serving as both resources and coping skills, with a positive impact on physical and mental health. Given that older persons are the most involved in religious activities, spiritual resources can thus constitute a source of resilience for managing the stressful period of the pandemic [15].

Generically referred to as information disorder, misinformation and fake news have dominated the media scene during the COVID-19 pandemic. The sharing of fake content has called into question both medicine and technology. The fact that older persons have little experience with digital media makes them more vulnerable and prevents them from detecting manipulative images, clickbait news, or any other form of deception [4]. Thus, mass media or traditional media are considered more credible than social media due to the processing of information using journalistic standards and verifiable sources. During the COVID-19 pandemic, the news disseminated information related to death and dramatic aspects that generally produced panic and negative effects. On the other hand, mass-media channels focused less on presenting information about virus prevention, treatment, spread control, or healthy practices [16]. In this regard, it is possible that the media tried to focus more on the effects of the virus by presenting information related to the number of deaths to make people aware of the effects and the gravity of the situation.

Considering the importance of COVID-19 in terms of the mortality and morbidity among older persons, a previous study conducted in Latin America pointed out that the pandemic mainly affected older persons and that for this vulnerable group, "the probable defining factor for mortality is the morbidity burden, rather than age" [17]. Furthermore, other studies showed that chronic diseases, as well as age, influenced the risk of becoming

infected with the virus or experiencing more severe systems [18]. Comparing groups of people under 60 years old with those over 60 years old, the mortality rate was higher in the latter group [19].

The fear of infection and the lack of a specific treatment for COVID-19, along with pre-conceptions related to the vaccine, caused negative emotions, stress, and anxiety. Although age is a critical factor in vaccine acceptance, with older people being more willing to be vaccinated, this decision was influenced by information sources. During the COVID-19 pandemic, in addition to the large amount of fake news, there were also conspiracy theories about the disease and the vaccine. Thus, misinformation presented as evidence-based information could affect vaccination behavior, as older persons have a lower ability to differentiate between conventional and fake news [20].

During the pandemic, social media platforms have spread misinformation about the virus, treatment methods, and alternative treatments. They have also disseminated information about unscientific remedies and unverified drugs promoted by fake doctors, leading people to become negligent, refuse hospitalization, and spread the disease [21]. In this regard, by having a significant impact on people's subsequent behavior, the media can negatively influence the government's effort to properly inform the population during the pandemic [22]. Also, by spreading the information that older persons are almost the only demographic group affected by COVID-19 due to their vulnerability, the media has created stigmatization and increased psychosocial suffering among them [23].

If, in 2015, the population over 65 totaled 9% of the world's population, it is expected that by 2030 this will increase to 12%, amounting to approximately 1 billion older persons. Aging is a global issue that, regardless of the geographical location or the level of development of countries, challenges health systems by increasing the need for care [24]. In addition to increasing care costs, aging also implies diminishing functional abilities and decreasing quality of life. In this regard, occupational therapy can play an important role in maintaining or improving the independence and mobility of older persons [25].

Cognitive decline is a problem characteristic of older persons in that it can produce dementia and, implicitly, increase the risk of mortality. Although cognitive decline is associated with a low quality of life in older persons, its contributing factors include hypertension, myocardial infarction, stroke, and depression. On the other hand, balanced diets rich in fruits and vegetables, as well as physical activity, are associated with a lower risk of cognitive impairment [24].

Moreover, frailty is the most visible expression of aging. Frailty is rather a consequence of the aging process, which involves changes in physiological systems, increased vulnerability, and, implicitly, the alteration of health. Repeated falls, disability, dependence on long-term care, hospitalization, and mortality are some of the characteristics of older persons who are considered frail [26,27].

Loneliness is also a risk factor for mortality, with older people feeling this more acutely because of the changes and functional losses associated with aging. Social loneliness refers to the lack or diminution of social relationships or social support, while emotional loneliness represents the lack of closeness or intimacy with another person. The latter is often experienced by older persons whose partners have died, causing them to live alone and lack reliable relationships with others. Regardless of its specifics, loneliness has negative consequences for both the mental and the physical health of older persons, manifesting in depression, increased stress levels, and sudden mood changes [28]. Thus, loneliness, defined as an unpleasant subjective state of sensing a discrepancy between the desired amount of affection or emotional support and the amount received, is an effect of social isolation prevalent among older persons [29]. In addition to health consequences, loneliness is also associated with malnutrition, sleep disorders (nighttime insomnia and daytime sleepiness), and other risky behaviors, such as excessive alcohol consumption and tobacco use [30,31].

Although most seniors prefer to remain in the community, in their familiar environment, institutionalization becomes imminent when functional disability or frailty occurs.

The latter is defined by weight loss, exhaustion, weakness, slow walking speed, and low physical activity. Thus, the chances of institutionalization are up to five times higher for frail older persons. The transition to a care center can even amplify the loss of autonomy and independence of older persons [32]. At the same time, institutionalization is a feasible alternative when the older person presents with a severe cognitive impairment. Professional care, including medical care, can improve the resident's quality of life and reduce the stress and burden on caregivers [33]. Thus, the decision to institutionalize the older person requires their relocation and acceptance of a new lifestyle, which is very difficult from an emotional point of view. For some beneficiaries, moving to a care center is associated with the opportunity to socialize and make new friends, while others see it as a loss of freedom and independence. Therefore, given that institutionalization is a stressful event by its very nature, older persons who overestimate their ability to care for themselves at home do not understand the need to move, do not cooperate, and have difficulties adapting to the new environment [34].

Smoliner et al. [35] consider malnutrition and depression to be two major problems that particularly affect institutionalized older persons, with a prevalence of 60% and 45%, respectively. Undernutrition indicates an insufficient intake of energy and nutrients, which increases the risk of complications such as infections, falls, frailty, and sarcopenia. On the other hand, obesity involves an excessive accumulation of fat, both of which pose health risks [36]. Older persons usually consume insufficient amounts of food or inappropriate food due to reduced basal metabolic rates, low levels of physical activity, difficulties in chewing and swallowing, and reduced digestion capacity [37]. Therefore, the consequences of malnutrition and depression increase the degree of dependence and, implicitly, the risk of mortality. There is also a causal relationship between the two, as depression, an increasingly common problem among institutionalized older persons, can cause weight loss. Very often, depression among older persons is not diagnosed and remains untreated [35].

At the same time, approximately 70% of institutionalized older persons face a decrease in sleep quality, a fact generated by medical conditions, anxiety, stress, fear, or other associated factors. Insomnia is a facilitating factor of mental disorders in general and depression in particular, hence its association with difficulties in managing emotions. Sleep disturbances can be lessened by physical activity that helps institutionalized seniors improve their cognitive function and increase their self-esteem. In this regard, previous studies have shown that physical exercise can be an efficient method of managing insomnia among older adults [38]. Regular exercise can improve the cognitive functions of older adults [39] and, along with social relationships, is related to good sleep quality in older adults [40]. Furthermore, exercise encourages psychosocial interactions and has positive effects on attention and memory, significantly reducing anxiety among older persons [41]. At the same time, physical exercise can be a way to prevent and even treat frailty in older persons. It can improve gait, increase muscle strength, and decrease weakness [32].

Furthermore, the residential environment and the physical and social facilities near older persons' homes (including shops, public lighting, green areas, recreational spaces, bicycle paths, and medical services) are associated with their functional performance. On the other hand, steep or uneven streets, lack of infrastructure for pedestrians, and lack of street safety can constitute dangers for older persons, restricting their participation in the community space [42]. Therefore, to this end, older persons must benefit from enabling infrastructure, including adequate sidewalks, seating areas, and chairs or benches along their routes [43].

Physiological conditions, community design, social participation, and social support strongly influence the psychological health of older persons. Just as teaching portfolios must offer students the chance to cooperate [44], older persons must have the chance to interact and socialize. Hence, Lu et al. [45] appreciate that in the context of the COVID-19 pandemic, older persons accustomed to living in areas with developed infrastructure and increased security also have greater material and spiritual demands. For this reason, dissatisfaction makes them prone to negative emotions and an acute need for emotional support (such as

telephone conversations and the company of family members). Thus, to reduce the risk of psychological problems, stress, and feelings of loneliness and abandonment among older persons, the younger generations must offer them emotional support.

Older persons living in the community are prone to frequent falls, with about one-third of them experiencing this problem. In addition to the physical effects (bruises, fractures), many of the falls also have psychosocial consequences in the form of isolation, fear, or even depression. Thus, falls in older persons may require medical treatment, and in extreme cases, they may even cause death [46]. A high risk of falling is caused by malnutrition. Even if it has a higher prevalence among institutionalized older persons, those in the community also face this pathology, with weight loss being a predictive factor. Malnourished older persons are prone to injury, long-term hospitalization, slower recovery from illness, and thus a shorter life expectancy [47]. Falls among older persons can also be caused by the number of medications they take and, implicitly, by their adverse effects, functional disorders, or an inappropriately organized environment. Other predictive factors for falls among older persons may include comorbidities such as diabetes or hypertension [48].

Considering the aspects mentioned above, the purpose of our study was to examine how care centers for older persons acted and adapted, mainly during the pandemic period, from the perspective of the older persons (beneficiaries), the employees, and the managers of such centers. Related to this purpose, we also formulated the following series of objectives: (i) measuring the general level of satisfaction of beneficiaries in specialized care centers; (ii) identifying the main difficulties faced by the beneficiaries during the institutionalization period and the pandemic; (iii) identifying the main medical/therapeutic services that the beneficiaries receive; (iv) identifying the main leisure activities of the beneficiaries; (v) evaluating beneficiaries' perceptions regarding the pandemic period and how their general health, mental health and personal needs were affected; (vi) identifying the beneficiaries' proposals for improving the way of life in the care centers; and (vii) identifying perceptions regarding the pandemic period from the perspective of employees and managers of care centers. This research was conducted between February and June 2022.

Moreover, we formulated a list of hypotheses that were tested during the investigation: (i) the satisfaction with life in care and support centers treatment is significantly different with gender, initial residence environment, life stage, and time spent in this kind of organization; (ii) there are statistically significant differences in the types of therapies in care and support centers according to the gender of respondents and the age category; (iii) the biggest difficulties encountered during the pandemic were significantly different with gender, residence environment, life stage, and time spent in care center; and (iv) the more the pandemic affected the physical condition of the beneficiaries, the better the perception was of the relationship with the staff in the care centers.

## 2. Materials and Methods

### 2.1. Data Collection Method

This research was conducted between February and June 2022. We used a mixed-methods design named a convergent parallel design [49]. This design refers to the implementation of quantitative and qualitative techniques simultaneously, with both being equally prioritized. From a quantitative perspective, we applied a questionnaire to a quota sample of beneficiaries of care centers for older persons in Timis County, Romania. From a qualitative perspective, we conducted interviews with beneficiaries, employees of care centers, and managers of these centers.

We applied questionnaires and conducted interviews in the following care centers for older persons: "Saint Francis" socio-medical care center for older persons and chronically ill from Bacova, "Periam" Neuropsychiatric Recovery and Rehabilitation Center, "Gavojdia" Neuropsychiatric Recovery and Rehabilitation Center, "Ciacova" Care and Assistance Center for Adults with Disabilities, "Schwabenhause Diana" care center from Lenauheim, "Inocentiu Micu Klein" home for older persons from Timisoara, "Support Center for Crisis Situations" from Timisoara, "Sinersig" Neuropsychiatric Recovery and Rehabilitation

Centre, "Adam Müller Guttenbrunn" care center from Timisoara, "Saint Nicholas" complex for older persons from Lugoj, and "Anitaheim Varel" care center from Lugoj.

The sample for our research consisted of retired people who live in the state or private care centers listed above. The subjects were selected by controlled quota sampling. The sample size was 430 institutionalized older persons. The structure of the resulting sample was recorded following a series of independent variables: gender (male—49%, female—51%), initial residence environment (urban—53%, rural—47%), life stage (adults under 64 years old [20%], young-old, ages 65–74 [50%], the middle-old, ages 75–84 [20%]), and the old-old, over age 85 [10%]), time spent in care and support center (up to 2 years—28%; 2–4 years—33.5%; 4 years and over—38.5%), and the type of care center (public and private). All these quotas were established by having as a model the characteristics of the research population transposed into a descriptive matrix [50]. Furthermore, in the qualitative research, we conducted interviews with 31 beneficiaries of the care centers, 7 employees, and 4 managers.

## 2.2. The Research Instrument

The questionnaire that we applied to the beneficiaries can be seen in Table S1. It is structured based on a series of thematic areas as follows: A—Questions about the life in the care center/home before the COVID-19 pandemic; B—Questions about the life in the care center during the COVID-19 pandemic, and C—Identification questions.

According to the objectives of the research, the questions from the questionnaire were used either for descriptive data or for stating and testing the hypotheses. In the qualitative research, the three interview guides used in discussions with the beneficiaries, employees, and managers can be found in Table S2. In the interview guide applied with the beneficiaries, we considered dimensions such as adjusting to the changes imposed by the move to the care center, adapting to the changes that have occurred due to the COVID-19 pandemic, changes in the care mode due to the COVID-19 pandemic, the most important task they had to accomplish during the COVID-19 pandemic, contracting the virus, losing loved ones due to the COVID-19 virus, mood during the COVID-19 pandemic, solidarity among the institution's employees, respondent's greatest achievement, and respondent's relationship with God. In the interview guide applied with employees, we considered dimensions such as physical distancing measures during the COVID-19 pandemic, the greatest difficulty encountered by the beneficiaries, losing relatives, friends and/or loved ones due to the COVID-19 virus, the most important task they had to accomplish during the COVID-19 pandemic, mood during the COVID-19 pandemic, solidarity in the behavior of the institution's employees and beneficiaries, changes in the activity of the institution during the COVID-19 pandemic, care of the older persons in other institutions, and respondents' relationship with God. Furthermore, in the interview guide applied with the managers, we measured the following dimensions: physical distancing measures during the COVID-19 pandemic, the greatest difficulty encountered by the beneficiaries, losing beneficiaries, relatives, or acquaintances due to the COVID-19 virus, the most important task they had to accomplish during the COVID-19 pandemic, mood during the COVID-19 pandemic, solidarity among the institution's employees and beneficiaries, changes in the activity of the institution during the COVID-19 pandemic, changes that managers would like to make in the future, models of good practices identified in other institutions, and respondents' relationship with God.

## 2.3. Data Analysis

The data collected after applying the questionnaires in the care centers were analyzed with the 20th version of the program Statistical Package for the Social Sciences (SPSS). The analyzed variables were a word describing the life in the care and support center, reason for being in the care center, seniority in the center, decision to stay in the center, Likert scale about satisfaction with treatment in the center, six Likert scales about satisfaction with different services, general attitude of the staff, the biggest difficulty encountered in the cen-

ters, kinds of medical/therapeutic services, main relaxation activities, and communications with family members or other acquaintances/close people. For the pandemic situation, the analyzed variables were a word describing life in the care and support center during the pandemic, physical and mental health affected by COVID-19, emotional states during the pandemic, concerns during the pandemic, activities allowed during the pandemic, activities missed the most, physical distancing measures, quality of the services in the care centers, biggest difficulty encountered during the pandemic, types of contacts with family members, types of communications with family members, relationship evolution with family members, digital communications, staff attitudes during the pandemic, evaluation of relations with staff, socialization with beneficiaries, ways of socialization, emotional states during the pandemic, needs respect, and suggestions for improving life in the care center. Socio-demographic variables were also included.

In our analysis, we included gender, age categories, initial residence environment, life stage, and time spent in care centers as predictors. To test the hypotheses, we used the construction of some statistical indexes, parametric independent T-test, Kruskal–Wallis non-parametric test, chi-square test of independence, and Spearman correlation.

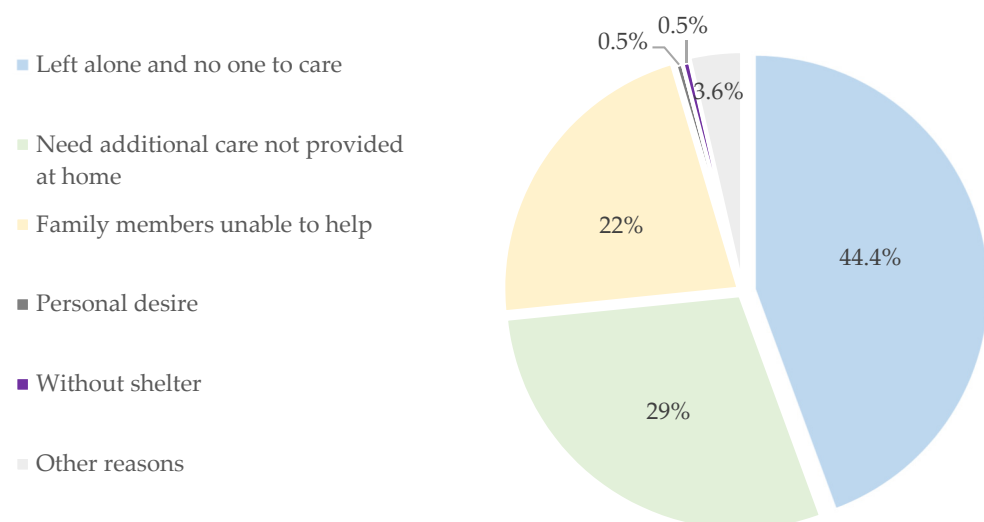
### 3. Results

#### 3.1. Quantitative Research

##### 3.1.1. General Evaluation of the Care and Support Center

In line with the first objective, we asked the respondents what the first word is that comes to mind when they think about the lifestyle in the care and support center. The results showed that the most often used words are good feelings (44.7%), care (7.9%), bad feelings (6%), restlessness (4.7%), and serenity (4.7%). However, it is important to note that a high percentage failed to express their feelings about their residence (21.4% with the answer “I do not know”). All the items were obtained after recoding the answers. For example, the term “bad feelings” refers to many aspects, such as maladjustment, “it’s not like home”, regret or tendency to leave the center/asylum, etc.

Regarding the main causes of why these beneficiaries arrived in the care center (Figure 1), most of respondents answered that they were left alone and had no other people to care about their well-being, due to their health, or they needed additional care that cannot be provided at home.



**Figure 1.** The main reason for older people being in care and support centers.

To test the first hypothesis stated at the beginning, we constructed a general index of satisfaction (GIS) with all the items from the A6 question in the applied questionnaire. The items from these questions refer to satisfaction with the offered food, entertainment opportunities, organized activities, medical care, accommodation services, and spiritual

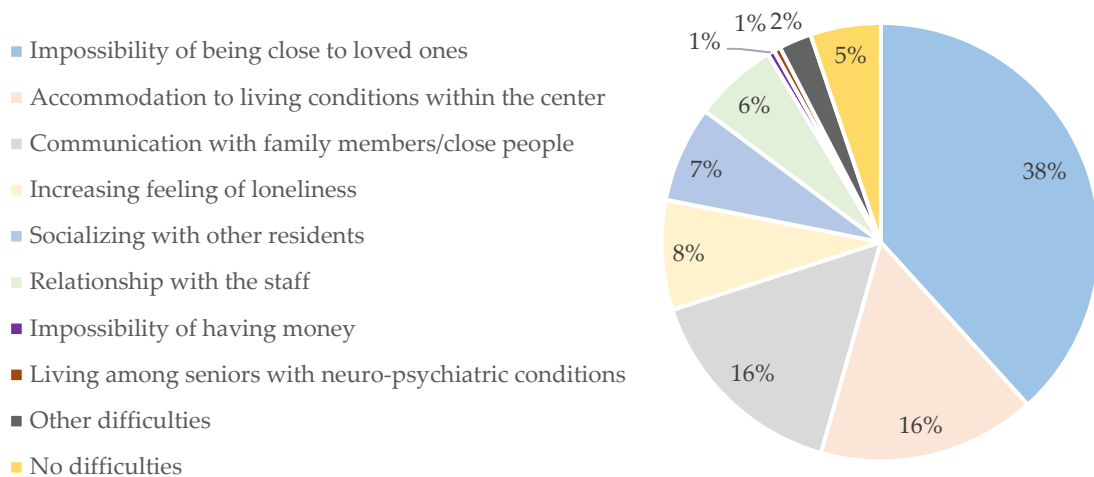
assistance. The new GIS scale measuring satisfaction with life has good reliability (with Cronbach's alpha = 0.917 > 0.700 for six items). The newly constructed index for 430 interviewees has the following descriptive values—M = 5.36 and SD = 1.13.

Hypothesis 1 (H1) was divided into four tested sub-hypotheses:

- a. Independent sample T-test was conducted to determine if the GIS for the 208 interviewed males (M = 5.45, SD = 1.11) is significantly different compared to the 222 interviewed female (M = 5.27, SD = 1.14). The results showed no significant difference,  $t(428) = 1.626, p = 0.105$ . This sub-hypothesis is not confirmed.
- b. The 222 interviewees (who come from the urban environment) asked about their general satisfaction with the care and support center (M = 5.39, SD = 1.18) compared to the 198 interviewees (who come from the rural environment) (M = 5.30, SD = 1.08) demonstrated that it does not show significant differences,  $t(428) = 1.62, p = 0.420$ . This sub-hypothesis is not confirmed.
- c. A Kruskal–Wallis test was conducted to examine the differences in general satisfaction with treatment according to the life stages. Significant differences (chi-square = 30.69,  $df = 3, p = 0.000$ ) were found among the four categories of life stage (1. under 64 years old, 2. young-old, 3. the middle-old, and 4. old-old). A Mann–Whitney U-test showed that adults under 64 years old are significantly more satisfied than young-old, ages 65–74 (U = 6722,  $z = -3.668, p = 0.000$ ; mean ranks: 179.3 > 138.9), middle-old are significantly more satisfied than young-old (U = 5988,  $z = -4.993, p = 0.000$ ; mean ranks: 190.4 > 135.4), and middle-old are significantly more satisfied than old-old (U = 1346,  $z = -2.507, p = 0.012$ ; mean ranks: 71.2 > 53.5). All the other comparisons were non-significant. In conclusion, we cannot decide whether satisfaction increases or decreases with age.
- d. A Kruskal–Wallis test was conducted to examine the differences in satisfaction with the time spent in the care and support center. Significant differences (chi-square = 15.501,  $df = 2, p = 0.000$ ) were found among the three categories of time spent in care and support centers (1. Up to two years, 2. 2–4 years, and 3. 4 years and over). A Mann–Whitney U-test showed that clients who lived in these centers for up to two years are significantly more satisfied than those who lived in them for 2–4 years (U = 6376,  $z = -3.676, p = 0.000$ ; mean ranks: 151.3 > 116.7) and significantly more satisfied than clients who lived in them for over four years (U = 8514,  $z = -2.104, p = 0.03$ ; mean ranks: 155.5 > 134.7). For the last two categories (2–4 years and over 4 years), we also found significant differences (U = 10032,  $z = -2.451, p = 0.01$ ; mean ranks: 167 > 142); the people with over four years are significant more satisfied than the people with 2–4 years of stay. Generally, we conclude that a shorter period spent in the center is more satisfactory, but in the last case, we found an opposite situation. In conclusion, Hypothesis 1 (H1) is partially confirmed, and in some cases, future research can deepen the analysis with a qualitative methodology.

Furthermore, we asked the respondents to indicate the biggest difficulty they have encountered since they were institutionalized (Figure 2). The main difficulties reported the most often were the impossibility of being close to loved ones, becoming accustomed to the living conditions within the center, communication with family members/close people, and the increasing feeling of loneliness.

One of the main tasks of the care centers is to provide medical and therapeutic assistance to patients. Various care techniques were included in the questionnaire in question A9, and the needs of these patients are specific and varied. Over the past year, they have utilized the forms of help that are presented in Table 1.



**Figure 2.** The main difficulty encountered by older persons within care and support centers.

**Table 1.** The crosstabulation of medical/therapeutic services variables and independent variables (gender and the life stage).

Medical/Therapeutic Services	Total	Male	Female	Under 64 Years Old	Young-Old	Middle-Old	Old-Old
	n (%)				n		
Therapeutic massage	374 (19.6)	194	180	76	196	70	32
Recuperative gymnastics	362 (18.9)	174	188	80	184	68	30
Physical therapy	352 (18.4)	174	178	72	186	64	30
Assistance in carrying out basic activities (hygiene, travel, feeding)	202 (10.6)	94	108	28	116	34	24
Psychological assistance	174 (9.1)	82	92	26	84	44	20
Medical assistance (routine/basic medical consultations)	48 (2.5)	28	20	10	24	8	6
Other services	400 (20.9)	186	214	82	198	80	40
Chi-square test of independence		Chi-square = 25.93, df = 7, p = 0.001		Chi-square = 65.01, df = 21, p = 0.000			

To provide an image of the frequency with which these techniques/procedures are applied, we calculated a count type variable that accumulates the types of activities. We found that 0.5% of all the samples utilized all seven categories of therapy, 21% utilized six of them, 35% utilized five therapies, 26% utilized four therapies, and 17.5% utilized one to three therapies. These data prove the urgent needs of these people and suggest areas for capacity building in the infrastructure specific to such care strategies.

To test the second hypothesis, we applied the chi-square test of independence using a variable with multiple choices for the type of therapies and the two independent variables (gender and life stage; see Table 1).

The statistical analysis showed that there are statistically significant differences in the requests for specific therapies according to the gender of the respondents (chi-square = 25.93, df = 7, p = 0.001) and according to the age category of the beneficiaries (chi-square = 65.01, df = 21, p = 0.000). In conclusion, our hypothesis is confirmed.

The specific differences can be seen directly in Table 1, from which we derived detailed explanations: a. Regarding the independent gender variable, it is observed that men request to a greater extent than women therapeutic massage (194 > 180) and medical assistance (28 > 20). Women request more than men recuperative gymnastics (188 > 174), physical therapy (178 > 174), assistance in basic activities (108 > 94), psychological assistance

(92 > 82), and other services (2014 > 186). b. Regarding the independent life stage variable, there is a concentration of the demand for therapeutic services for older persons in the second column (young-old).

These findings can be very useful in improving the services offered. For example, the services could be diversified (considering the demand for “other services” mentioned in Table 1) or there could be an investigation into why the requests for specific therapies are so low in other age categories (adults under 64 years old, the middle-old, and the old-old) and dominant for the second age category (young-old).

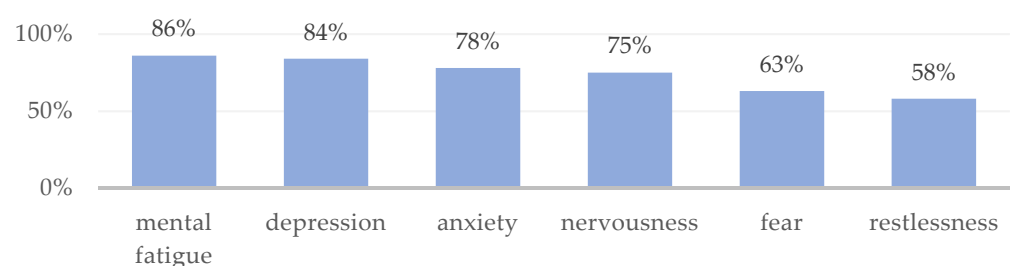
### 3.1.2. Life, Adaptation, and Pandemic Condition

The period of the pandemic was a significant challenge for our questioned subjects, especially in the context of collective living in these care and support centers. They faced problems related to several important variables: age, comorbidities, the protection strategies put into practice, etc. The European Asylum Support Office (EASO) published a report titled *COVID-19 Emergency Measures in Asylum and Reception Systems* [51], in several series as an alarm signal regarding protection against COVID-19, accumulating experiences from all the EU countries. To explain the results of the quantitative research, we preferred to split the presentation into several sections based on the items in the questionnaire.

#### Personal Representation and Evaluation of the Pandemic

When describing with a single word (or a few) the pandemic situation, we observed that it was not very simple for the interviewees. Positive terms (silence—1%, adaptation—3%, safety—4%, same situation as before the pandemic—7%, good feeling—32%), in comparison with the situation before the pandemic, were this time complemented by predictable negative items (confusion—3%, restlessness—3%, bad feelings—10%, stress and fear—11%, isolation and restriction—12%). These items reflect a balance between well-being and the panic created by the pandemic. The care centers did not experience serious problems in terms of illnesses or deaths (although these do not include the emotional states of the residents). Analysis of the websites of these organizations reveals that strict measures were implemented during the pandemic. This equilibrium also resulted from the descriptive analysis of questions B3 (evaluation of health status), B4 (evaluation of mental health), and B24. The percentage of those who declared that the COVID-19 pandemic affected to a small/very small extent the process of improving their physical health was 47%, to a great extent—34%, and neither great nor to a small extent—19%. A similar situation was observed for the influence of the impossibility of socializing with other residents on their mental health, where 52% stated if affected them to a small/very small extent, 32% to a great extent, and 14% neither great nor to a small extent. At the same time, 75% of the interviewees declared that they felt their needs were respected during the pandemic.

The first impression is that these statistical data may suggest a positive background and an under-control social framework. Nevertheless, we insisted on finding out the weight of some emotional states that interviewees felt during the pandemic. The results show that most of the respondents felt mental fatigue, depression, anxiety, nervousness, fear, and restlessness (Figure 3).



**Figure 3.** Emotional states of the older persons during the pandemic.

Regardless of the duration of these emotional states, we observed high weights among all the subjects: the great majority experienced one or more kinds of negative emotional states. By applying a chi independence test, we found no significant statistical differences according to gender (chi-square = 9.65,  $df = 5$ ,  $p = 0.08 > 0.05$ ). In other words, these negative emotional states affected the respondents equally regardless of their gender. With a count-type variable, we concluded that all six states were felt by 41% of respondents, five states by 30%, four states by 7.5%, three states by 11.5%, two states by 3%, one state by 4%, another negative state by 2.5%, and none of them by 0.5%.

Thinking about the emotional states that the impossibility/reduced possibility of socializing with the other members of the center created for them, most often during the pandemic they felt: alone (16%), restless (31%), nervous (10%), helpless (9%), and sad (26%). To all these traumas is added the concern for “own state of health” (45%), for “the health status of the family members” (24%), the decision to be vaccinated or not against COVID-19 (14%), or for “the health of friends/acquaintances” (3%).

#### Evaluation of Organizational Limitations Generated by the Pandemic

For the social problems explained earlier, we can add specific organizational measures, such as a series of limitations imposed for social distancing, of which the interviewees mentioned the limitation of the number of people with access to common spaces (12%), limitation of the amount of time spent in the common spaces (17%), the ban on socializing through board games (22%), reduction in the number of roommates (30%), and wearing of masks (20%). In this situation, we expected that the staff’s activity would be strongly criticized. However, the opinions about the quality of the provided social services of the interviewees were significantly positive: 85% declared that they consider the quality of all the services offered during the pandemic to be good and very good, 10% declared that it was neither good nor weak, and only 5% declared that it was extremely weak/rather weak.

The strictness of the rules applied in the care centers predictably blocked activities that, according to respondents, were typically taking place: reading (7.9%), watching TV shows (22%), walking in the inner courtyard of the center (12.1%), socializing during playing board games (15%), physical exercises (6.1%), music evenings (4.2%), and other activities (taking care of green spaces, taking care of/playing with the animals in the center, participation in religious services, occupational therapy, playing on the piano, occupational workshops, crosswords, dishwashing, drawing, painting—32.7%).

We observed that all the limitations were accepted as such and reflected the fact that they were effective and unequivocal. Most of the respondents declared that during the pandemic they did not have access to reading (83%), were not allowed to watch TV shows (84%), walk in the inner courtyard (53%), socialize during board games (66%), or to participate in music evenings (71%), along with other restricted activities (86%). Applying a chi independence test, we found that there were no significant statistical differences regarding the perception of specific limitations according to the gender of the respondents (chi-square = 9.36,  $df = 6$ ,  $p = 0.154 > 0.05$ ). All the limitations were perceived the same regardless of the gender of the subject.

Very strict restrictions, generated by social distancing, triggered social isolation or negative emotional states that have already been presented. It was also very suggestive that the respondents remembered which specific activities they missed the most: walks outside the care center (32%), socializing with other residents during common activities (15%), meetings with family/relatives (9%), physical activities/sport (6%), religious activities (4%), watching TV shows and participation in music evenings (3%). Walks outside the care center were felt to be the most desirable, but the possibility of leaving the center and returning already infected was a credible threat. On the other hand, socializing with other residents during common activities could also be a source of infection.

The other answers to this open question were much more diverse and even surprising. Here are some of the most interesting answers about the desired activities: “I want to paint” (declared a male person, 70 years, higher education, urban environment); “I want

freedom" (male, 78, gymnasium, rural environment); "I wasn't allowed to scream" (female, 70, gymnasium, rural environment); "celebrations and theatre" (male, 31, gymnasium, urban environment); "to drink coffee and smoke cigarettes" (female, 70, gymnasium, urban environment), etc. Of course, this kind of answer can also be tracked for in-depth research according to the principle of serendipity (see, for example, [52]). Also, a starting point can be the 22% of those who declare that they do not know how to specify the activities they miss the most.

Finally, we initiated item B12 from the questionnaire as a look at the problem of the consequences of organizational limitations, questioning the biggest difficulty encountered during the pandemic in the care center. The responses are presented in Table 2 and were the starting point in the statement of the third hypothesis.

**Table 2.** Crosstabulation of the life stage and time spent in the care center variables.

Variables	n	Encountered Difficulties during the Pandemic *						$\chi^2$	df	p
		1	2	3	4	5	6			
		n (%)								
Life stage										
1. Under 64 years old	74	8 (10.8)	30 (40.5)	12 (16.2)	4 (5.4)	2 (2.7)	18 (24.3)	38.51	10	0.000
2. Young-old	202	24 (11.9)	84 (41.6)	50 (24.8)	28 (13.9)	4 (2)	12 (5.9)			
3. Middle-old and old-old	124	10 (8.1)	74 (59.7)	16 (12.9)	8 (6.5)	0	16 (12.9)			
Total	400	42 (10.5)	188 (47)	78 (19.5)	40 (10)	6 (1.5)	46 (11.5)			
Time spent in the center										
1. Up to two years	108	8 (7.4)	46 (42.6)	26 (24.1)	20 (18.5)	2 (1.9)	6 (5.6)	28.55	10	0.001
2. 2–4 years	132	18 (13.6)	52 (39.4)	26 (19.7)	14 (10.6)	2 (1.5)	20 (15.2)			
3. 4 years and over	160	16 (10)	90 (56.3)	26 (16.3)	6 (3.8)	2 (1.3)	20 (12.5)			
Total	400	42 (10.5)	188 (47)	78 (19.5)	40 (10)	6 (1.5)	46 (11.5)			

\* Codification: 1—impossibility of socializing with other residents; 2—impossibility of communicating with family members/close persons; 3—becoming accustomed to the new living conditions within the center; 4—accentuated feeling of loneliness; 5—understanding the truth about the pandemic and the treatment of the COVID-19 disease; 6—relations with care center staff.

Starting with the data from Table 2, we formulated our third hypothesis, which was divided into four sub-hypotheses as follows:

- a. Regarding the independent gender variable, statistical analysis showed that there are no statistically significant differences in terms of the perception of the biggest difficulty during the pandemic by gender (chi-square = 6.92, df = 5,  $p = 0.226$ ). There are no differences in perception according to the respondents' gender.
- b. Regarding the independent residence environment variable, statistical analysis showed that there are no statistically significant differences in terms of the perception of the biggest difficulty during the pandemic with the environment (chi-square = 6.92, df = 5,  $p = 0.226$ ). There are no differences in perception according to the respondents' residence environment.
- c. Regarding the independent life stage and time spent in center variables, we preferred to present statistical data in the same table (Table 2). The initial crosstabulation of the variables, including the life stage (adults under 64 years old, young-old, middle-old, and old-old), generated seven cells (29.2%) with an expected count of less than five. In this situation, we recorded the variable life stage for three categories (adults under 64 years old, young-old, middle-old, and old-old) but the variable "time spent in the center" remained the same (Table 2).

The statistical analysis showed that there are statistically significant differences regarding the perception of the biggest difficulty during the pandemic with the life stage (chi-square = 38.51, df = 10,  $p = 0.000$ ) and the same statistically significant differences with time spent in the center (chi-square = 28.55, df = 10,  $p = 0.001$ ).

Some descriptive conclusions can be drawn. For example, the “impossibility to communicate with family members/close persons” remained the dominant difficult problem for every category of the independent variables: 40.5% of the beneficiaries under 64 years old; 41.6% from young-old; and 59.7% from the middle-old and old-old. The same situation is seen in the case of the categories from the time spent in the center variables: 42.6% from the beneficiaries who stayed in centers for up to 2 years; 39.4% for those who have been staying for 2–4 years, and 56.3% from those who have been there for four years and over.

The significant statistical differences come from the fact that in both cases, the dominant percentages are capitalized in general by the “young-old” and those who have been in the centers between two and four years.

As a general conclusion, we observe that hypothesis 3 is partially confirmed. If, for gender and residence environment, there are no statistically significant differences, regarding the perception of the biggest difficulty during the pandemic in the case of the last two variables, life stage and time spent in the center, there are statistically significant differences.

### 3.1.3. Maintaining Ties with the Family and Methods of Communication

Some of the previous questions referred to the links that the beneficiaries have with their families. This situation characterizes the relationships with the family starting from the specific conditions of hospitalization in a care center. In this case, we could observe that 47% of the beneficiaries considered the “impossibility to communicate with family members/close persons” as one of the major difficulties, while 22% declared that “family members no longer had the opportunity to provide them with the necessary care” while “communication with family members/close people” was considered “the main difficulty encountered within care and support center” by 15.6% of respondents. During the pandemic period, it was expected that the difficulties with relationships would increase, but the answers were contradictory in the first phase. Thus, only 30% of the respondents declared that they maintained contact with the family to a small or very small extent, and on the opposite side, 49% declared that they managed to maintain contact to a large or very large extent. This fact was primarily due to virtual meetings and not to face-to-face (physical) ones.

There is a low use of video calls (14.5%), with the explanations being multiple: difficulties using new technologies, lack of Internet connection, or lack of upgrades specific to modern telephony. These figures are consistent with the results of research on a representative sample at the level of Romania, research carried out by Metro Media Transylvania [53] regarding the use of electronic communication services. According to that research, Romanians use mobile phones in a high proportion (over 90%) but only 34% have Internet on their phone. People aged 65 and over were distinguished by the fact that 43% stated that they do not use messaging or calling on the Internet, 63% did not download/watch videos, and 71% stated that they never downloaded/listened to music on the Internet. Regarding our sample, 64% of the interviewees declared that they rarely or very rarely use video applications on their phones to communicate with their families. Also, we notice that physical visits practically disappear (due to the pandemic situation). In fact, in the context of the pandemic, family visits have significantly decreased (76% of respondents stated that family members were not allowed to come to the center). Even in these conditions, the respondents consider in this context that either the relations with the family remained the same (57%) or even improved (7%). Only 12% declared that relations with the family worsened during the pandemic period.

### 3.1.4. Relationship with the Center’s Staff and the Assessment of Its Activity

The evaluation of the care staff in the respective centers by the beneficiaries proves to be particularly useful, especially in the context of the COVID-19 pandemic. To begin with, following question B18 from the questionnaire, most of the beneficiaries specified that the relations with the staff in the centers were rather positive (65%), and fewer described them as neither positive nor negative (32%) or rather negative (3%). We deduce from this a

dominant positive institutional context, where the relationship with the respective staff is extremely important. The respondents specified that compared to the pre-pandemic period, they felt that during the pandemic the staff paid more attention to the beneficiaries (58% of the respondents declared that). A more complex evaluation of the involvement of the staff in the centers by the beneficiaries can be outlined starting from question B20 from the questionnaire, which has three items, as follows: 1. The employees of the care center have been more reluctant toward me during the pandemic; 2. For the nurses and caregivers at the center, my needs have been a priority during the pandemic; and 3. Nurses and carers have socialized less with beneficiaries during the COVID-19 pandemic.

Based on these three items (actually three seven-point Likert scales), we built a statistical index of the perception of staff involvement in the pandemic (variable abbreviated per staff). The index is a summative one obtained after recoding items one and three (through the inversion of the scales) and with the following descriptive values— $M = 4.91$  and  $SD = 1.23$  ( $N = 422$ ).

With the help of this index, we formulated the fourth statistical hypothesis, and to test it, we used the previously constructed statistical index and the variable that comes from question B3—Considering your health, to what extent do you consider that the COVID-19 pandemic has affected the process of maintaining/improving physical health (abbreviated affected state of health). The Spearman correlation analysis results are presented in Table 3.

**Table 3.** Correlation between the per staff index and affected state of health.

		Affected State of Health	Per Staff
Affected state of health	Correlation Coefficient	1.000	−0.386 *
	Sig. (2-tailed)		0.000
	N	428	420
Per staff	Correlation Coefficient	−0.386 *	1.000
	Sig. (2-tailed)	0.000	
	N	420	422

\* Correlation is significant at the 0.01 level (2-tailed).

### 3.1.5. Relationship with Other Residents

The relationship with the other residents is equally important for the beneficiaries of the centers, especially in the conditions of the pandemic. The obligatory social distancing has influenced the answers of those interviewed. We note that 50% of the respondents stated that they socialized with the other residents to a low/extremely low extent, 20% to a neither large nor to a small extent, and 30% to a large/extremely large extent. In this context, the ways of socializing were still dominated by watching TV shows in common spaces while respecting the rules of physical distancing (69% of the respondents), talking on the phone with the other residents (27%), and only 4% declared that they use video calls. The emotional states felt during the pandemic contributed to a certain weakening of relations with the other beneficiaries: they felt restlessness (31%), sadness (26%), loneliness (16%), nervousness (10%), and helplessness (9%).

### 3.1.6. Global Assessment of the Center and Suggestions for Improving the Way of Life in the Care Centers

The beneficiaries were asked to provide suggestions for improving the conditions in the care centers. The answers of the beneficiaries presented the following suggestions (with the specification that we present only the valid answers, excluding the non-responses): more collective/recreational activities (17.3%); freedom/freedom of movement (10.9%); arrangements of the interior/exterior space (10.9%); more respect, empathy from the staff (8.2%); more visits of the family/relatives (8.2%); more discipline, order, and peace (8.2%); the return to normality (7.3%); reducing the number of beneficiaries per room (7.3%);

improving nutrition (3.6%); better hygiene and care conditions (2.7%); religious life (1.8%); no change (6.4%); and other proposals (7.3%).

We also list a series of original proposals by the beneficiaries: “attracting sponsorships” (declared a female person, 76 years, gymnasium, urban environment); “finding jobs for beneficiaries” and “stop segregating people with disabilities” (male with health problems, 42, higher education, urban environment); “beneficiaries involved in self-management” (female, 70, gymnasium, rural environment); “establishment of a gym” (male, 72, gymnasium, rural environment); and “to bring new employees” (female, 56, gymnasium, rural environment). All the proposals from the beneficiaries must be considered and that is why we would recommend to all the managers of the centers to conduct permanent consultations with the beneficiaries through opinion polls or by encouraging collaborations to improve the collective life of the older persons.

### 3.2. Qualitative Research

In the qualitative analysis, we were interested in obtaining a clearer view of the lifestyle institutionalized older persons had in the care centers during the pandemic. The results of the qualitative analysis were analyzed according to the dimensions established in the interview guide.

#### 3.2.1. Analysis of the Interviews Applied to Institutionalized Older Persons

Most of the respondents stated that they adjusted rather well to the changes imposed by their move to the care center. Out of the sixteen women and fifteen men who were interviewed as beneficiaries, one woman did not provide an answer, another woman mentioned both the positive aspects as well as the negative aspects of adjusting, while six other women and six men stressed the difficulty of the adjustment.

The key features associated by the respondents with the emergence of the COVID-19 pandemic are isolation and the implementation of more drastic hygiene measures. When specifically mentioned, the challenges that arose during the process of adapting to the changes determined by the pandemic were correlated with the impossibility of receiving visits from their relatives. Another respondent emphasized the fact that she had no other choice. Most respondents who specified the difficulty of adapting to the changes generated by the restrictions imposed during the COVID-19 pandemic did not explain the causes. Out of the respondents who were beneficiaries, ten women and three men specifically stated that it was hard to adapt to the changes that have occurred due to the COVID-19 pandemic.

The interviewed beneficiaries stated that isolation and the ban on visits, outside walks, and socializing were the most noticeable changes determined by the emergence of the COVID-19 pandemic. Furthermore, greater attention was paid to the beneficiaries' hygiene and health condition. The beneficiaries had to wear surgical or N95 masks in public contexts. Social distancing and restricting the number of persons in public spaces were other measures taken by the nursing personnel. The mandatory wearing of masks, prohibition of visits and socializing, social distancing, and restricting the number of people in enclosed spaces were among the measures considered by the respondents to be the most exaggerated, wrong, and even abusive.

Taking care of their health, respecting the rules of living in harmony, maintaining cleanliness in their space, and keeping morale up were the tasks they had to accomplish during the pandemic and were most mentioned by the interviewed beneficiaries. Three of the respondents stated that respecting the rules of living in harmony with each other was paramount and twelve mentioned their health as being the priority.

Nine of the respondents admitted that they had contracted COVID-19: six of them were women and three were men. Only one woman chose to describe her experience, stating that she had a less serious form of the disease. Three women and five men stated that they had lost relatives, acquaintances, or loved ones. All of those who admitted to losing people due to the COVID-19 virus chose not to offer other information on the topic.

The mood during the COVID-19 pandemic, declared by eleven men, was good or very good, while five men declared that the mood was precarious and/or bad. Regarding women, twelve of them declared that the mood was okay or good, while one woman declared that it was either agitated or bad. Out of the women who declared that the mood was good, one respondent claimed that the fact the institutionalized beneficiaries were together was an advantage for all of them.

The mood of the employees was assessed by the interviewed beneficiaries as being acceptable, good, or optimistic. Three respondents claimed that the employees were either psychically exhausted, burned out, or restless. Another three of the interviewees stated that the personnel was either resigned, reserved, or demoralized. The effects of the COVID-19 pandemic were considered to bring at least partial changes in terms of the consciousness and the behavior of the respondents' peers. For example, isolation was a consequence specifically mentioned by one of the respondents as being determined by the pandemic. Furthermore, the increased focus on improving hygiene measures was another aspect mentioned by another of the interviewees.

The achievements mentioned by the interviewed beneficiaries cover a plethora of areas that are difficult to sum into one category. Children, freedom, the fact that the respondents were able to survive the pandemic, happy marriage, family, their studies, and returning to Romania are all considered by various respondents to be the greatest achievements in their lives. The most frequently mentioned achievement mentioned by the beneficiaries was their children: ten women and three men referred to it specifically as their greatest achievement. Interestingly, two respondents stated that their greatest achievement was surviving and reaching their current age.

When addressing their relationship with God, most of the respondents declared that they were believers. Ten interviewees specifically claimed that they had either a relation with God or benefited from Divine intervention in one form or another: for example, one respondent stated that he was saved from two heart attacks. Another four respondents asserted that they have a good relationship with God. One respondent specified that he would rather not answer when asked whether he has faith in God or not. Another respondent stated that she does not believe in God.

### 3.2.2. Analysis of the Interviews Applied to Employees of the Care Centers

The nursing staff respondents stated that the physical distancing measures during the pandemic entailed the strict isolation of the beneficiaries. Daily information sessions on anti-COVID-19 prevention measures were organized in the older persons' care centers. Wearing surgical or N95 masks and isolation at the workplace were among the most difficult measures that were recurrently mentioned by the interviewed personnel. Aside from these measures, the interviewed employees stated that strict compliance with the hygiene regulations and distancing rules were accompanied by offsetting the schedule of all the beneficiaries. The number of activities developed in all the institutions surveyed decreased significantly: all the respondents stated that some activities were either limited or stopped altogether.

The respondents declared that the most difficult measures imposed on the beneficiaries were isolating them from their relatives and the community and distancing them from their peers. All the interviewed women stated that the quarantine subjected both the beneficiaries and themselves to increased pressure during their everyday activities. Two of the men who were interviewed asserted that the isolation was associated with limiting the rights of the beneficiaries; particularly, the quarantine removed the possibility of meeting their relatives and partaking in social events. The new measures entailed by the quarantine also increased the volume of work. This meant that the employees had longer work schedules.

Due to the COVID-19 virus, 11 out of the 29 interviewed employees declared that they had lost relatives, friends, and/or loved ones. While most of those who admitted to losing friends and/or loved ones did not offer any additional explanations, two specifically claimed that they had lost relatives.

The most important tasks that had to be accomplished by the employees during the COVID-19 pandemic were enforcing the new rules of conduct with an emphasis on social distancing and ensuring that the health measures decided nationwide were enforced at the institutional level. Nine women and two men, who were employees during the pandemic, stated that aside from doing their jobs, taking care of their health was a priority. Except for three employees, all the respondents stated that maintaining the health of the beneficiaries was a top priority. Interestingly, two of the employees (both men) stated that social distancing was the most important task they had to accomplish.

The mood of the beneficiaries was characterized as being good by most of the respondents. Ten of the employees stated that the beneficiaries were disturbed and manifested sadness, confusion, anger, frustration, and even desperation since they were not able to interact with their families and the community. Six of the respondents claimed that their mood was influenced by tiredness. For example, one of the women asserted that her mood and that of her colleagues was disturbed. Nevertheless, the rest of the respondents specified that their mood was good, although, as employees, they had to respect the new rules, were subjected to stress, and had to endure longer working hours.

In terms of the behavior of their colleagues, managers, and beneficiaries, after the emergence of the pandemic, 24 respondents claimed that they noticed real solidarity, while four stated that they did not. Two respondents argued that while there were situations in which they noticed solidarity, there were also circumstances when it did not manifest in the various interactions between the employees, managers, and beneficiaries. The responses associated with this topic tended to be quite succinct: only five of the employees offered more detailed responses. Two of them said that there were both moments of solidarity and tension. The other three claimed that everybody in their institutions helped each other, but they did not provide additional details.

All the employees said that there were significant changes in the consciousness and behavior of their colleagues, managers, and beneficiaries. The responses offered on this topic by the employees vary considerably. When asked about the most important changes noticed, the respondents stressed that the various types of documentation needed for many institutional activities were no longer submitted on a face-to-face basis. Instead, all submissions were sent online. Furthermore, there were no resignations and layoffs. The employees were no longer able to conduct the social surveys on a face-to-face basis with the beneficiaries, but only by phone. The respondent from "Schwabenhause Diana" emphasized that while there were no layoffs, the isolation period in the institution was difficult. One of the employees from "Saint Nicholas" emphasized the personal hygiene requirements. In "Adam Müller Guttenbrunn", one of the three interviewed employees detailed the changes that have occurred in the activity and personnel scheme of the institution: unlike the other two respondents, he emphasized that there were three resignations and two employments. At "Sinersig", one of the respondents stated that there was an outbreak of COVID-19 for two weeks at their institution. Accordingly, wearing protective equipment was a necessity, a statement confirmed by the other interviewed employee. The three employees from "Periam" emphasized that in the direct activities with the beneficiaries, the activities were developed in small groups. Keeping a distance of at least two meters was actively enforced. At "Saint Francis", both respondents declared that the pandemic brought with it a change for the worse in people's daily behavior. One of the interviewees emphasized that there were no changes in the personnel scheme, but the activities changed dramatically and the number of restrictions increased considerably. One of the respondents from "Inocentiu Micu Klein" specified that the most important change in the behavior of her colleagues and the beneficiaries brought about by the pandemic was the attainment of greater awareness in some areas of life. Both employees interviewed mentioned that isolation in the workplace was the most important change in the activities undertaken at their center. At "Support Center for Crisis Situations", one of the two respondents mentioned that isolation, the enforcement of wearing mandatory protective equipment,

and social distancing were noticeable changes. Furthermore, the employees were separated into small groups and their work schedule was changed.

The interviewees answered that caring for the elderly is difficult in all contexts and the measures necessary for offering them a good standard of living are similar in all institutions. The employees from “Inocentiu Micu Klein” mentioned that they found out about how elder beneficiaries were cared for in other institutions via mass media (i.e., television, radio, and newspapers). The personnel from “Ciacova” did not detail their answers: only one of the respondents mentioned the Internet as a means of finding out what actions were undertaken in other institutions. When asked about this topic, 13 of the employees declined to offer any answers or stated that they did not know what the situation was in other centers.

The responses regarding the employees’ relationship with God were varied. They can be placed on a continuum between statements that emphasize the good relation between the interviewee and God and assertions that deny the existence of God and/or refute any relation between any form of divinity and the COVID-19 pandemic. For example, the response of one of the interviewees from “Saint Francis” is suggestive. She answered that “I have a good relationship with God; I put all my hope in Him in these difficult times. He can cure any disease if he wants to. Everything depends on us, on how we live our lives, listening, keeping or not His commandments” (woman, 54 years, bachelor graduate). On the other hand, another employee from the same institution stated that “faith has no influence on what man invents” (man, 31 years old, bachelor graduate). Those who mentioned their belief in God stated that their faith helped them during the pandemic. Two of the employees from “Gavojdia” replied that during the pandemic they felt closer to God (woman, 40 years old, high school graduate; man, 42 years old, master graduate). One employee from “Saint Nicholas” claimed she only got through the first year of the pandemic by having faith in God (woman, 40 years old, master graduate).

The final question in the interview guide invited the respondents to add other aspects they deemed to be relevant. The interviewees’ responses cover specific topics on religious themes and mental well-being. For example, one of the employees from “Saint Francis” expounded the lengthiest response to this question on religious themes, emphasizing the importance of God for people’s lives during the pandemic (woman, 54 years old, bachelor graduate). Faith and prayer were mentioned to a lesser extent by other respondents. Another woman who works as a caregiver stated that she passed easier through the pandemic than her colleagues. She mentioned that her colleagues had to stay in isolation at their workplace for three fourteen-day periods. Accordingly, she mentioned that the isolation marked her colleagues because they claimed to have panic attacks, fear, and low morale (woman, 33 years old, master graduate). One employee from “Saint Nicholas” stressed her hopes that the experiences associated with the pandemic will never be repeated and the situation will revert to “normal” (woman, 40 years old, master graduate).

### 3.2.3. Analysis of the Interviews Applied to the Managers of the Care Centers

The interviewed managers enumerated the concrete measures taken to ensure physical distancing. These included wearing masks/protection equipment, limiting the number of beneficiaries in each room, separating the daily meal schedule, and marking routes with stickers to avoid crowding. Social distancing between beneficiaries and employees was enforced everywhere except in “Gavojdia”, where this measure was impossible due to the specific activities with the beneficiaries. In this institution, the employees used protection equipment during all their interactions. The sanitary measures imposed throughout the country were deemed as being either (a) good or (b) panic-inducing, illogical, and/or chaotic. For example, the manager from “Schwabenhause Diana” responded that sometimes the imposed measures were beneficial, while other times they were exaggerated and made work difficult at the expense of the beneficiaries. The measures were considered to be good and/or necessary, albeit insufficient, by the managers of the following centers: “Periam”, “Gavojdia”, “Sinersig”, and “Anitaheim Varel”. Conversely, the chaoticity of

the health measures imposed at the national level was emphasized by the managers of five institutions: “Saint Francis”, “Inocentie Micu Klein”, “Support Center for Crisis Situations”, “Adam Müller Guttenbrunn”, and “Saint Nicholas”. Accordingly, it was difficult to respect all the imposed measures to protect the beneficiaries and the employees. Aside from the aforementioned measures, the manager from “Inocentie Micu Klein” also added the interdiction of receiving visits from the exterior and restrictions regarding exiting the institution. The managers that were interviewed stated that the governmental measures imposed in Romania generally had a negative impact on the activities of their institutions. Consequently, it was very difficult for the employees to carry out their activities and to ensure that all the people involved (beneficiaries and employees) equally respected the established norms and rules. The manager from “Sinersig” mentioned that communication became difficult as well: the messages were hard to send and their understanding was problematic due to the online platforms used and the lack of face-to-face interactions. The three managers from “Adam Müller Guttenbrunn” expounded that the biggest difficulties they encountered during the pandemic were associated with the process of hospitalization of the beneficiaries, the excessive bureaucracy developed during the pandemic, the physical exhaustion, and the deficit of personnel. The excessive bureaucracy was mentioned as the most difficult aspect of the pandemic by the manager from “Schwabenhause Diana” as well. The manager from “Anitaheim Varel” claimed that the biggest difficulty he was confronted with was gaining access to protective equipment. The managers from “Saint Nicholas” responded that for them, the most difficult aspects were the compulsory isolation at their workplace and the quarantine.

The three managers from “Adam Müller Guttenbrunn” responded that the biggest difficulty encountered by the beneficiaries was associated with the fact that they were unable to understand what was happening. Accordingly, the beneficiaries tended to become frightened by the new evolutions. The rest of the interviewed managers stated that the inability to socialize, the limitations imposed on their freedom (e.g., the quarantine), the rejection of the reality outside their institutions (e.g., the number of deaths attributed to the COVID-19 pandemic), and the inability to meet their relatives were the most significant difficulties encountered by the beneficiaries.

Six of the managers answered that they did not lose any beneficiaries, relatives, or acquaintances. Nine of them responded that they have lost people belonging to at least one of the categories mentioned above. Most of the interviewees offered single-word answers on this topic. There were a few that detailed their replies. For example, the manager from “Anitaheim Varel” claimed that he lost two of the beneficiaries for whom he was responsible due to COVID-19. He also stated that between March 2020 and March 2021 his institution was confronted with more deaths than in any other year. The reason expounded for this situation was the precarious health state of the beneficiaries from that institution (man, 74 years old, bachelor graduate). The manager from “Schwabenhause Diana” mentioned that there were a few deceased beneficiaries, who were declared by the medical authorities as being infected with COVID-19. They had multiple associated comorbidities and/or complications (woman, 32 years old, bachelor graduate). Five respondents claimed to have lost people who did not contract the COVID-19 virus. Death resulted because those mentioned by the managers did not receive the necessary medical care on time because of the enforcement of anti-COVID-19 measures. Notably, the manager from “Anitaheim Varel” stated that two of his employees and one beneficiary died because of not receiving medical care in time, even though they were not infected with COVID-19 (man, 74 years old, bachelor graduate).

Regarding the most important task they had to accomplish during the COVID-19 pandemic, the managers offered a plethora of responses on this topic, all associated with one form of responsibility or another. Their responses can be grouped into two categories. Some respondents emphasized the importance of maintaining a veneer of “normality” in their institutions and improving the relations between beneficiaries. This was the case in institutions such as “Saint Francis”, “Sinersig”, and “Schwabenhause Diana”. Other

managers stressed the importance of protecting their employees and beneficiaries and providing them with information daily (e.g., “Ciacova”, “Periam”, “Gavojdia”, “Anitaheim Varel”, and “Saint Nicholas”).

The mood of the beneficiaries was characterized by some of the managers as being subsumed by anxiety, fear, irritability, and irascibility. Furthermore, the employees and the managers themselves were described as stressed and overloaded. This description was expounded by the managers of the following institutions: “Support Center for Crisis Situations”, “Saint Francis”, “Ciacova”, and “Adam Müller Guttenbrunn”. The majority of the respondents claimed that the mood of their beneficiaries and employees was optimistic, such as the managers of “Inocentiu Micu Klein”, “Periam”, “Gavojdia”, “Sinersig”, “Adam Müller Guttenbrunn”.

The responses of all the managers confirmed that there was a noticeable solidarity between the employees and the beneficiaries. The manager from “Anitaheim Varel” emphasized that this solidarity is the reason why both the employees and the beneficiaries were able to go through the pandemic more easily (man, 74 years old, bachelor graduate).

The managers from most of the institutions participating in the study responded that the pandemic did not bring with it a change for the better in the consciousness of the employees and beneficiaries. Furthermore, the respondents enumerated the following changes that occurred and/or were imposed in the organization of their institutions’ activities during the pandemic: the isolation of the employees, quarantine and social distancing imposed on the beneficiaries, new sets of sanitary rules were enforced (including weekly PCR testing), and the location of some activities was changed. The manager from “Periam” claimed that some of the most important changes were the mandatory wearing of protective equipment and frequent disinfection. She also mentioned that there were two resignations. On the other hand, the four managers from “Gavojdia”, “Sinersig”, “Schwabenhause Diana”, and “Saint Nicholas” answered that the pandemic brought with it a change for the better, without offering any details. The latter respondent replied that she hired new employees (woman, 32 years old, bachelor graduate). The manager from “Gavojdia” stated that there were no significant changes in the organization of his institution’s activities (man, 57 years old, bachelor graduate). The three managers from the “Adam Müller Guttenbrunn” specifically stated that they had to consider a series of resignations when they organized their activities. They did not offer any other details on this topic. The manager from “Anitaheim Varel” mentioned that the mood of the employees and beneficiaries worsened, which had an impact on the various activities. The work shifts had to be changed to take better care of the beneficiaries with special needs and to strengthen the relationship between employees and beneficiaries.

On the topic regarding the changes that they would like to make in the future, the managers offered a plethora of answers on this topic. They encompass numerous directions of development associated by the respondents with the term “improvement” rather than “change”: (1) keeping and improving discipline in the activities with beneficiaries (“Saint Francis”); (2) improving the ties between beneficiaries and employees (“Inocentiu Micu Klein”); (3) training the personnel for potential special situations that may require changes in the organization and operation of the institution (“Support Center for Crisis Situations”); (4) hiring new personnel (“Ciacova”); (5) permanent improvements in various fields (“Periam”); (6) improvements in accordance with the changing legislation (“Gavojdia”); (7) improving teamwork by integrating the beneficiaries in the team of “Sinersig”; (8) new equipment—emphasized by two of the three managers from the “Adam Müller Guttenbrunn” (woman, no declared age, bachelor graduate; man, 65 years old, master graduate), while the third manager stated that she did not want any changes for the time being (woman, 65 years old, master graduate); (9) improving the connections and the involvement of the local community as well as acquiring greater support from the authorities (“Anitaheim Varel”); (10) expanding the internment capacity and building a kitchen in the institution’s cafeteria (“Schwabenhause Diana”); and (11) supplementing the specialist

positions and modifying the regulations regarding the accessibility of the service (“Saint Nicholas”).

The managers from “Saint Francis”, “Inocentiu Micu Klein”, “Support Center for Crisis Situations”, “Sinersig”, “Adam Müller Guttenbrunn” (two managers), and “Saint Nicholas” offered no answer on the topic regarding the models of good practice identified in other institutions. The manager from “Ciacova” answered that the models are “identical” to the ones used in his institution. The manager from “Periam” and one of the three managers from the “Adam Müller Guttenbrunn” (woman, no declared age, bachelor degree) stated that she did not know models of good practices from other institutions, but she assumed that in most institutions everything possible was done in the best interest of the beneficiaries (woman, 42 years old, master graduate). The good practices from other institutions were correlated with legal norms issued by the authorities by the managers of “Gavojdia” and “Schwabenhause Diana”. The manager from “Anitaheim Varel” mentioned that social distancing remains a necessary issue that is difficult to tolerate.

Except for the managers from “Ciacova”, all the interviewees mentioned that their faith in God helped them get through the pandemic more easily.

#### 4. Discussion and Conclusions

##### 4.1. Conditions of Institutionalized Older People before Pandemic

In our research, we aimed to examine how care centers for older persons acted and adapted during the pandemic period, considering the opinions of the beneficiaries, employees, and managers of those centers. In this regard, we used a mixed-methods approach, applying a questionnaire to the beneficiaries of the care centers and conducting interviews with beneficiaries, employees, and managers of the care centers.

Considering the results of the quantitative research, our study showed that, generally, the institutionalized older persons described the care centers using positive words. The research also revealed that most of the older persons were institutionalized because they lived alone, with no other people to care for them. A significant number of the respondents also declared that they were institutionalized because they had health problems that required assistance that could no longer be provided at home.

Regarding the beneficiaries’ satisfaction with their life in the care center before the pandemic, the results of the research revealed that most respondents were mainly satisfied with their lives, and the level of satisfaction did not differ depending on their gender or their initial living environment (urban/rural). The first hypothesis—that the satisfaction with life in the care and support centers treatment is significantly different with gender, initial residence environment, the life stage, and time spent in this kind of organization—was partially confirmed. Significant differences were only found in relation to the life stage and time spent in the care center. The research revealed differences depending on the age of the respondents; adults under 64 years old were significantly more satisfied than adults aged 65 to 74, but also adults aged 75 to 84 were significantly more satisfied than those aged 65 to 74. Although the results showed differences according to age, we could not conclude whether the level of satisfaction with life in the centers increases or decreases with age. Thus, to clarify the matter, this issue could also be analyzed from a qualitative perspective.

Moreover, the findings showed that the time spent in the care center can influence the beneficiaries’ level of satisfaction with their life. The results revealed that those who spent up to two years in the care centers were significantly more satisfied than adults who lived there for a period of two to four years.

Given the difficulties the older persons experienced in the care centers, the main difficulty mentioned was the impossibility of being close to loved ones, followed by the difficulty of adapting to the living conditions within the center. Hence, the institutionalized older persons were affected by the fact that while being in the center, they were away from their family and friends and that they had to adjust to a new way of living compared to the one they had at home. In this regard, our research is in line with a previous study [4],

which emphasized the disadvantages of living in a care center, such as social exclusion, or the impossibility of establishing solid social relationships.

Considering the type of medical services, most respondents declared they receive therapeutic massages and that they do therapeutic gymnastics and physical therapy. Thus, as expected, the results of the research showed that gender and age are elements that influence the type of medical help received by the beneficiaries. This means that the second hypothesis—that there are statistically significant differences in the calls for therapies in care centers according to the gender of respondents and the age category—was fully confirmed. In this regard, men requested to a greater extent than women therapeutic massages and medical assistance, while women requested more than men recuperative gymnastics, physical therapy, or assistance in basic activities. Also, adults aged 65 to 74 were the ones who requested therapeutic services more than the other age group categories.

Regarding the main leisure activities carried out by the beneficiaries, the findings revealed that most respondents declared they mostly watch TV shows and play board games with other residents.

Considering the lives of the older people in care centers before the pandemic, other studies confirmed that they highlighted the positive relationships they had with other institutionalized older people and mentioned that they had the chance to get involved in daily activities. However, they also mentioned feeling lonely or isolated from their family [54]. Another study that aligns with our findings, conducted prior to the pandemic, showed that institutionalized older persons experienced feelings of loneliness, but it also showed that they had trust in the nursing staff and had the chance to socialize and take trips outside the center to visit their friends and families or for religious purposes [55]. In this regard, from a before and during the COVID-19 pandemic perspective, it can be stated that the older people from care centers felt lonely both before and during the pandemic, but before the pandemic, they were able to be more involved in social activities within or outside the care centers.

#### *4.2. Conditions of Institutionalized Older People during Pandemic*

In the context of the COVID-19 pandemic, the beneficiaries described the period using positive words but also negative words such as isolation, restriction, and stress. The respondents considered to a small extent that the pandemic influenced the process of improving their physical health, and most of them declared that their needs have largely been met during this period. Most respondents stated that they have felt alone, restless, nervous, helpless, and sad during the pandemic, and the research revealed that these emotional states were not influenced by the gender of the respondents. In other words, we found no differences in the emotions felt by the older persons depending on their gender.

Given the restrictions the older persons had to comply with during the pandemic period, our research is in line with previous studies that described similar measures taken to ensure the well-being of people, such as the prohibition of group activities, the limitation of movements outside the premises, isolation in their rooms [9,12], limiting all social activities, and restricting all visits [10]. Hence, most of the respondents to our research mentioned restrictions such as having fewer roommates, the impossibility of playing board games, wearing masks, the limitation of the number of people who had access to common spaces, and the limitation of the time they were allowed to spend in the common spaces. Despite our expectations regarding the residents' negative attitudes toward staff during the pandemic, most respondents had positive opinions, rating the quality of the services as good or very good. Furthermore, according to the results of the research, the measures taken within the centers were quite restrictive, with the beneficiaries not being allowed to watch TV shows, take walks in the inner courtyard of the center, or interact with the other members of the center.

When asked to state the biggest difficulty encountered during the pandemic, most of the respondents referred to the impossibility of communicating with family members/close persons, the fact that they had to adapt to the new living conditions in the center, that they

were not allowed to interact with the other members of the center, and that their feelings of loneliness increased. From this perspective, our research is in line with a previous study [6], which highlighted that the pandemic increased older persons' feelings of loneliness and limited their social relationships. Comparing the responses of the older persons about the difficulties encountered in general and in the COVID-19 period in particular, we observed that those difficulties are similar in the sense that they refer to the idea of adapting to a new lifestyle and to the idea that institutionalization and the pandemic both affected communication with family members or friends. Moreover, testing the third hypothesis—that the biggest difficulties encountered during the pandemic were significantly different with gender, residence environment, the life stage and time spent in care center—showed that variables such as age or living environment did not influence the opinions about the main difficulties encountered. However, opinions were influenced by age and time spent in the care center. In this regard, while the main difficulty mentioned referred to the impossibility of communicating with family members, the dominant percentages of the respondents who felt this difficulty were represented by adults aged 65 to 74 and by those who had been in the center for a period of 2 to 4 years.

Considering the way the beneficiaries managed to maintain communication with their family members or loved ones, the finding indicated that the communication process was mainly maintained through the usual phone calls. We expected the older persons to communicate with friends or family through video calls, but due to a lack of technology, skills and knowledge, most of them resorted to phone calls. From this perspective, our study is in line with a previous study [53], which showed that even if they have phones, older persons do not usually use apps that require internet.

Furthermore, face-to-face interaction with family members was not possible during the pandemic, and the interesting results of our research showed that even in these conditions, most respondents declared their relationships with family members remained the same, and some of them even stated that they improved. A possible explanation for this result could be represented by the fact that it is possible that during the pandemic the families were more concerned with the well-being of the institutionalized older persons, and as a result, they may have called them more often compared to the pre-pandemic period. This idea is indirectly supported by a previous study [13], which showed that the frequency of communication influences the satisfaction of the beneficiaries and that the social support received through the phone calls decreased the negative effects of isolation on mental health of the patients.

Similar to the attitude toward the relationship with family members, the research revealed that the older persons were satisfied with the interactions they had with the staff of the care centers and they even mentioned that in the pandemic period, the employees paid more attention to them than before. However, the fourth hypothesis—that the more the pandemic affected the physical condition of the beneficiaries, the better the perception was of the relationship with the staff in the care centers—was not supported by the findings. Instead, when measuring the influence of the pandemic on older persons' opinions about their interactions with employees, the results showed that the greater the impact of COVID-19, the more negatively the beneficiaries perceived their relationship with the staff.

Taking into account the suggestions of the beneficiaries regarding improving the way of life of the residents of the care centers, the main suggestions mentioned referred to developing more collective/recreational activities, offering residents more freedom of movement, improving the spaces of the centers, encouraging the employees to have more empathy and respect for the patients, offering the possibility to receive more visits from family and friends, or implementing measures to reassure discipline and peace within the centers. Such measures should be taken into consideration by the employees and the managers of care centers and the matter should also be approached in detail in future research.

The results of the qualitative research showed that while most beneficiaries adjusted well to their move to the centers, they had difficulties with adapting to the changes caused

by the COVID-19 pandemic. These findings are similar to the results of the quantitative research in the sense that in both types of research, the beneficiaries stated that their main difficulty was represented by the impossibility of communicating or receiving visits from family and friends. The beneficiaries described the attitude of the employees as being good or acceptable.

Given the opinions of the employees, the findings revealed that physical distancing measures during the pandemic comprised the strict isolation of the beneficiaries, that the activities developed within the center decreased significantly, that the main measure taken referred to isolating the older persons from their families and the community and that their working hours increased. The main task of the employees was ensuring that the beneficiaries complied with social distancing rules while maintaining a positive attitude toward them, but they observed the beneficiaries' sadness, confusion, anger, frustration, and desperation during the pandemic. Most of them stated they experienced solidarity from their colleagues or their managers, and significant changes took place within the center during the pandemic period, such as isolation, the need to wear masks, and social distancing.

In the context of the opinions of the managers, the findings showed that the managers highlighted the inconsistencies between the measures imposed by the government at the national level. They emphasized the difficulty of complying with all the measures to protect the health both of the beneficiaries and of the employees. Other difficulties encountered were represented by bureaucracy, having access to protective equipment, or the deficit of personnel. Regarding the most difficulty encountered by the beneficiaries, the managers stated that the older persons had a hard time understanding what was happening. They had difficulties because they had to remain isolated and they no longer had the opportunity to interact with their relatives or with the other members of the center. Considering the most important task they had, the managers declared that they struggled with keeping things normal. They had to make sure the health of the beneficiaries and the employees was protected, and they had to offer updated information to the beneficiaries and the employees. The managers described their mood as being stressed and even overloaded, and they perceived the beneficiaries to be anxious and afraid. Furthermore, the managers also highlighted that they observed solidarity between employees and beneficiaries and they mentioned a series of measures that they would like to take in the future to improve the activity of the care center. The main measures mentioned were keeping and improving discipline in the activities with beneficiaries, improving the ties between beneficiaries and employees, training the personnel for potential special situations that may require changes in the organization, hiring new personnel, improving teamwork by integrating the beneficiaries in the team or improving the connections and the involvement of the local community.

Hence, both the employees and the managers were aware of the difficulties encountered by the beneficiaries during the pandemic. They tried to maintain a positive mood in their interactions with the beneficiaries and to protect their health and well-being by complying with the social distancing rules. Moreover, the pandemic period generated feelings of solidarity between the beneficiaries and the employees, and it also made the managers aware of some measures they were required to take to improve the way the care centers function.

#### *4.3. Recommendations for Improving the Lives of Older Persons in Care Centers*

Given the results of our research and the findings of previous studies [55], some recommendations for improving the lives of older persons in care centers could include: (i) improving communication with the relatives of the older persons by facilitating access to technology; (ii) enhancing the social activities developed within the center by diversifying them and ensuring that health measures are followed; (iii) developing activities outside the center (visits to museums, churches, etc.); (iv) improving the living conditions and allowing residents to personalize their space; (v) providing residents and staff with constant mental health support and counselling; (vi) providing staff training focused on showing empathy

and respect toward the residents; (vii) improving safety protocols so that they can easily be adapted to any type of crisis situation; (viii) improving the connection with the local community by developing volunteer programs or partnerships with various organizations; and (ix) adjusting administrative and bureaucratic procedures in order to allow the staff to focus more on the care of residents.

Therefore, considering the theoretical and practical implications of our study, from a theoretical point of view, our research contributes to the literature on the effects of the pandemic on older persons. From a practical perspective, our research offers insights into the lifestyle and struggles of institutionalized older persons during the pandemic, raising awareness regarding the struggles of the beneficiaries as well as of the employees and managers of these institutions. Moreover, it suggests a series of measures that managers could consider to improve the activity of care centers. Given the practical implications of our study, care centers could focus on investing in technology to ensure that institutionalized people can better communicate with their loved ones even in crisis periods. They could also provide constant mental help support and increase the number of social activities developed to help older adults cope with feelings of anxiety and loneliness. Furthermore, care centers could also train staff to be more empathetic and respectful toward residents and provide mental health support for the staff also.

Given the policy implications of our study, the focus could be on diminishing bureaucracy to better address the needs of residents in crisis situations, developing policies to strengthen the connections between the care centers and the community, creating volunteering programs to assist institutionalized people, and elaborating a clear emergency response plan to be followed and implemented in the event of a crisis situation.

#### 4.4. Research Limitations

Considering the limitations of this research, one limitation is represented by the fact that the study was conducted in only a specific area of Romania, Timis County, and thus the results cannot be generalized. However, the results are relevant considering that most care centers had to comply with the same rules during the pandemic. To obtain a larger view of the lifestyle of institutionalized older persons during the pandemic, future research should consider care centers from other regions of Romania and from other countries.

Another limitation refers to the fact that we only obtained the opinions of the institutionalized older persons. Future research should consider examining the opinions of older persons who had to stay at home during the pandemic as well, to further analyze if the COVID-19 pandemic influenced the lifestyle and the mental health of older persons who stayed at home differently from institutionalized older persons.

Furthermore, the period in which the study was conducted could also represent a limitation. Thus, the specific period chosen may not highlight long-term changes or trends. In this regard, future research could be conducted to assess the lifestyle of institutionalized older people after the pandemic. One more limitation is represented by the fact that, in the context of the qualitative research, only interviews were conducted. In future research, a longitudinal study could be conducted, which could facilitate the development of a social intervention model aimed at improving the quality of life of institutionalized older persons.

**Supplementary Materials:** The following supporting information can be downloaded at <https://www.mdpi.com/article/10.3390/soc14060091/s1>, Table S1: Questionnaire applied with the beneficiaries; Table S2: Interview guides.

**Author Contributions:** Conceptualization, C.C., C.G. and L.P.; methodology, F.A., C.G., C.B. and M.C.B.; software, A.N. and C.C.; validation, C.C., M.C.B., C.B. and L.P.; formal analysis, C.C. and A.N.; investigation, C.B., F.A., L.P. and D.B.; resources, C.G., C.B., L.P. and F.A.; data curation, C.C., A.N., M.C.B., C.G., C.B., F.A. and L.P.; writing—original draft preparation, C.B., C.G., L.P., F.A., A.N., M.B. and M.C.B.; writing—review and editing, C.C., C.B., C.G., M.C.B., F.A., L.P., A.N., M.B., D.B., N.T. and B.P.; visualization, C.C., C.B., M.C.B. and B.P.; supervision, C.C.; project administration, C.C., C.G., A.N. and M.C.B. All authors have read and agreed to the published version of the manuscript.

**Funding:** This research received no external funding.

**Institutional Review Board Statement:** The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Institutional Review Board (or Ethics Committee) of Council of the Faculty of Sociology and Communication (Transilvania University of Braşov) (protocol code Decision of the faculty council No. 1930 and date of approval is 29 January 2022).

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:** The raw data supporting the conclusions of this article will be made available by the authors on request.

**Conflicts of Interest:** The authors declare no conflicts of interest.

## References

1. Rojo-Perez, F.; Rodriguez-Rodriguez, V.; Fernandez-Mayoralas, G.; Sánchez-González, D.; Perez de Arenaza Escribano, C.; Rojo-Abuin, J.-M.; Forjaz, M.J.; Molina-Martínez, M.-Á.; Rodriguez-Blazquez, C. Residential Environment Assessment by Older Adults in Nursing Homes during COVID-19 Outbreak. *Int. J. Environ. Res. Public Health* **2022**, *19*, 16354. [[CrossRef](#)] [[PubMed](#)]
2. Dolberg, P.; Lev, S.; Even-Zahav, R. “Let Me Touch Him”: Perceptions and Experiences of Family Caregivers of Nursing Home Residents during the COVID-19 Outbreak in Israel. *J. Aging Stud.* **2023**, *64*, 101115. [[CrossRef](#)] [[PubMed](#)]
3. Chen, C.-Y. Analysing the Quality of Life of Older Adults: Heterogeneity, COVID-19 Lockdown, and Residential Stability. *Int. J. Environ. Res. Public Health* **2022**, *19*, 12116. [[CrossRef](#)] [[PubMed](#)]
4. Oliveira, A.F.; Brites, M.J.; Cerqueira, C. Intergenerational Perspectives on Media and Fake News During Covid-19: Results From Online Intergenerational Focus Groups. *Media Commun.* **2022**, *10*, 277–288. [[CrossRef](#)]
5. Rodriguez-Rodriguez, V.; Rojo-Perez, F.; Perez de Arenaza Escribano, C.; Molina-Martínez, M.-Á.; Fernandez-Mayoralas, G.; Sánchez-González, D.; Rojo-Abuin, J.-M.; Rodríguez-Blázquez, C.; Forjaz, M.J.; Martín García, S. The Impact of COVID-19 on Nursing Homes: Study Design and Population Description. *Int. J. Environ. Res. Public Health* **2022**, *19*, 16629. [[CrossRef](#)] [[PubMed](#)]
6. Pascut, S.; Feruglio, S.; Crescentini, C.; Matiz, A. Predictive Factors of Anxiety, Depression, and Health-Related Quality of Life in Community-Dwelling and Institutionalized Elderly during the COVID-19 Pandemic. *Int. J. Environ. Res. Public Health* **2022**, *19*, 10913. [[CrossRef](#)] [[PubMed](#)]
7. Kabir, H.; Merati, M.; Abdekhodaie, M.J. Design of an effective piezoelectric microcantilever biosensor for rapid detection of COVID-19. *J. Med. Eng. Technol.* **2021**, *45*, 423–433. [[CrossRef](#)]
8. Marginean, C.M.; Popescu, M.; Vasile, C.M.; Cioboata, R.; Mitrut, P.; Popescu, I.A.S.; Biciusca, V.; Docea, A.O.; Mitrut, R.; Marginean, I.C.; et al. Challenges in the Differential Diagnosis of COVID-19 Pneumonia: A Pictorial Review. *Diagnostics* **2022**, *12*, 2823. [[CrossRef](#)]
9. Noten, S.; Stoop, A.; De Witte, J.; Landeweer, E.; Vinckers, F.; Hovenga, N.; van Boekel, L.C.; Luijckx, K.G. “Precious Time Together Was Taken Away”: Impact of COVID-19 Restrictive Measures on Social Needs and Loneliness from the Perspective of Residents of Nursing Homes, Close Relatives, and Volunteers. *Int. J. Environ. Res. Public Health* **2022**, *19*, 3468. [[CrossRef](#)] [[PubMed](#)]
10. Wu, S.; Xiao, L.D.; Nan, J.; Zhao, S.; Yin, P.; Zhang, D.; Liao, L.; Li, M.; Yang, X.; Feng, H. Nursing Home Residents’ Perceptions of Challenges and Coping Strategies during COVID-19 Pandemic in China. *Int. J. Environ. Res. Public Health* **2023**, *20*, 1485. [[CrossRef](#)]
11. Burgaña Agoües, A.; Serra Gallego, M.; Hernández Resa, R.; Joven Llorente, B.; Lloret Arabi, M.; Ortiz Rodriguez, J.; Puig Acebal, H.; Campos Hernández, M.; Caballero Ayala, I.; Pavón Calero, P.; et al. Risk Factors for COVID-19 Morbidity and Mortality in Institutionalised Elderly People. *Int. J. Environ. Res. Public Health* **2021**, *18*, 10221. [[CrossRef](#)] [[PubMed](#)]
12. Richardson, G.; Cleary, R.; Usher, R. The Impact of the COVID-19 Restrictions on Nursing Home Residents: An Occupational Perspective. *J. Occup. Sci.* **2022**, *29*, 386–401. [[CrossRef](#)]
13. Crespo-Martín, A.; Palacios-Ceña, D.; Huertas-Hoyas, E.; Güeita-Rodríguez, J.; Fernández-Gómez, G.; Pérez-Corrales, J. Emotional Impact and Perception of Support in Nursing Home Residents during the COVID-19 Lockdown: A Qualitative Study. *Int. J. Environ. Res. Public Health* **2022**, *19*, 15712. [[CrossRef](#)] [[PubMed](#)]
14. Elaidy, A.M.; Hammoud, M.S.; Albatineh, A.N.; Ridha, F.M.; Hammoud, S.M.; Elsadek, H.M.; Rahman, M.A. Coping Strategies to Overcome Psychological Distress and Fear during COVID-19 Pandemic in Kuwait. *Middle East Curr. Psychiatry* **2023**, *30*, 12. [[CrossRef](#)]
15. Chirico, F. Spirituality to Cope with COVID-19 Pandemic, Climate Change and Future Global Challenges. *J. Health Soc. Sci.* **2021**, *6*, 151–158.
16. Giri, S.P.; Maurya, A.K.A. Neglected Reality of Mass Media during COVID-19: Effect of Pandemic News on Individual’s Positive and Negative Emotion and Psychological Resilience. *Pers. Individ. Dif.* **2021**, *180*, 110962. [[CrossRef](#)] [[PubMed](#)]
17. Pérez-Zepeda, M.U.; Campos-Fajardo, S.; Cano-Gutierrez, C. COVID-19 related mortality in older adults: Analysis of the first wave in Colombia and Mexico. *Rev. Panam. Salud. Publ.* **2021**, *45*, e109. [[CrossRef](#)]
18. Okuyan, C.B.; Begen, M.A. Why are Elderly at Higher Risk and what should be done for them During the COVID-19 pandemic? *Int. J. Caring Sci.* **2021**, *14*, 767–771.

19. Mittal, K.; Dhar, M.; Pathania, M.; Jha, D.; Saxena, V. A comparative study of mortality differences and associated characteristics among elderly and young adult patients hospitalised with COVID-19 in India. *BMC Geriatr.* **2023**, *23*, 247. [[CrossRef](#)] [[PubMed](#)]
20. Pakalniškienė, V.; Kairys, A.; Jurkuvėnas, V.; Mikuličiūtė, V.; Ivleva, V. Could Belief in Fake News Predict Vaccination Behavior in the Elderly? *Int. J. Environ. Res. Public Health* **2022**, *19*, 14901. [[CrossRef](#)]
21. Anwar, K.; Adnan, M. Online Learning amid the COVID-19 Pandemic: Students Perspectives. *J. Pedagog. Res.* **2020**, *1*, 45–51. [[CrossRef](#)]
22. Ng, R.; Tan, Y.W. Media Attention toward COVID-19 across 18 Countries: The Influence of Cultural Values and Pandemic Severity. *PLoS ONE* **2022**, *17*, e0271961. [[CrossRef](#)]
23. Giritli Nygren, K.; Klinga, M.; Olofsson, A.; Öhman, S. The Language of Risk and Vulnerability in Covering the COVID-19 Pandemic in Swedish Mass Media in 2020: Implications for the Sustainable Management of Elderly Care. *Sustainability* **2021**, *13*, 10533. [[CrossRef](#)]
24. Lor, Y.-C.M.; Tsou, M.-T.; Tsai, L.-W.; Tsai, S.-Y. The Factors Associated with Cognitive Function among Community-Dwelling Older Adults in Taiwan. *BMC Geriatr.* **2023**, *23*, 116. [[CrossRef](#)]
25. Steultjens, E.M.J.; Dekker, J.; Bouter, L.M.; Jellema, S.; Bakker, E.B.; van den Ende, C.H.M. Occupational Therapy for Community Dwelling Elderly People: A Systematic Review. *Age Ageing* **2004**, *33*, 453–460. [[CrossRef](#)]
26. Clegg, A.; Young, J.; Iliffe, S.; Rikkert, M.O.; Rockwood, K. Frailty in Elderly People. *Lancet* **2013**, *381*, 752–762. [[CrossRef](#)]
27. Nerobkova, N.; Park, Y.S.; Park, E.-C.; Shin, J. Frailty Transition and Depression among Community-Dwelling Older Adults: The Korean Longitudinal Study of Aging (2006–2020). *BMC Geriatr.* **2023**, *23*, 148. [[CrossRef](#)]
28. Ibáñez-del Valle, V.; Corchón, S.; Zaharia, G.; Cauli, O. Social and Emotional Loneliness in Older Community Dwelling-Individuals: The Role of Socio-Demographics. *Int. J. Environ. Res. Public Health* **2022**, *19*, 16622. [[CrossRef](#)]
29. Golden, J.; Conroy, R.M.; Bruce, I.; Denihan, A.; Greene, E.; Kirby, M.; Lawlor, B.A. Loneliness, Social Support Networks, Mood and Wellbeing in Community-Dwelling Elderly. *Int. J. Geriatr. Psychiatry* **2009**, *24*, 694–700. [[CrossRef](#)]
30. Crewdson, J. The Effect of Loneliness in the Elderly Population: A Review. *Healthy Aging Clin. Care Elder.* **2016**, *8*, 1. [[CrossRef](#)]
31. Oduro, J.K.; Okyere, J.; Nyador, J.K.M.T. Risky Health Behaviours and Chronic Conditions among Aged Persons: Analysis of SAGE Selected Countries. *BMC Geriatr.* **2023**, *23*, 145. [[CrossRef](#)]
32. Kojima, G. Frailty as a Predictor of Nursing Home Placement Among Community-Dwelling Older Adults: A Systematic Review and Meta-Analysis. *J. Geriatr. Phys. Ther.* **2018**, *41*, 42–48. [[CrossRef](#)]
33. Chen, P.; Cai, H.; Bai, W.; Su, Z.; Tang, Y.-L.; Ungvari, G.S.; Ng, C.H.; Zhang, Q.; Xiang, Y.-T. Global Prevalence of Mild Cognitive Impairment among Older Adults Living in Nursing Homes: A Meta-Analysis and Systematic Review of Epidemiological Surveys. *Transl. Psychiatry* **2023**, *13*, 88. [[CrossRef](#)]
34. Johnson, R.; Popejoy, L.L.; Radina, M.E. Older Adults' Participation in Nursing Home Placement Decisions. *Clin. Nurs. Res.* **2010**, *19*, 358–375. [[CrossRef](#)]
35. Smoliner, C.; Norman, K.; Wagner, K.-H.; Hartig, W.; Lochs, H.; Pirlich, M. Malnutrition and Depression in the Institutionalised Elderly. *Br. J. Nutr.* **2009**, *102*, 1663–1667. [[CrossRef](#)]
36. Vossius, C.; Borda, M.G.; Lichtwarck, B.; Myhre, J.; Sollid, M.I.V.; Borza, T.; Feiring, I.H.; Benth, J.Š.; Bergh, S. Body Mass Index in Nursing Home Residents during the First Year after Admission. *BMC Nutr.* **2023**, *9*, 50. [[CrossRef](#)]
37. Hua, N.; Zhang, Y.; Tan, X.; Liu, L.; Mo, Y.; Yao, X.; Wang, X.; Wiley, J.; Wang, X. Nutritional Status and Sarcopenia in Nursing Home Residents: A Cross-Sectional Study. *Int. J. Environ. Res. Public Health* **2022**, *19*, 17013. [[CrossRef](#)]
38. Varrasse, M.; Li, J.; Gooneratne, N. Exercise and sleep in community-dwelling older adults. *Curr. Sleep Med. Rep.* **2015**, *1*, 232–240. [[CrossRef](#)]
39. Xu, L.; Gu, H.; Cai, X.; Zhang, Y.; Hou, X.; Yu, J.; Sun, T. The effects of exercise for cognitive function in older adults: A systematic review and meta-analysis of randomized controlled trials. *Int. J. Environ. Res. Public Health* **2023**, *20*, 1088. [[CrossRef](#)]
40. Seol, J.; Lee, J.; Nagata, K.; Fujii, Y.; Joho, K.; Tateoka, K.; Inoue, T.; Liu, J.; Okura, T. Combined effect of daily physical activity and social relationships on sleep disorder among older adults: Cross-sectional and longitudinal study based on data from the Kasama study. *BMC Geriatr.* **2021**, *21*, 623. [[CrossRef](#)]
41. Effendy, E.; Prasanty, N.; Utami, N. The Effects of Brain Gym on Quality of Sleep, Anxiety in Elderly at Nursing Home Care Case Medan. *Open Access Maced. J. Med. Sci.* **2019**, *7*, 2595–2598. [[CrossRef](#)]
42. Segura Cardona, A.; Cardona Arango, D.; Segura Cardona, A.; Robledo Marín, C.; Muñoz Rodríguez, D. Friendly Residential Environments That Generate Autonomy in Older Persons. *Int. J. Environ. Res Public Health* **2023**, *20*, 409. [[CrossRef](#)]
43. Wang, Z.; Shepley, M. The Relationship of Neighborhood Walking Behavior to Duration of Aging in Place—A Retrospective Cohort Study. *Int. J. Environ. Res. Public Health* **2022**, *19*, 16428. [[CrossRef](#)]
44. Tîru, M.C. The use of students' portfolio within the assessment process at university level during the COVID-19 pandemic. *Educatia* **2022**, *21*, 41–49. [[CrossRef](#)]
45. Lu, L.; Shen, H.; Tan, L.; Huang, Q.; Chen, Q.; Liang, M.; He, L.; Zhou, Y. Prevalence and Factors Associated with Anxiety and Depression among Community-Dwelling Older Adults in Hunan, China: A Cross-Sectional Study. *BMC Psychiatry* **2023**, *23*, 107. [[CrossRef](#)]
46. Vandervelde, S.; Vlaeyen, E.; de Casterlé, B.D.; Flamaing, J.; Valy, S.; Meurrens, J.; Poels, J.; Himpe, M.; Belaen, G.; Milisen, K. Strategies to Implement Multifactorial Falls Prevention Interventions in Community-Dwelling Older Persons: A Systematic Review. *Implement. Sci.* **2023**, *18*, 4. [[CrossRef](#)]

47. Van Offenwert, E.; Schoenmakers, B. The Predictive Value of Weight Evolution in Screening for Malnutrition in Community-Dwelling Older Persons (70+) in Antwerp. *BMC Prim. Care* **2023**, *24*, 64. [[CrossRef](#)]
48. Farrell, A.; Castro, T.; Nalubola, S.; Lakhi, N. Trauma-Related Falls in an Urban Geriatric Population: Predictive Risk Factors for Poorer Clinical Outcomes. *Inj. Epidemiol.* **2023**, *10*, 7. [[CrossRef](#)]
49. Creswell, J.W.; Plano Clark, V.L. *Designing and Conducting Mixed Methods Research*, 2nd ed.; SAGE Publications: Los Angeles, CA, USA, 2011; ISBN 978-1-4129-7517-9.
50. Babbie, E. Practica Cercetarii Sociale. In *The Practice of Social Research*, 2nd ed.; Polirom: Iasi, Romania, 2010; ISBN 978-973-46-1274-1.
51. The European Asylum Support Office. COVID-19 Emergency Measures in Asylum and Reception Systems, Public—Issue No. 3. 2020. Available online: [https://euaa.europa.eu/sites/default/files/publications/COVID-19\\_emergency\\_measures\\_in\\_asylum\\_and\\_reception\\_systems-December-2020\\_new.pdf](https://euaa.europa.eu/sites/default/files/publications/COVID-19_emergency_measures_in_asylum_and_reception_systems-December-2020_new.pdf) (accessed on 10 May 2022).
52. Merton, R.K.; Barber, E. *The Travels and Adventures of Serendipity: A Study in Sociological Semantics and the Sociology of Science*; Princeton University Press: Princeton, New Jersey, United States, 2024. Available online: <http://www.jstor.org/stable/j.ctt7sm3v> (accessed on 15 October 2023).
53. Metro Media Transilvania, Studiu Cantitativ Privind Utilizarea Serviciilor de Comunicații Electronice de Către Utilizatorii Finali-Persoane Fizice. Available online: <https://statistica.ancom.ro/sscpds/public/alldocuments/marketstudy> (accessed on 21 May 2022).
54. Evangelista, R.A.; Bueno, A.D.A.; Castro, P.A.D.; Nascimento, J.N.; Araújo, N.T.D.; Aires, G.P. Perceptions and experiences of elderly residents in a nursing home. *Rev. Esc. Enferm. USP* **2014**, *48*, 81–86. [[CrossRef](#)]
55. Mohammad, H.; Kassim, N.; Yasir, A. Older adult social needs nursing home. *Med. J. Babylon* **2013**, *10*, 625–631.

**Disclaimer/Publisher’s Note:** The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.