FLORIDA

Licensure Terms

Assisted Living Facilities

General Approach

The state views assisted living facilities (ALFs) as an important part of the continuum of its long-term care system, to be operated and regulated as residential environments with supportive services and not as medical or nursing facilities.

The Bureau of Health Facility Regulation licenses several types of ALFs, which can range in size from one resident to several hundred. Facilities are licensed to provide routine personal care services under a "standard" license or more specific services under the authority of "specialty" licenses. ALFs meeting the requirements for a standard license may also qualify for specialty licenses.

The purpose of specialty licenses is to allow individuals to "age in place" in familiar surroundings that can adequately and safely meet their continuing health care needs. Specialty licenses include limited nursing services (LNS), extended congregate care (ECC), and limited mental health (LMH) services. To obtain a specialty license, facilities must meet additional requirements, including those related to staffing and staff training.

Adult Foster Care. An adult family care home (AFCH) is a licensed, full-time, family-type living arrangement in a private home, under which individuals who own or rent a home provide room, board, and personal care on a 24-hour basis to no more than five disabled adults or frail elders who are not relatives. Each AFCH must designate at least one licensed space for a resident receiving an optional state supplement (OSS). AFCH operators must live in the home; if they do not, the home must be licensed as an ALF. If an AFCH provides room, board, and personal services for only 1-2 adults who do *not* receive an OSS, it does not have to be licensed. *Regulatory provisions for adult family homes are not included in this profile but a link to the provisions can found at the end*.

Unless noted as a provision for one of the specialty licenses, this profile includes summaries of selected regulatory provisions for ALFs with a standard license. The complete regulations are online at the links provided at the end.

Definitions

Assisted living facility means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, which undertakes through its ownership or management to provide housing, meals, and one or more personal services (e.g., assistance with activities of daily living (ADLs) and self-administered medication) for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator. An ALF can have a standard license or a specialty license as defined below.

Standard means a facility licensed to provide housing, meals, and one or more personal care services for a period exceeding 24 hours. Personal care services include direct physical assistance with or supervision of a resident's ADLs and the self-administration of medication and similar services. The facility may employ or contract with licensed persons to administer medication and perform other nursing tasks, such as taking vital signs, managing individual weekly pill organizers for residents who self-administer medication, giving pre-packaged enemas ordered by the physician, and observing residents.

Limited nursing services means a facility licensed to provide any of the services under a standard license and additional LMH specified in rules, which include: conducting passive range of motion exercises; applying ice caps or collars and heat; cutting toenails of diabetic residents or residents with a documented circulatory problem, if approved in writing by the resident's health care provider; performing ear and eye irrigations; conducting a urine dipstick test; replacing established self-maintained in-dwelling catheter or performing intermittent urinary catheterizations; applying and changing routine dressings that do not require packing or irrigation; caring for Stage II pressure sores; conducting nursing assessments if conducted by, or under the direct supervision of, a registered nurse (RN); and providing any nursing service permitted within the scope of the nurse's license, including 24-hour supervision, for hospice patients.

Extended congregate care means a facility licensed to provide any of the services under a standard license and LNS license, including any nursing service permitted within the scope of the nurse's license consistent with ALF residency requirements and the facility's written policy and procedures. A facility with this type of license enables residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency under a standard or LNS license. This definition creates a higher level of care in assisted living.

Limited Mental Health. A facility licensed to provide any of the services under a standard license must obtain an LMH license to serve three or more residents who receive Social Security Disability Insurance or Supplemental Security Income (SSI) benefits due to a mental disorder, and who also receive a state SSI supplement--called the OSS. The facility must meet additional requirements, including the development of a community living support plan with the mental health resident and a case manager,

which specifies the resident's needs that must be met to enable the resident to live in an ALF and the community.

Resident Agreements

The resident contract must contain a list of specific services, supplies, and accommodations to be provided--including those provided under any specialty license; the daily, weekly or monthly rate and the notice policy for rate increases; additional services available and their cost; residents' rights, duties and obligations; refund policies and procedures; the bed hold policy; a statement of the organization's religious affiliation and related requirements, if any; and discharge policies and procedures.

Disclosure Provisions

A facility that advertises that it provides special care for persons who have Alzheimer's disease or other dementias must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other dementias offered by the facility and must maintain a copy of all such advertisements and documents in its records. The licensing agency examines all such advertisements and documents in the facility's records as part of the license renewal procedure.

Admission and Retention Policy

Facilities must determine the appropriateness of admission and retention based on the ability of the facility to meet an individual's needs and preferences.

To be admitted and retained, an individual must be capable of performing ADLs, including transfers, with supervision or assistance; not require 24-hour nursing supervision; be free of Stage II, III, or IV pressure sores; be able to participate in social and leisure activities; be ambulatory; and not display violent behavior or be a danger to self or others.

Terminally ill residents may continue to reside in any ALF if the arrangement is mutually agreeable to the resident and the facility, additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the resident's physical needs are being met.

In standard and LNS facilities, people who are bedridden more than 7 days or develop a need for 24-hour nursing supervision may not be retained. Residents with Stage II pressure sores may remain if the facility has a limited nursing license or

resident contracts with a home health agency or RN. Residents in ECC facilities may not be retained if they are bedridden for more than 14 days.

EEC facilities must promote aging in place by determining the appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

Services

Facilities provide different services depending on their licensure types. Standard facilities provide personal care services and assistance with self-administration of medications.

Facilities with an LNS license can provide additional nursing services specified in regulations, such as applying and changing routine dressings that do not require packing or irrigation, but are for abrasions, skin tears, and closed surgical wounds; caring for Stage II pressure sores; catheter, colostomy, and ileostomy care and maintenance; caring for casts, braces, and splints; conducting nursing assessments if conducted by an RN or under the direct supervision of an RN; and providing any nursing service permitted under the facility's license and total help with ADLs for residents admitted to hospice.

Facilities with an ECC license can provide more extensive ADL assistance and additional nursing services if required by the resident's service plan: total help with bathing, dressing, grooming and toileting; nursing assessments conducted more frequently than monthly; measurement and recording of basic vital functions and weight; dietary management, including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output; assistance with self-administered medications; or the administration of medications and treatments pursuant to a health care provider's order.

ECC facilities may not provide oral or nasopharyngeal suctioning, assistance with nasogastric tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, skilled rehabilitative services; or treatment of surgical incisions, unless the surgical incision and the condition which caused it have been stabilized and a plan of care developed.

Service Planning

Within 60 days prior to admission, but no later than 30 days after admission, residents must be examined by a physician or advanced RN practitioner who must provide the administrator with a medical examination report.

Licensed nurses who are employed by or under contract with a facility must, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician (except administration of medication), and must document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility.

ECC facilities are allowed to use managed risk agreements, which are defined as "the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney-in-fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly."

"Shared responsibility" means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney-in-fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.

Third-Party Providers

Residents or their representative, designee, surrogate, guardian, or attorney-in-fact may arrange, contract, and pay for services provided by a third-party of the resident's choice, provided the resident meets the criteria for appropriate placement in the facility and complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third-party to coordinate with the facility regarding the resident's condition and the services being provided.

When residents require specified care or services from a third-party provider and when requested by residents or their representatives, the facility administrator or designee must assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals.

Medication Provisions

Licensed nursing staff may administer medications. Unlicensed staff may assist with self-administration of routine, regularly scheduled medications that are intended to be self-administered by residents with a medically stable condition. Unlicensed persons may not assist with certain types of medication administration, described in detail in the regulations, including “as-needed” (PRN) medications and injections.

Assistance with self-administration is described in detail in the regulations and includes taking previously dispensed, properly labeled containers from where they are stored and bringing them to the resident; reading the label, opening the container, removing a prescribed amount of medication, and closing the container; placing an oral dosage in the resident’s hand or in another container and helping the resident lift the container to his or her mouth; applying topical medications; and keeping a record of when a resident receives assistance with self-administration.

Assistance with self-administration of medication by an unlicensed person is allowed only if: (1) he or she has met training requirements--4 hours upon hire and 2 hours of training annually; and (2) upon a documented request by, and the written informed consent of, a resident or the resident’s surrogate, guardian, or attorney-in-fact.

Informed consent means advising the resident, or the resident’s surrogate, guardian, or attorney-in-fact that an ALF is not required to have a licensed nurse on staff, that the resident may be receiving assistance with self-administration of medication from an unlicensed person, and that such assistance, if provided by an unlicensed person, will or will not be overseen by a licensed nurse.

Food Service and Dietary Provisions

The facility must provide a variety of regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident’s health care provider for residents who require special diets. Meals must be adapted to residents’ food habits, preferences, and physical abilities.

The meals must be planned based on the current U.S. Department of Agriculture Dietary Guidelines for Americans, 2010 and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies. Therapeutic diets must meet these nutritional standards to the extent possible.

All regular and therapeutic menus must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional requirements. Daily food servings may be divided among three or more

meals per day, including snacks, as-necessary to accommodate resident needs and preferences.

Staffing Requirements

Type of Staff. Every facility must be under the supervision of an *administrator* who is responsible for its operation and maintenance, including the management of all staff and the provision of adequate care to all residents. Facilities must employ *direct care staff*. A staff member who has completed courses in first-aid and cardiopulmonary resuscitation must be in the facility at all times.

LNS and ECC facilities must employ or contract with a *nurse*, who must be available to provide nursing services as-needed by residents. In addition, the EEC facility nurse must participate in the development of resident service plans and perform monthly nursing assessments. An ECC staff member must serve as the *ECC supervisor* who is responsible for the general supervision of the day-to-day management of an ECC program and ECC resident service planning, if the administrator does not perform this function.

Staff Ratios. In all ALFs, sufficient staff must be employed to ensure the safety and proper care of individual residents and to implement the evacuation and emergency management plan, and at least one employee certified in first-aid must be present at all times.

The rules contain minimum staff hours per week for different numbers of residents, for example: (1) up to five residents, 168 staff hours per week; (2) 6-15 residents, 212 hours; (3) 16-25 residents, 253 hours; and (4) 26-35 residents, 294 hours. For every 20 residents over 95, 42 staff hours must be added each week, which equates to about one full-time employee per 20 residents. Notwithstanding the minimum staffing requirements, facilities must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and all required resident care standards.

ECC facilities must have enough qualified staff to meet the needs of ECC residents and to provide the services established in each resident's service plan. Facilities must ensure that adequate staff are awake during all hours to meet residents scheduled and unscheduled needs. If the licensing agency determines that service plans are not being followed or that residents' needs are not being met because of insufficient staffing, facilities must immediately provide additional or appropriately qualified staff.

Training Requirements

The ALF core training requirements established by the Department of Elder Affairs consists of a minimum of 26 hours of training plus a competency test. Administrators must complete the core training and competency test no later than 90 days after becoming employed as a facility administrator. Administrators must also receive 12 hours of continuing education every 2 years on topics related to assisted living.

Staff who provide direct care to residents--other than nurses, certified nursing assistants, or home health aides--must receive a minimum of 1 hour in-service training in infection control, including universal precautions, and facility sanitation procedures before providing personal care to residents; and must receive 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with ADLs.

Staff who have not taken the core training program, and who provide direct care to residents, must receive within 30 days of employment a minimum of 1 hour in-service training that covers resident rights in an ALF and recognizing and reporting resident abuse, neglect, and exploitation; and a minimum of 1 hour in-service training that covers reporting major incidents, reporting adverse incidents, and facility emergency procedures, including chain-of-command and staff roles relating to emergency evacuation.

In addition to the core training, the administrator of an ECC facility and the ECC supervisor must complete 6 hours of initial training on the physical, psychological, or social needs of frail elders or persons with Alzheimer's disease and adults with disabilities, and 6 hours of continuing training every 2 years. In ECC facilities, direct care staff must complete at least 2 hours of in-service training within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an ECC facility.

The administrator, managers and staff who have direct contact with mental health residents in an LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses within 6 months of the facility's receiving an LMH license or within 6 months of employment in an LMH facility, and a minimum of 3 hours of continuing education on mental health topics, including diagnoses, treatments, services, behaviors and appropriate interventions.

All facility staff must receive in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment.

Provisions for Apartments and Private Units

Standard and LNS facilities do not have to provide apartment-style units or private rooms. Facilities licensed prior to October 1999 may provide rooms shared by four people; one toilet and sink must be provided for every six residents and bathing facilities for every eight residents. Facilities licensed after October 1999 may provide rooms shared by a maximum of two persons and must have bathrooms shared by no more than four residents.

ECC facilities must provide a private room or apartment, or a semi-private room or apartment, shared with a roommate of the resident's choice. Bathrooms with a toilet, sink, and bathtub or shower can only be shared by a maximum of four residents.

Medicaid Requirements. Apartment-style units are not required for ALFs that provide assistive care services through the Medicaid State Plan program. Facilities participating in the Managed Long-Term Care (MLTC) Waiver program must offer a private room or apartment or a unit that is shared only with the approval of the waiver participant.

Provisions for Serving Persons with Dementia

Dementia Care Staff. A facility that advertises that it provides special care for persons with dementia must meet the following staffing requirements: (1) it must have 24-hour staffing capability; (2) if the facility has 17 or more residents, it must have an awake staff member on duty at all hours of the day and night; or (3) if the facility has fewer than 17 residents, it must have an awake staff member on duty at all hours of the day and night, or have mechanisms in place to monitor and ensure residents' safety.

Dementia Staff Training. Facilities that advertise that they provide special care for persons with dementia or who maintain secured areas are required to ensure that staff who have regular contact with or provide direct care to residents with dementia have specialized training.

In addition to core training requirements, staff in special care units must receive 4 hours of initial training covering the characteristics of Alzheimer's disease, communicating with residents who have dementia, family issues, the residents' environment, and ethical issues. Direct caregivers must obtain an additional 4 hours training within 9 months of employment covering behavior management, assistance with ADLs, activities for residents, stress management for the caregiver, and medical information.

Direct care staff must receive 4 hours of continuing education each year that includes one or more topics covered in the dementia-specific training developed or approved by the Department, in which the caregiver has not received previous training.

Employees of facilities that provide special care for residents with dementia but who have only incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with dementia within 3 months after beginning employment.

The Department, or its designee, must approve the initial and continuing education courses and providers. Any facility with more than 90 percent of its residents receiving monthly optional supplementation payments is not required to pay for the training and education programs. A facility that has one or more such residents may pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the Department, for such training and education programs.

Dementia Facility Requirements. Facilities must offer activities specifically designed for persons who are cognitively impaired and have a physical environment that provides for the safety and welfare of the facility's residents.

Background Checks

Florida law has extensive criminal background screening provisions for ALFs. All ALF owners (if individuals), administrators, financial officers, and employees must have a criminal history record check obtained through a fingerprint search through the Florida Department of Law Enforcement and the Federal Bureau of Investigation, to determine whether screened individuals have any disqualifying offenses. An analysis and review of court dispositions and arrest reports may be required to make a final determination. The cost of the state and national criminal history records checks are born by the licensee or the person being fingerprinted. All individuals who are required to have an initial background screen, must be re-screened every five years.

Inspection and Monitoring

Facilities are inspected prior to licensure and at any time deemed necessary by the licensing agency to determine compliance with requirements. Inspections that are conducted for reasons other than initial licensure must be unannounced. Inspections for re-licensure must be conducted every 2 years, unless otherwise specified by authorizing statutes or applicable rules.

An RN or appropriate designee representing the licensing agency must visit ECC facilities quarterly to monitor residents and to determine facility compliance. An RN representing the agency must also visit LNS facilities twice a year to monitor residents who are receiving LNS and to determine facility compliance.

Public Financing

Florida covers services in ALFs with a standard license and with a specialty license under a statewide 1915(b)(c) MLTC program. This program replaced two 1915(c) Waiver programs--Assisted Living for the Elderly and Nursing Home Diversion. Only facilities with a standard license and private or semi-private rooms and bathrooms are allowed to participate in the MLTC program. Waiver participants must be offered a private room or apartment or a unit that is shared only with their approval.

The state also covers services in ALFs and licensed adult family homes under a Medicaid State Plan program--called Assistive Care Services--that includes health support, assistance with ADLs and instrumental activities of daily living, and assistance with self-administration of medication.

Facilities may serve residents eligible for either program--MLTC and Assistive Care Services--or both. Residents eligible for both must have a service plan which separately identifies the services that will be provided under each program.

Room and Board Policy

Medicaid does not cap the room and board rate. For waiver participants, room and board and service rates are negotiated by the provider and the MLTC plan.

To help pay for room and board, the state provides an OSS to residents in ALFs and AFCHs who are receiving the federal SSI benefit or who are determined by the Department of Children and Family Services to be eligible for the supplement.

The Department establishes the base rate of the OSS payment, which was $78.40 in 2014. Additional amounts may be provided for mental health residents in facilities designed to provide LMH services. The base rate of payment does not include the personal needs allowance of $54, which is retained by the resident.

Family Supplementation

Supplementation by families or other third parties is permitted to contribute to the cost of care. This supplementation may be provided under the following conditions:

- Payments are made to the ALF or to the operator of an AFCH on behalf of the person and not directly to the OSS recipient.

- Contributions made by third parties are entirely voluntary and must not be a condition of providing proper care to the resident.

- The additional supplementation must not exceed two times the provider rate recognized under the OSS program.

The state does not count supplementation in accordance with these provisions as income to the resident for purposes of determining eligibility for, or computing the amount of, OSS benefits. The state does not increase an OSS payment to offset the reduction in SSI benefits that will occur because of the third-party contribution.

Location of Licensing, Certification, or Other Requirements

Agency for Health Care Administration. Assisted Living Facility. *The following website contains links to all applicable statutes, regulations, and other information about assisted living facilities*. http://www.ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/alf.shtml

Agency for Health Care Administration. Adult Family Care Home. *The following website contains links to all applicable statutes and regulations about adult family care homes*. http://www.ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/afc.shtml

Information Sources

Lee Ann Griffin
Director
Quality and Regulatory Services
Florida Health Care Association

Keith Young
Government Analyst
Federal Authorities Section
Bureau of Medicaid Services
Agency for Health Care Administration

COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

Files Available for This Report

FULL REPORT

Executive Summary	http://aspe.hhs.gov/execsum/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-executive-summary
HTML	http://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition
PDF	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition

SEPARATE STATE PROFILES

[***NOTE***: These profiles are available in the full HTML and PDF versions, as well as each state available as a separate PDF listed below.]

Alabama	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alabama-profile
Alaska	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alaska-profile
Arizona	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-arizona-profile
Arkansas	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-arkansas-profile
California	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-california-profile
Colorado	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-colorado-profile
Connecticut	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-connecticut-profile
Delaware	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-delaware-profile
District of Columbia	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-district-columbia-profile
Florida	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-florida-profile

Georgia	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-georgia-profile
Hawaii	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-hawaii-profile
Idaho	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-idaho-profile
Illinois	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-illinois-profile
Indiana	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-indiana-profile
Iowa	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-iowa-profile
Kansas	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-kansas-profile
Kentucky	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-kentucky-profile
Louisiana	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-louisiana-profile
Maine	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-maine-profile
Maryland	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-maryland-profile
Massachusetts	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-massachusetts-profile
Michigan	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-michigan-profile
Minnesota	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-minnesota-profile
Mississippi	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-mississippi-profile
Missouri	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-missouri-profile
Montana	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-montana-profile
Nebraska	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-nebraska-profile
Nevada	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-nevada-profile
New Hampshire	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-new-hampshire-profile
New Jersey	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-new-jersey-profile

New Mexico	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-new-mexico-profile
New York	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-new-york-profile
North Carolina	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-north-carolina-profile
North Dakota	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-north-dakota-profile
Ohio	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-ohio-profile
Oklahoma	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-oklahoma-profile
Oregon	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-oregon-profile
Pennsylvania	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-pennsylvania-profile
Rhode Island	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-rhode-island-profile
South Carolina	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-south-carolina-profile
South Dakota	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-south-dakota-profile
Tennessee	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-tennessee-profile
Texas	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-texas-profile
Utah	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-utah-profile
Vermont	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-vermont-profile
Virginia	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-virginia-profile

Washington	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-washington-profile
West Virginia	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-west-virginia-profile
Wisconsin	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-wisconsin-profile
Wyoming	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-wyoming-profile