MAINE

Licensure Terms

Assisted Housing Program, which includes the following types: Assisted Living Programs; Residential Care Facilities Levels I, II, III, and IV; and Private Non-Medical Institutions Levels I, II, III, and IV

General Approach

The Maine Department of Health and Human Services (DHHS), Division of Licensing and Regulatory Services licenses nine types of facilities that provide assisted living services under the umbrella licensing term of assisted housing programs, namely: assisted living programs (ALPs) and four levels each of residential care facilities (RCFs) and private non-medical institutions (PNMIs). The latter two may offer the same services as ALPs, but provide bedrooms rather than apartment units.

The rules for PNMIs are the same as those for RCFs; they are licensed as a separate type of assisted housing program only because they receive Medicaid funding for the provision of personal care services to their residents and therefore must comply with additional requirements as specified in various sections of the licensing rules. In this profile, the rules listed for each of the four levels of licensing apply to both RCFs and PNMIs.

Multilevel facilities are assisted housing programs that are located on the same contiguous grounds with licensed nursing facilities, adult day services programs, or home health agencies. For such facilities, a single license is issued that identifies each level of service and the facility must meet all of the state rules and regulations with regard to the operation of each type of facility.

An adult family care home (AFCH) is a residential-style home for eight or fewer residents, which is licensed by DHHS as an Assisted Housing Program Residential Care Facility,[1] Level III or IV, and is primarily engaged in providing services to the elderly. MaineCare, the state's Medicaid program, covers services that include personal care, medication management, and supervision. If an AFCH serves only private pay residents, it can be licensed as a Level I or Level II Assisted Housing Program Residential Care Facility.

[1] This constitutes a conflict of information between the DHHS licensing rules and the MaineCare Benefits Manual chapter on adult family care in that RCFs funded through Medicaid must be licensed as private non-medical institutions, as stated above. We were unable to get clarification of this conflict of information from state staff.

The information in this profile, unless it specifically references different types of licensed assisted housing programs, applies to all of them. This profile includes summaries of selected regulatory provisions. The complete regulations are online at the links provided at the end.

Definitions

Assisted living services means the provision by an assisted housing program--either directly by the provider or indirectly through contracts with persons, entities or agencies--of: (1) assisted housing services, which include personal supervision; protection from environmental hazards; assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); diversional, motivational or recreational activities; dietary services; and care management services; (2) assisted housing services with the addition of medication administration; or (3) assisted housing services with the addition of medication administration and nursing services, which are defined as services provided by licensed professional nurses that include coordination and oversight of resident care services provided by unlicensed health care assistive personnel.[2]

Assisted living services may be provided in four settings--ALPs, independent housing with services programs (IHSPs), RCFs, and PNMIs.

Assisted living program means a program of assisted living services provided to residents in private apartments in buildings that include a common dining area. The types of ALPs are as follows:

- Type I: services include medication administration.
- Type II: services include medication administration and nursing services as defined above.

Independent housing with services program means a program of assisted living services provided to residents in private apartments in buildings that include a common dining area, either directly by the provider or indirectly through contracts with persons, entities, or agencies. Like ALPs, they assist residents with ADLs and IADLs. The major difference between the two settings is that IHSP providers do not offer medication administration or nursing services and therefore do not require licensure.

Residential care facility means a house or other place that is maintained wholly or partly for the purpose of providing residents with assisted living services. RCFs provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. The four types of RCFs are:

[2] Unlicensed health care assistive personnel means individuals employed to provide hands-on assistance with ADLs to individuals in homes, ALPs, RCFs, private non-medical institutions, hospitals, and other health care settings. Unlicensed health care assistive personnel does not include certified nursing assistants (CNAs) employed in their capacity as CNAs.

- Level I: licensed capacity of 1-2 residents (licensing is voluntary for this group).
- Level II: licensed capacity of 3-6 residents.
- Level III: licensed capacity of 3-6 residents and employment of three or more persons who are not owners and are not related to the owner.
- Level IV: licensed capacity of more than six residents.

Private non-medical institution means a house or other place that is maintained wholly or partly for the purpose of providing residents with assisted living services. PNMIs are a type of RCF that receives Medicaid funds and complies with additional requirements as specified in various sections of the licensing rules. Otherwise, the four levels of PNMIs are the same as the four RCF levels defined above.

Alzheimer's/dementia care unit means a unit, facility, or distinct part of a facility that provides care/services in a designated separate area for residents with Alzheimer's disease or other dementias. The unit, facility, or distinct part provides specialized programs, services, and activities and is locked, segregated, or secured to provide or limit access by a resident outside the designated or separated area.

Resident Agreements

Each provider and each resident, or someone authorized to act on the resident's behalf, must sign a standard contract issued by the Department at admission and when an existing contract is to be modified. All resident contracts must contain provisions regarding services and accommodations to be provided and the rates and charges for such, and any other related charges not covered by the facility's/program's basic rate.

The contract may contain additional provisions that do not conflict with the licensing regulations. The provider may supplement but not replace the standard provisions, as long as they are consistent with the applicable assisted housing program rules. The facility's grievance procedure, tenancy obligations (if applicable), admissions policy, and residents' rights must be appended to the standard contract.

Disclosure Provisions

In addition to the resident contract, facilities must provide an information packet that includes information about advance directives; the type of facility, its licensing status, and staff qualifications; admission, transfer, and discharge policies and procedures; and the Maine Long-Term Care Ombudsman Program. The packet must also include toll-free telephone numbers for the Adult Protective Services program, the licensing agency, and the Office of Advocacy of the Department of Behavioral and Developmental Services (BDS) if the facility has residents who receive BDS services.

When an assisted housing program operates a unit meeting the requirements of an Alzheimer's/dementia care unit as all or part of its program, it must give residents and family members, or any other authorized representative, the following information:

- A written statement of the provider's service philosophy.
- The process used for resident assessment and the establishment of a residential services plan and its implementation.
- The physical environment and design features that support the functioning of adults with cognitive impairments.
- The frequency and types of group and individual activities the program provides.
- A description of family involvement and the availability of family support programs.
- A description of the facility's security measures.
- A description of in-service training provided for staff.
- Admission and discharge policies and procedures.

Assisted housing programs must list all standard charges and make them available to the public.

Admission and Retention Policy

The rules encourage aging in place through flexible provisions. When applying for licensure, all facilities must describe their admission policies and the types of services, including the scope of nursing services, to be provided.

Residents may be discharged if: (1) the facility cannot meet their needs; (2) their intentional behavior results in substantial physical damage to the property; or (3) they become a direct threat to others' health or safety.

At the time of admission to an Alzheimer's/dementia unit, or within 30 days of admission, a resident's individual record must contain documentation of a physician's diagnosis of Alzheimer's disease or dementia, and documentation of the legal representative's authority to admit the individual to the unit.

Services

Assisted living programs must offer service coordination, housekeeping services, assistance with ADLs and IADLs, chore services, and other services identified in a service plan.

Residential Care Facilities/Private Non-Medical Institutions. Levels I, II, and III providers must coordinate appropriate health care services and assist residents to access them. The facility must provide or arrange transportation to medical and other appointments. Nursing services must be provided by professional nurses, including the coordination and oversight of assisted living services that are provided by unlicensed assistive personnel.

Level IV residents are able to receive individualized services to help them age in place, function optimally in the facility and in the community, engage in constructive activity, and manage their health conditions. The facility must ensure, to the extent practicable, that residents' choices and preferences will be accommodated. The licensing rules require the provision of reasonable accommodation in regulations, policies, practices, or services, including permitting reasonable supplementary services to be brought into the facility/program unless it imposes an undue financial burden or results in a fundamental change in the program.

Medicaid covers services provided by PNMIs as follows: personal care, housekeeping, laundry, dietary, and other services, including clinical consultant services; interpreter services; licensed practical nurse services; licensed social workers or other social worker services; practical nurses; registered nurse (RN) consultant services; and other qualified medical and remedial staff.

Alzheimer's/dementia care units must provide individual and/or group activities covering gross motor skills, self-care, social interaction, crafts, and sensory enhancement, as well as outdoor and spiritual activities.

Service Planning

Assisted Living Programs. Residents in ALPs need to be assessed within 30 calendar days of admission and reassessed at least every 6 months thereafter.

Residential Care Facilities/Private Non-Medical Institutions Levels I and II. Providers must ensure that each resident's abilities and needs are adequately assessed and that each resident is offered all necessary services.

Residential Care Facilities/Private Non-Medical Institutions Levels III and IV. Residents must be assessed[3] within 30 calendar days of admission and reassessed

[3] PNMI residents must be assessed using the state-approved Resident Assessment Instrument as required by the agency providing Medicaid funding.

annually or when there is a significant change in condition. A service plan must be developed and implemented within 30 calendar days of admission.

Third-Party Providers

Assisted living services may be provided indirectly through written contracts with persons, entities, or agencies.

Medication Provisions

All Facilities. Upon admission, all residents must be assessed for their ability to self-administer medications and their need for assistance. Unlicensed staff who have successfully completed a training program approved by the licensing agency may administer medications and/or treatments. Administration of medications means reading labels for residents, observing residents taking their medications, checking the dosage, removing the prescribed dosage, filling a syringe and administering insulin and bee sting kits (when permitted), and the maintenance of a medication record for each resident.

With the exception of bee sting kits and insulin, no injectable medications may be administered by an unlicensed person. Unlicensed persons must be trained by a registered professional nurse with regard to safe and proper use of a bee sting kit and insulin administration.

Assisted living program and Residential Care Facilities/Private Non-Medical Institutions Levels III and IV. A person qualified to administer medications must be on site at the ALP whenever a resident has medications prescribed "as-needed" (PRN) if this medication is not self-administered. All unlicensed assistive personnel administering medications and/or treatments must complete a Department-approved 8-hour refresher course every 2 years for recertification within 2 years of the original certification. Whenever the standards or guidelines of the medication administration course are substantially revised, unlicensed personnel must be recertified within 1 year of the revision, using a Department-approved method.

Food Service and Dietary Provisions

Assisted Living Programs. At least one nutritious meal a day must be provided by the ALP.[4] A registered dietician must approve menus annually. Menus must be planned in accordance with residents' needs and preferences. Therapeutic diets are considered treatments and must be ordered, in writing, by a duly authorized licensed practitioner, and must be planned, in writing, and approved by a registered dietitian.

[4] The regulations do not address how residents in facilities that provide only one meal can obtain additional meals.

Residential Care Facilities/Private Non-Medical Institutions. Levels I-IV require a nourishing, well-balanced diet that meets the daily nutritional and special dietary needs of each resident and that meets the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. In addition, Level IV facilities must have a meal plan that provides three meals in a 24-hour period and a dietary coordinator who has experience and/or training in food service suitable to the size of the facility.

Staffing Requirements

Assisted Living Programs

Type of Staff. Each facility must have an *administrator* who holds a current professional license related to residential care, ALPs, or health care.

Staff Ratios. *No minimum ratios*.

Residential Care Facilities/Private Non-Medical Institutions

Type of Staff. Level I, II, and III *providers* are responsible for the overall operation of the facility and must have a person available to provide supervision in their absence. The provider must coordinate appropriate health care services and assist residents to access them. Nursing services are provided by *professional nurses*.

The Department reserves the right to require: (1) pharmacist consultation if it finds serious or multiple deficiencies in medication administration; (2) licensed nurse consultation if it finds serious or multiple deficiencies in residents' health care; and (3) a qualified consultant dietitian if it finds serious or multiple deficiencies in food service.

Level IV facilities require an on-site *administrator* who is licensed as a multilevel or resident facility administrator[5] and who is responsible for the facility's overall operation. In the absence of the administrator during the normal working day, a competent individual, authorized to act must be designated. Each facility must retain a *registered nurse* (other than the administrator), either on staff or on a contractual basis, to observe residents' signs and symptoms, review residents' records for completeness and accuracy, review medication records, review medication administration practices and procedures, review therapeutic diets, recommend staff training, and undertake other reviews or make other recommendations as necessary.

Each facility of more than ten beds must retain the services of a *pharmacist* consultant no less than quarterly. The Department reserves the right to require the facility to obtain the services of a qualified consultant dietitian if it finds serious or multiple deficiencies in food service.

[5] Unlicensed administrators must complete an approved training program.

Staff Ratios. Staffing in all licensed RCF/PNMI settings must be adequate to implement service plans and provide a safe setting. The Department may require additional staff based on residents' needs and the facility's size and layout.

Level IV facilities with ten or fewer beds are required to have, at a minimum, one responsible adult on-site at all times whenever residents are present, to perform resident care and provide supervision. This person must possess the health and judgment determined necessary by the Department to carry out assigned duties; to determine this, the Department may require an examination and submission of a written report from a duly authorized licensed practitioner or licensed psychologist.

Level IV facilities with more than ten beds are required to have at least two responsible awake adults on duty and readily available at all times. In addition, the following ratios of minimum *resident care* staff-to-residents must be maintained at all times: 1:12 from 7:00 a.m. to 3:00 p.m., 1:18 from 3:00 p.m. to 11:00 p.m., and 1:30 from 11:00 p.m. to 7:00 a.m.

Resident care staffing means the functions of direct care and supervision, activities, housekeeping, laundry, and social services. It does not include the functions of administration, maintenance, and dietary services. If fewer than two resident care staff are required by the minimum staff-to-resident ratio in a facility with more than ten beds (e.g., between 11:00 p.m. to 7:00 a.m.), a staff person serving in another capacity may be considered as the required second responsible on-duty awake person.

Training Requirements

Assisted Living Programs. The licensee must attend any training sessions that the Department determines are necessary to meet licensing standards. The administrator must attend any training sessions mandated by the Department.

Residential Care Facilities/Private Non-Medical Institutions. All staff in Levels I, II, and III must attend and show evidence of successful completion of any training that the Department determines is needed.

Level IV staff (other than CNAs and licensed professional staff) whose job responsibilities include direct service to residents for at least 20 hours per week, must successfully complete a Personal Support Specialist certification course within 120 days of hiring. All regular staff must have in-service training, at least annually, in areas related to the specific needs of the residents served. Administrators must complete 12 hours of continuing education per year in areas related to the care of the population the facility serves.

Provisions for Apartments and Private Units

Assisted living programs are multi-unit residential buildings that provide apartments and must meet state and local building codes. A private apartment is a private dwelling unit with an individual bathroom, bedroom, and a food preparation area. The rules require facilities to permit reasonable modifications to the existing premises at the tenants' expense, or other willing payer, to enable persons with disabilities to reside in licensed facilities. Providers may require disabled individuals to return the premises to its prior condition upon their discharge.

Residential Care Facilities/Private Non-Medical Institutions provide housing and services to residents in private[6] or semi-private bedrooms in buildings with common living areas and dining areas. Only two residents are allowed per unit. Couples who reside in the facility have the right to share a room.

For all Level I, II, and III facilities licensed on or after 2004,[7] a bathroom equipped with flush toilets and hand-washing facilities must be provided for each six users. Users include residents, as well as staff on duty. *No provisions identified for bathtubs or showers*.

Level IV facilities must provide one toilet and sink for every six users. Users include residents, as well as staff on duty. There must be at least one dedicated staff bathroom and public toilets at specified ratios (e.g., one public bathroom for 1-25 residents). Facilities licensed on or after May 30, 2002, must have one bathing facility for every ten users (one for 15 users for facilities licensed prior to May 30, 2002). Facilities initially licensed after May 29, 1998, must have at least one tub or shower for each floor that has resident bedrooms. Facilities initially licensed on or after May 30, 2002, must have at least one bathroom that includes, at a minimum, a toilet and hand-washing sink on each floor that has resident bedrooms.

Provisions for Serving Persons with Dementia

Dementia Care Staff. *No provisions identified*.

Dementia Staff Training. Pre-service training is required for staff who work in Alzheimer's/dementia care units and includes a minimum of 8 hours classroom orientation and 8 hours of clinical orientation. The trainer(s) must be qualified with experience and knowledge in the care of individuals with Alzheimer's' disease and other dementias. In addition to the usual facility orientation, which covers such topics as residents' rights, confidentiality, emergency procedures, infection control, facility

[6] Private rooms are not required under MaineCare, but if there is a medical necessity for a private room, the facility must make one available.

[7] No provisions were identified for facilities licensed before 2004.

philosophy related to Alzheimer's/dementia care, and wandering/egress control, the 8 hours of classroom orientation must also include the following topics:

- A general overview of Alzheimer's disease and other dementias.
- Basic communication techniques.
- Creating a therapeutic environment.
- Activity-focused care.
- Dealing with difficult behaviors.
- Understanding and addressing family issues.

Dementia Facility Requirements. The unit must be designed to accommodate residents with dementia, enhance their quality of life, and promote their safety. In addition to the physical plant standards required for licensure, an Alzheimer's/dementia care unit must have adequate space for dining, group and individual activities and family visits, and must provide freedom of movement between common areas and residents' rooms. Residents may not be locked inside or outside their rooms.

For facilities licensed after May 29, 1998, the design must include: secured outdoor space and walkways, which allow residents to ambulate but prevent undetected egress; high contrast between floors, walls, and doorways; non-reflective surfaces; and lighting to minimize glare. Facilities must also have policies and procedures to deal with wandering. Electronic locking devices may be used on exterior doors if they release in an emergency.

Residents are encouraged and assisted to decorate their unit with personal items and furnishings and facilities must individually identify each resident's room to help with recognition.

Background Checks

All Facilities. During the licensure process, a criminal background check is conducted for CNAs, CNAs who have received special training in medication administration (CNA-M), and the administrator. Facilities may not employ a CNA or CNA-M who is not on the CNA Registry, or who has been cited for abuse, neglect, or misappropriation of patient/client/resident funds in a health care setting.

Assisted Living Programs. The facility may not hire as unlicensed assistive personnel any individuals who have been convicted in a court of law of a crime involving abuse, neglect or misappropriation of property in a health care setting; or who have been the subject of a complaint involving abuse or neglect that was substantiated by the Department and that was entered on the Maine Registry of Certified Nursing Assistants; or has been the subject of a complaint involving the misappropriation of property in a health care setting, which was substantiated by the Department and entered on the Maine Registry of Certified Nursing Assistants.

Inspection and Monitoring

DHHS makes regular and unannounced inspections of all facilities prior to initial licensure, prior to the expiration of a license, in response to complaints, and as often as deemed necessary to determine continued compliance with applicable laws and regulations.

Public Financing

The state pays for services in assisted housing programs through the Medicaid MaineCare State Plan and the MaineCare 1915(c) Elderly Waiver program. Maine also has several non-Medicaid state-funded affordable assisted living facilities (ALFs) and IHSP facilities.

Room and Board Policy

The state limits room and board charges for Medicaid-eligible residents in PNMIs, residential care homes, and AFCH s to the current Supplemental Security Income (SSI) payment plus an optional state supplement (OSS). In 2011, the SSI payment was $674 and the maximum OSS payment was $234. The amount of a personal needs allowance (PNA) was not stated.[8]

PNMIs may permit payment by a relative of an additional amount to enable a Medicaid-eligible resident to obtain a private room, telephone, television, or other non-covered services. However, the additional charge may not exceed the charge to private pay residents. For example, the supplement for a private room must be no more than the difference between the private pay rate for a semi-private room and a private room rate. This provision does not apply if private rooms are standard in the facility. The resident or relative making the additional payment must sign a statement that he/she was notified and agreed to the payment for the private room or non-covered services before they were provided.

Room and board charges for residents in the non-Medicaid state-funded ALFs and IHSP settings are subject to the U.S. Department of Housing and Urban Development Fair Market Rents for the town in which they live.

[8] Social Security Administration, *State Assistance Programs for SSI Recipients*, January 2011. http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/me.html. Current information about the OSS and the PNA was not available online or through other sources.

Location of Licensing, Certification, or Other Requirements

Code of Maine Regulations, Title 10-144, Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs. Department of Health and Human Services, Division of Licensing and Regulatory Services. [August 20, 2008]
http://www.maine.gov/sos/cec/rules/10/ch113.htm

Code of Maine Regulations, Title 10-144, Chapter 101: MaineCare Benefits Manual, various chapters/sections, including: Chapter 2, Section 2: Adult Family Care Services. [July 1, 2008]; Chapter 2, Section 97: Private Non-Medical Institution Services [October 16, 2013]; and Chapter 3, Section 97: Principles of Reimbursement for Private Non-Medical Institution Services [May 15, 2010]. Department of Health and Human Services.
http://www.maine.gov/sos/cec/rules/10/ch101.htm

Information Sources

Michael Swann
Division of Licensing and Regulatory Services
Medical Facilities Unit
Department of Health and Human Services

David C. Projansky
Housing Resource Developer
Office of Aging and Disability Services
Maine Department of Health and Human Services

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
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Louisiana	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-louisiana-profile
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Massachusetts	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-massachusetts-profile
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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