DISTRICT OF COLUMBIA

Licensure Terms

Assisted Living Residence, Community Residence Facility

General Approach

The Department of Health, Health Regulation and Licensing Administration licenses assisted living residences (ALRs) and community residence facilities; ALRs can provide a higher level of care than community residence facilities. The District of Columbia (DC) does not state in law or in regulation a minimum number of residents that triggers a requirement for licensure, but an agency source confirmed that the minimum number is one resident. There is no separate licensure for adult foster care; the DC licenses small facilities as ALRs or community residence facilities.

This profile includes summaries of selected regulatory provisions for ALRs and community residence facilities. The complete regulations are online at the links provided at the end. However, the online sources do not yet reflect some changes that have been made to the regulatory provisions--either through rule-making or statutory change. Some of these changes are included in this profile and indicated with footnotes.

Definitions

Assisted living residence means an entity, whether public or private, that combines housing, health services, and personal assistance--in accordance with individually developed service plans--for the support of individuals who are unrelated to the owner or operator of the entity. The definition does not include a group home for persons with intellectual disabilities or a mental health community residence.

The philosophy of assisted living emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. Further, the services and physical environment of an ALR should enhance a person's ability to age in place in a home-like setting by increasing or decreasing the amount of assistance in accordance with the individual's changing needs.

Community residence facility means a residence that provides safe, hygienic, sheltered living arrangements for one or more individuals aged 18 years or older who are not related by blood or marriage to the residence director, and who are ambulatory and able to perform activities of daily living (ADLs) with minimal assistance.

The definition includes facilities for the elderly and physically disabled and group homes for persons with intellectual disabilities that provide a sheltered living arrangement for persons who desire or require supervision or assistance within a protective environment because of physical, mental, familial, or social circumstances, or intellectual disability.

Resident Agreements

Assisted Living Residences. A written contract/resident agreement must be provided prior to admission. It must include a range of topics, including the residence's organizational affiliation, the nature of any special care offered, services included or excluded, residents' rights and grievance process, unit assignment procedures, admission and discharge policies, responsibilities for coordinating health care, obligations for handling finances, coordinating and contracting for services not provided by the residence, and policies and procedures for payments and refunds.

Community Residence Facilities. *No provisions identified*.

Disclosure Provisions

Assisted Living Residences. Facilities must disclose contract terms and billing practices to residents.

Community Residence Facilities. Facilities must provide a written copy of residents' rights and privileges to each resident and his or her representative, if any, upon admission.

All residents, next of kin, and representatives (if any) must be given the address and telephone number of the DC government office that licenses health care facilities.

Facilities must develop a statement on the following topics: program and facilities; staffing patterns; consultant services; activities offered; fees and charges; payment and refund policies; characteristics of populations served; admission and discharge policies, including parameters of length of stay; and formal and informal relationships to community health services and social services.

Admission and Retention Policy

Both types of facilities may involuntarily discharge residents if they are unable to: (1) meet a resident's documented health care needs; (2) provide services in accordance with the prescribed level of care; or (3) safeguard the resident or other residents from physical or emotional injury.

Assisted Living Residences. Prior to admission, the facility must determine that it can meet the needs of an individual in addition to the needs of the other residents. The facility may admit only individuals to whom it can provide appropriate services, unless it (or the individuals, with the agreement of the facility) arranges for third-party services. Facilities may not admit or retain individuals who: (1) are dangerous to themselves or others; (2) exhibit behavior that negatively impacts the lives of others; (3) are at risk for health or safety complications that cannot be addressed by the facility; (4) require more than 35 hours a week of skilled nursing and home health aide services combined, provided on less than a daily basis; and (5) require more than intermittent skilled nursing care; treatment of Stage III or IV skin ulcers; ventilator services; or treatment for an active, infectious, and reportable disease or condition that requires more than contact isolation.

A facility must facilitate aging in place to the best of its ability with the understanding that there may be a point reached where adequate and appropriate services cannot be marshalled to support the resident safely, making transfer to another setting necessary. A facility may involuntarily discharge residents if it cannot continue to meet the care needs of the resident as provided in the individual service plan. But, residents have the right to remain in the residence despite a recommendation to transfer, if they obtain additional services that are acceptable to the residence.

Community Residence Facilities. Prospective residents, the residence director and the resident's physician must agree that the prospective resident does not need professional nursing care and can be assisted safely and adequately within a community residence facility.

Short-term nursing care--up to 72 consecutive hours--may be provided when needed if the facility can provide or arrange for the provision of the physical environment and professional services appropriate to the resident's condition.

Residents must be able to perform ADLs with minimal assistance, generally be oriented as to person and place, and capable of exercising proper judgment in taking action for self-preservation under emergency conditions.

By special permission of the licensing body, persons who are not generally oriented or who are substantially ambulatory but need minimal ADL assistance may be admitted if sufficient staff are available.

Services

Assisted Living Residences. Services include 24-hour supervision and oversight to meet scheduled and unscheduled needs, some assistance with ADLs and instrumental activities of daily living (IADLs), and laundry/housekeeping services. ALR also must facilitate access to appropriate health/medical, rehabilitation, and psychosocial services as established in a resident's individualized service plan (ISP),

and ensure appropriate oversight, monitoring, and coordination of all components of the ISP, including necessary transportation and the delivery of needed supplies.

Community Residence Facilities. Meals, housekeeping, laundry, and dietary services are provided. Short-term nursing care--up to 72 consecutive hours--may be provided or arranged by the facility. Facilities with fewer than 30 residents must assist residents in obtaining needed social services.

Service Planning

Assisted Living Residences. Within 30 days prior to admission, an individual's physician must conduct a medical, rehabilitation, and psychosocial assessment and the facility must conduct a functional assessment. The facility must complete another assessment within 30 days after admission. An ISP must be developed prior to admission and updated following the completion of the "post move-in" assessment. The ISP must include the services to be provided, and when, how often, how, and by whom they will be provided and assessed.

The ISP must be reviewed 30 days after admission and at least every 6 months thereafter. It must be updated more frequently if there is a significant change in the resident's condition.

A shared responsibility agreement is a formal written agreement that outlines the responsibilities and actions of all parties. The agreement is a process for resolving discrepancies between the individual resident's right to independence and the provider's concerns for the safety and well-being of the individual and others. It is a tool for facilities to recognize an individual resident's right to autonomy by respecting his or her right to make individual decisions regarding lifestyle, personal behavior, and ISPs.

In some cases, a resident's decision may involve increased risk of personal harm and therefore potentially increase the risk of liability by the facility absent an agreement between the resident and the facility concerning such decisions or actions. In such instances, the facility must explain to the resident, or surrogate, why the decision or action may pose risks, suggest alternatives, and discuss with the resident, or surrogate, how the facility might mitigate potential risks.

If the resident decides to take action that may involve increased risk of personal harm and conflict with the facility's usual responsibilities, the facility describes to the resident the action or range of actions subject to negotiation and negotiates a shared responsibility agreement--with the resident as a full partner--that is acceptable to the resident and the facility and meets all reasonable requirements implicated. The shared responsibility agreement must be signed by the resident or surrogate and the ALR.

Community Residence Facilities. All residents must have a medical examination by a physician not more than 30 days prior to admission and an examination at least once each year after admission. If a resident is unable to make

arrangements for his or her annual examination, the residence director must make the arrangements and assist the resident in complying with this requirement.

Each resident's personal physician must certify that the resident is free of communicable disease and provide the community residence facility with a written report containing sufficient information concerning the resident's health to assist the facility in providing adequate care, including any treatment orders, prescribed drugs, prescribed special diets, and any rehabilitation program.

Third-Party Providers

Assisted Living Residences. Facilities with 17 beds or more are responsible for providing or coordinating personalized care to individuals who reside in their own living units. Under certain conditions, residents have the right to arrange directly for medical and personal care with an outside agency.

Community Residence Facilities. Short-term nursing care--up to 72 consecutive hours--may be provided when needed if the facility can furnish or arrange for the provision of the physical environment and professional services appropriate to the resident's condition.

Medication Provisions

Assisted Living Residences. Within 30 days prior to admission, the facility must consult with the prospective resident's health care practitioner regarding his or her current medication profile, including a review of non-prescription drugs, possible adverse interactions, common expected or unexpected side effects, and the potential that such medications have to act as chemical restraints.

Facilities must assess whether a resident: (1) is capable of self-administering his or her own medications; (2) is capable of self-administering his or her own medication, but requires a reminder to take medications or requires physical assistance with opening and removing medications from the container, or both; or (3) requires that medications be administered by a licensed nurse, physician, physician assistant, or trained medication employee.

Facilities must arrange for an on-site review by a registered every 45 days to supervise medication administration by trained medication employees, and to assess resident responses to medications and residents' ability to self-administer medications.

A trained medication employee is an individual employed to work in an ALR who has successfully completed a DC training program approved by the Board of Nursing, and who is certified to administer medication to residents. To maintain certification trained medication employees must complete a DC-approved clinical update or refresher course every 2 years.

Community Residence Facilities. Assisting with self-administration is considered to be an ADL. Trained medication employees may assist residents with the self-administration of medication and may administer medications.

Food Service and Dietary Provisions

Assisted Living Residences. Facilities must provide three nutritious meals and additional snacks, modified to individual dietary needs as-necessary, on a daily basis; and a variety of fresh and seasonal foods, adapted to the food habits, preferences, and physical abilities of the residents.

Community Residence Facilities. Facilities must provide for the reasonable nutritional, emotional, religious, cultural, and therapeutic dietary requirements of its residents. They must serve, provide for, or arrange for on a daily basis, at least three meals that are nutritious and suited to residents' special needs.

Facilities that admit and retain residents who need special or therapeutic diets must provide for those diets to be planned, prepared, and served as prescribed by the attending physician. Facilities must consult regularly with a dietitian, who must have access to the resident's permanent record containing the physician's prescriptions for medications and special diet and must document in that record all observations, consultations, and instructions regarding the resident's acceptance and tolerance of prescribed diets.

The dietitian and the residence director, or a qualified person designated by the residence director, must review residents' therapeutic diets at least every 6 months.

Staffing Requirements

Assisted Living Residence

Type of Staff. An *assisted living administrator*--the licensee or person designated by the licensee--is responsible for the management of personnel and services within the facility. During periods of temporary absence of the assisted living administrator, when residents are on the premises, a staff member who is at least 18 years of age and meets the staffing standards of the assisted living administrator required in statute must assume the responsibilities of the administrator.

Staff Ratios. *No minimum ratios*. Sufficient staff must be employed and a staffing plan developed to ensure residents' safety and proper care based on their scheduled and unscheduled needs, the size and layout of the facility, and staff capabilities and training. A sufficient number of staff must be on the premises at all times to implement evacuation and emergency management plans and emergency procedures. At least

one staff member who is certified in first-aid and cardiopulmonary resuscitation must be in the facility at all times.

Community Residence Facility

Type of Staff. A *residence director* must be responsible for the daily overall management of the facility. Each facility with more than 30 residents must provide the services of a *social worker* for a minimum of 8 hours per week; with more than 80 residents, 20 hours per week; with more than 100 residents, the facility must provide the services of a social worker on a full-time basis.

Each facility with 50 or more residents must employ a full-time *resident activities specialist* with current registration in the National Therapeutic Recreation Society as a therapeutic recreation specialist, or possess the qualifications necessary for that registration.

Each facility with 30 or more residents must, by written agreement, retain the services of a *licensed physician* who must advise on medical matters, review the community residence facility's program of residential health care, and handle medical emergencies if a resident's personal physician is unavailable.

Staff Ratios. *No minimum ratios*. A sufficient number of qualified employees and other adults must be present in each facility to provide for residents' welfare, comfort, and safety at all times of the day and night.

Training Requirements

Assisted Living Residences. Within 7 days of employment, facilities must train new staff members on the following topics: specific duties and assignments; purpose and philosophy of the ALR; services provided; daily routines; residents' rights; emergency procedures and disaster drills and techniques of complying, including evacuating residents when applicable; elementary body mechanics, including proper lifting and in place transfer; choking precautions and methods to remove airway obstructions, including the Heimlich maneuver; and infection control.[1]

After the first year of employment, and at least annually thereafter, each staff member must complete 12 hours of in-service training annually on emergency procedures and disaster drills and residents' rights, and 4 hours training on cognitive impairment in an in-service training approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association.

[1] A regulatory requirement (in DC Statute) that staff receive 40 hours of training on specific topics has been superseded by a 2012 law requiring all staff in ALRs to be either a certified medication aide or a certified home health aide. We were unable to ascertain if the new law also applies to staff in community residence facilities.

Community Residence Facilities. Facilities with more than six unrelated occupants must have written personnel policies that include plans for the orientation of all employees. *No other training provisions identified*.

Provisions for dementia training below.

Provisions for Apartments and Private Units

Assisted Living Residences. Apartment-style units are not required and shared units are allowed. Roommate choice is not required.

An ALR must have one full bathroom for every six residents, including live-in family or staff. Additional full or half-baths must be available to non–live-in staff. Residents must not be required to traverse more than one flight of stairs to access a bathroom, and appropriate accommodations must be made for residents who are unable to climb stairs.

Facilities serving more than 16 residents have specific requirements. They may offer living units that include a kitchenette, living room, and bathroom, and no more than two persons may share a bedroom. Units that do not include bathrooms must limit sharing of bathrooms to four residents. Shared bathrooms must be in close proximity and on the same floor as living units or bedrooms. Living units or bedrooms may be locked at the discretion of the residents, except when the resident's assessment documents indicate otherwise.

Community Residence Facilities. Roommate choice is not required. No more than four persons may share a bedroom. At least one sink, one toilet, and one bathing facility must be provided for the use of each six occupants of the facility. Each facility employing more than three full-time employees (including the residence director) must provide toilet and sink facilities separate from the rooms used by residents.

In each community residence facility with more than 30 residents, when residents have the use of common living or eating space on floors other than floors on which their bedrooms are located, additional toilets and sinks must be provided on those floors in the proportion of one toilet and sink for each 30 residents.

Provisions for Serving Persons with Dementia

No provisions identified for either type of facility.

Background Checks

Both ALRs and community residence facilities must conduct criminal background checks during the 45-day period preceding hiring or contracting with an unlicensed person. Facilities may not employ or use the contract services of unlicensed persons if they: (1) have been convicted of a criminal offense listed in the rules within 7 years prior to the criminal background check being conducted; or (2) if the person is listed in the DC Nurse Aide Abuse Registry.[2] Individuals subject to background checks must submit a sworn statement affirming that there are no criminal matters pending against them and denying the existence of any relevant convictions.

Inspection and Monitoring

Assisted Living Residences. Residences are inspected pre-licensure and re-inspected within 6 months of the effective date of the initial license. The licensing agency may also inspect a facility at its discretion to ensure compliance and to investigate complaints.

Community Residence Facilities. Any authorized official of the applicable DC Department has the right to enter a facility with or without notice before licensure, at license renewal, and in response to complaints, to investigate and determine compliance with requirements.

Public Financing

The Medicaid Elderly and Persons with Disabilities 1915(c) Waiver program covers assisted living services in ALRs. These services include any combination of 24-hour supervision and oversight; scheduled and unscheduled assistance with ADLs and IADLs; laundry and housekeeping services; medication administration; therapeutic social and recreational services; facilitating access to appropriate health and social services, including social work, home health agencies, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services; and coordinating scheduled transportation to community-based activities.

Room and Board Policy

In 2014, the DC provided an optional state supplement of $585 for residents in facilities with 50 or fewer beds, and $695 in facilities with more than 50 beds.[3]

[2] New statutory requirements are not yet reflected in the online regulations. A link to the new requirements is at the end of the profile.

[3] Information regarding which facilities--ALRs, community residential facilities, or both--was not available.

In 2009, residents were allowed to retain a $100 per month personal needs allowance (PNA), and the DC had no policy regarding family supplementation.[4]

Location of Licensing, Certification, or Other Requirements

District of Columbia Municipal Regulations, Title 22, Chapter 31: Licensing of Health Care and Community Residence Facilities.
http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Licensing_%20of_%20Health_%20Care_%20and_%20Community_%20Residence_%20Facilities.pdf

District of Columbia Municipal Regulations, Chapter 22-B34: Community Residential Facilities.
http://www.dcregs.dc.gov/Gateway/ChapterHome.aspx?ChapterNumber=22-B34

Department of Health website with link to *D.C. Statutes*, Section 44-101.01, Chapter 1: Assisted Living Residences Regulation.
http://doh.dc.gov/node/187502

District of Columbia Municipal Regulations, Title 22, Chapter 47: Health Care Facility Unlicensed Personnel Criminal Background Checks.
http://doh.dc.gov/publication/unlicensed-health-care-facility-personnel-criminal-background-checks

Information Sources

The DC has revised many regulatory provisions and these revisions are not yet reflected in the information provided at the websites listed above, nor are they accessible by any search engine. The information in this profile is from the websites listed above, unless otherwise noted.

[4] Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.
http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf. Current information about Medicaid room and board policies, the PNA, and family supplementation policy, was not available online or from other sources.

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