

WEST VIRGINIA

Licensure Terms

Assisted Living Residences, Residential Care Communities

General Approach

Two types of residential care settings are licensed by the Department of Health and Human Resources (DHHR), Bureau for Public Health, Office of Health Facilities Licensure and Certification: assisted living residences (ALRs) and residential care communities. The primary difference between ALRs and residential care communities is that residents in the latter must be capable of self-preservation in an emergency.¹

If a facility advertises or promotes itself as having a specialized unit for persons with Alzheimer's disease or other dementia, a separate license must be obtained. Such facilities must be licensed as either an ALR or a skilled nursing facility. Licensed facilities that do not market themselves as offering Alzheimer's/dementia special care units (ASCUs), may serve residents with early dementia symptoms.

Adult Foster Care. Health care homes are required to register with the DHHR and comply with applicable standards. These homes provide accommodations and personal assistance for up to three residents who are not related to the service provider or his or her spouse. Limited and intermittent nursing services may be provided by a registered nurse (RN). Providers must make arrangements for the administration or self-administration of medications. Payment is private pay only.

The DHHR, Adult Residential Services, certifies adult family care homes (AFCHs) that provide support and protection for up to three adults who are placed in the home because they lack either family and/or financial resources to provide for their needs. Eligibility criteria include age 65 or older, age 18 or older with an established disability, or age 18 or older and receiving Adult Protective Services. DHHR staff must either make or approve placements in these settings. Agency staff recruit suitable homes for certification, place residents, and provide ongoing support, monitoring, and review to ensure that providers offer appropriate care. *Regulatory provisions for health care homes and AFCHs are not included in this profile but a link to the provisions can found at the end.*

This profile includes summaries of selected regulatory provisions for ALRs and residential care communities. Unless otherwise stated, ASCUs must comply with the

¹ Only two residential care communities are licensed in the state and they accept only private pay residents.

requirements of their relevant licensure category. The complete regulations can be viewed online using the links provided at the end.

Definitions

Assisted living residences are accommodations, however named, available for four or more residents, which are advertised, offered, maintained or operated by the ownership or management for the express or implied purpose of providing personal assistance, supervision, or both, to any residents who are dependent upon the services of others because of physical or mental impairment, and who may also require limited nursing care. Small facilities have a bed capacity of 4-16; large facilities have 17 or more beds.

Residential care community means any group of 17 or more residential apartments, however named, which are part of a larger independent living community and which are advertised and operated for the purpose of providing residential accommodations, personal assistance, and supervision to persons who are or may be dependent upon the services of others by reason of physical or mental impairment, or who may require limited and intermittent nursing care but who are capable of self-preservation and are not bedfast.

Alzheimer's/Dementia Special Care Units (SCUs) and Programs. A SCU (in a licensed ALR or a skilled nursing facility) is one that provides specialized services, 24 hours per day, for residents with a diagnosis of Alzheimer's disease or other dementia. A program is a licensed facility that offers specialized services for a specified number of hours per day.

Resident Agreements

Assisted living residence agreements must indicate the type of resident population served; services provided; costs of basic and optional services; medication policies; the refund policy; discharge criteria and notification policies; complaint procedures; management of residents' funds; and liability insurance coverage (if any).

Residential care community agreements provide information about admission, retention, and discharge policies; assurance that the community will meet the resident's needs; costs and payment and refund policies; how health care will be provided or arranged; medication policies; and the complaint process.

Both ALRs and residential care communities must also provide the following information: house rules governing resident behavior and responsibilities; the residents' bill of rights; how residents' personal property will be protected from loss and theft; requirements for medical examinations and treatment orders; how the resident will be assisted in making appointments for medical, dental, nursing or mental health services,

and how transportation to and from these services will be arranged; and how to access information about the residence's (or community's) policies and procedures.

Alzheimer's/dementia special care units and programs must have a written policy that explains pre-admission screening, admission, transfer and discharge procedures, including an explanation of the level of care the facility is licensed to provide, and the conditions that may necessitate a resident's transfer or discharge.

Disclosure Provisions

Assisted living residences' and residential care communities' licensing rules do not require a specific disclosure document, but they require that specific information be provided at or before admission, including the cost of basic and optional services, and any other fees.

Alzheimer's/dementia special care units and programs must prepare a written disclosure document describing the form of care or treatment provided that distinguishes it as being especially applicable to, or suitable for persons with dementia. The disclosure form must be given to the resident or family before admission, and signed and dated by the resident and/or legal representative.

Admission and Retention Policy

Assisted living residences may not admit or retain individuals who: (1) require a level of service that the residence is not licensed to provide or does not provide; (2) need extensive or ongoing nursing care; (3) require the use of routine physical or chemical restraints; (4) or are likely to cause serious harm to themselves or to others if appropriate interventions are not provided in a timely manner.

Residents who become bedfast may remain in the home for 90 days during a temporary illness or post-surgery if they do not require nursing care in excess of limited and intermittent nursing care. Residents may be immediately discharged if they require transfer to a hospital or other higher level of care.

A resident whose condition declines after admission, and who is receiving services coordinated by a licensed hospice or certified home health agency, may receive these services in the residence. The licensee must ensure that such residents are provided the care and services necessary to meet their needs.

Residential care community residents must be certified by a physician to be capable of self-preservation. Residents may need personal assistance in activities of daily living (ADLs), supervision because of mental or physical impairment, or limited and intermittent nursing services. Following admission, facilities may retain residents who receive hospice services. Residents who are not capable of self-preservation because

of a temporary illness or recovery from surgery may be retained for 90 days if they do not require nursing care exceeding the type and amount allowed by regulation.

Alzheimer's/Dementia Special Care Units and Programs. Before move-in, the resident's physician must provide written documentation of the individual's diagnosis of Alzheimer's disease or other dementia.

Services

All facility types provide the following services: personal assistance; help with self-administration of medications and medication administration; help in following planned diets, activity regimens, or use of equipment; and assistance in making appointments for dental and medical services. In addition, Alzheimer's/dementia SCUs and programs must provide behavior management services to residents whose evaluation indicates the need based on behaviors that are persistent and constitute sources of distress or dysfunction for the resident, or present a danger to the resident or other individuals.

Service Planning

Assisted Living Residences and Residential Care Communities. Not more than 60 days prior to a resident's admission and no more than 5 working days following admission, and at least annually after that, each resident must receive a functional needs assessment completed in writing by a physician or other licensed health care professional authorized under state law to perform the assessment. The assessment must provide information about the resident's health status and functional, psychosocial, activity, and dietary needs. Within 45 days of admission, the facility must develop a service plan based on the assessment.

Alzheimer's/dementia special care units and programs must, within 3 days of admission, review the immediate care needs of the resident and establish a preliminary care plan, with the resident's and/or his/her legal representative's input. Within 7 days of admission, an interdisciplinary team that includes the unit coordinator, a social worker, the activities director, direct care staff, a RN, and other professional disciplines as appropriate, must complete an initial assessment of a new resident.

This assessment must include a social history; family supports; ADL functioning; cognitive level; behavioral impairment; and nutritional status, including weight and nutritional requirements. Within 21 days, an individualized care plan must be finalized that addresses several topics, including a description of specific needs, choices, problems and any inappropriate behaviors; specific desired outcomes and specific interventions to be used; and the job titles of staff who will provide the described services. The care plan must be reviewed by the interdisciplinary care team at least quarterly.

The unit or program must also evaluate residents who have behavioral problems to determine their intensity, duration, and frequency; antecedent behaviors; recent changes or risk factors in the resident's life; environmental factors; the resident's medical status; activities that have been successful in addressing the behaviors in the past; staffing patterns; and effective behavioral management techniques.

Third-Party Providers

Assisted living and residential care communities must arrange for limited and intermittent nursing care and hospice care for residents whose needs it cannot meet, and who have insurance coverage or the financial means to pay privately for these services. If the resident needs services that use electronic equipment requiring auxiliary electrical power in the event of a power failure (such as a suction apparatus and intravenous or tube feeding pumps), the facility must have a backup power generator.

If a resident in an ALR exhibits symptoms of a developmental or mental disorder that poses a risk to self or others, and the resident is not receiving behavioral health services, the residence must advise the resident--or his or her legal representative--of the availability of local behavioral health services.

If the resident or his or her legal representative fails to seek treatment within 30 days, then the residence, after consultation with the resident's physician, must refer the resident to a licensed behavioral health provider. However, the residence must seek immediate treatment for a resident if there is reason to believe that the resident may suffer serious harm, or is likely to cause serious harm to himself or herself or others if appropriate interventions are not provided in a timely manner.

Medication Provisions

Assisted living residence staff may supervise self-administration of medications if a licensed health care professional determines that a resident is capable of self-administration. Supervision includes reminding residents to take medication, opening medication containers for residents, reading the medication label to residents, observing residents while they take the medication, checking the self-administered dose against the label on the container, and reassuring residents that they have obtained and are taking the dosage as prescribed.

Staff may also administer medications, which includes opening a container of medication and giving the medication to the person for whom it is prescribed, giving injections, and administering eye drops. Approved Medication Assistive Personnel who complete required competency training and testing may administer medications and perform specified health maintenance tasks. Regulatory provisions address the evaluation of staff competency, re-training requirements, and requirements of RNs who approve unlicensed staff to administer medications.

An attending physician, or other health care professional, or a consulting pharmacist must review each resident's medication regimen as needed, but at least annually.

Residential care communities may administer medications and assist with self-administration of medications. A licensed health care professional must administer medication and determine whether or not a resident is capable of self-administration. An attending physician, or other health care professional, or a consulting pharmacist must review the medication regimen of each resident as needed, but at least annually.

Alzheimer's/dementia special care units and programs must follow medication administration provisions for their relevant state licensure category. In addition, the state provides guidelines for psychotropic and behavioral modifying medications, as well as for the use of non-medication behavioral management approaches. If these medications are used, the facility must ensure the following: (1) that the diagnosis justifies the medication use; (2) that the dosage is based on age recommendations; (3) that staff monitor daily for side effects or adverse effects and report such effects to the resident's physician; and (4) that measures to reduce the dose over time are taken. Monthly evaluation by a licensed health care professional is required for residents who take psychotropic medications, and a physician must review the resident's record every 6 months and assess the need for continued use of the prescribed medication and the potential to decrease the dose.

Food Service and Dietary Provisions

Assisted living residences and residential care communities must provide three meals a day, snacks, and special diets that substantially comply with the recommended dietary allowances of the National Academy of Science's Food and Nutrition Board. Therapeutic or modified diets must be prepared according to a physician's or dietician's orders. Staff training must include the topic of nutrition. The residence must accommodate residents who are unable to eat at planned mealtimes and provide for meal substitution if the resident does not tolerate or like the food provided.

Staffing Requirements

Assisted Living Residences

Type of Staff. Facilities must employ an *administrator* and *direct care staff*. If nursing services are provided, a *registered nurse* must be employed to provide oversight and supervision. At least one employee with current first-aid training and cardiopulmonary resuscitation (CPR) certification must be on-duty at all times.

Staff Ratios. *No minimum ratios.* Specific ratios of direct care staff are required on each work shift based on the numbers of residents who have the following care needs: (1) dependence on staff for eating, toileting, ambulating, bathing, dressing, repositioning, special skin care; (2) one or more inappropriate behaviors that reasonably requires additional staff to control, such as sexually acting out, removing clothing in public settings, refusing basic care, or destroying property; or (3) injurious behavior to self or others.

Facilities must have a minimum of one direct care staff person on duty 24 hours per day, including awake staff present in the residence during normal resident sleeping hours, and a sufficient number of qualified employees on duty to provide all the care and services residents require. In multilevel residences, at least one awake staff person must be on-duty while residents are sleeping, unless the residents have been certified by a physician or licensed psychologist as not requiring sleep-time supervision.

Residential Care Communities

Type of Staff. Facilities must employ an *administrator* and *residential staff*.

Staff Ratios. *No minimum ratios.* Sufficient staff must be available to care for residents. Awake staff are required when residents need supervision or intermittent nursing services. Multi-story facilities must have one awake staff person per floor unless supervision or intermittent nursing services are not needed and there is a call system.

Training Requirements

Assisted Living Residences. Administrators must complete at least 8 hours per year of continuing education related to the operation and administration of the residence.

Facilities must provide orientation for staff within 15 days of hire, and in-service training annually thereafter on the following topics: emergency procedures and disaster plans; the residence's policies and procedures; residents' rights; confidentiality; abuse prevention and reporting; the ombudsmen's role; complaint procedures; specialty care based on individualized residents' needs and service plans; group and individual resident activities; and infection control.

In addition, facilities must provide a minimum of 2 hours of training to all new employees within 15 days of hire and annually thereafter on Alzheimer's disease and other dementias; how to communicate with persons who have dementia; the prevention and management of problem behaviors; and activities and programming appropriate for persons with dementia.

Residential Care Communities. Administrators must receive annual training of at least 10 hours on relevant topics, including facility operation and administration.

Within the first 24 hours of hiring and admission, facilities must provide an orientation to all new employees and residents about emergency procedures; evacuation procedures; and how to report a missing resident, a medical emergency, accident, fire, natural disaster, or other emergency.

Within 15 days of hire staff must receive training on facility policies and procedures, residents' rights, complaint procedures, capabilities and needs of older persons and persons' with disabilities, personal assistance procedures, requirements of current residents, CPR, and infection control.

Provisions for Apartments and Private Units

Assisted living residences may provide both private and shared rooms. In facilities constructed or renovated after May 1, 2006, no more than two persons can share a bedroom. Facilities must have a minimum of one toilet and sink for every six residents and a minimum of one bathing facility per floor with a bathtub or shower for every ten residents.

Residential care communities must offer apartment units with lockable doors, at least one bedroom, a kitchenette with a sink and refrigerator, and one full bathroom. No more than two residents can occupy a multi-occupancy apartment.

Provisions for Serving Persons with Dementia

Dementia Care Staff. Staffing categories include an *administrator*, *direct care staff*, and a *program coordinator* whose job includes coordinating, as needed, with third-party behavioral health specialists; advocacy; and support group facilitation. A *licensed nurse* must be available on-site if any resident requires nursing procedures, including as-needed (PRN) injections, and as required by the facility's state licensure rule. The facility must have a licensed *social worker* or licensed professional *counselor* available to provide specified social services. Appropriate activities must be provided by a *therapeutic specialist*, *occupational therapist*, or *activities professional*.

Staffing patterns must enable the facility to provide 2.25 hours of direct care time per resident per day. At least two staff must be present for units serving more than five residents. An RN must be available if residents require nursing procedures.

Direct care staff may not have housekeeping, laundry, food preparation, or maintenance duties as their primary responsibilities. Any unlicensed direct care staff included to meet the minimum staffing ratio may not be responsible for medication administration during the day or evening shift, including staff who have completed training and passed the competency test as Approved Medication Assistive Personnel.

Dementia Staff Training. SCU and program staff must complete a minimum of 30 hours of training related to the care of residents with Alzheimer's disease or other dementias. Topics include the nature, stages, and treatment of dementia; positive therapeutic interventions; communication; behavior management; medication management; the role of family; staff burn-out prevention; abuse prevention; and service planning. Eight hours of annual continuing education are required.

Dementia Facility Requirements. SCUs and programs are required to have environmental features to ensure the safety of residents who might attempt to leave the residence, for example, high visual contrast between floor, walls, and walkways; non-reflective surfaces; secured outdoor space; a multipurpose room for dining, group and individual activities, and family visits; a monitoring or nurses' station, which includes a communication system; secured outdoor areas; and locking devices that promote safety.

Background Checks

Assisted living residences and residential care communities may only hire staff who do not have a prior record of, or evidence of: (1) abuse, fraud, or substantial and repeated violations of applicable laws and rules in the operation of any health or social care facility or service organization, or in the care of dependent persons; or (2) conviction of crimes related to the care of a dependent person, which are documented in the state's central abuse registry.

Inspection and Monitoring

Assisted living residences and residential care communities are inspected at initial licensing and then as-needed and to investigate complaints.

Alzheimer's/dementia special care units and programs are evaluated for compliance with applicable rules and their disclosure statement during the facility's state licensure surveys.

Public Financing

The state does not use Medicaid to cover services in any type of residential care setting.

Room and Board Policy

The state does not provide an optional supplement payment, but does provide assistance under the category of special needs circumstances that includes every aged or disabled person living in a supported living setting who has been approved for

Supplemental Security Income (SSI) and persons who are not eligible for SSI but are eligible for the state assistance payment.

In 2011, the state made a maximum monthly payment of \$879.90 to AFCHs, and \$1,122.32 to ALRs on behalf of eligible residents. Residents' income (minus a personal needs allowance [PNA]) was subtracted from the maximum payment to determine the amount of the state assistance payment.²

Family supplementation is allowed.

Location of Licensing, Certification, or Other Requirements

Administrative Law, Assisted Living Residences. [May 1, 2006]
<http://apps.sos.wv.gov/adlaw/csr/ruleview.aspx?document=2705>

Administrative Law, Residential Care Communities. [July 1, 1999]
<http://apps.sos.wv.gov/adlaw/csr/rule.aspx?rule=64-75>

Administrative Law, Alzheimer's/Dementia Special Care Units and Programs. [May 1, 2006]
<http://apps.sos.wv.gov/adlaw/csr/rule.aspx?rule=64-85>

Administrative Law, Legally Unlicensed Health Care Home. [July 1, 1999]
<http://apps.sos.wv.gov/adlaw/csr/ruleview.aspx?document=2821>

West Virginia Department of Health and Human Services, Adult Residential Services website: Adult Family Care Homes, including links to general information, provider guidelines, and Adult Residential Services law.
http://www.wvdhhr.org/bcf/children_adult/ars/provider_afc.asp

West Virginia Department of Health and Human Services, Office of Health Facility Licensure and Certification website: Approved Medication Assistive Personnel guidelines with links to resources and legislative rules.
<https://ohflac.wv.gov/Programs/AM.html>

Information Sources

Debra Anderson
West Virginia Health Care Association

² Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011.
http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/wv.html. ALRs used to be called personal care homes and residential board and care, the terms used by the Social Security Administration. Current information about the amount of the supplement was not available online or from other sources. A state source said that the PNA was about \$131 a month in 2014.

Sharon R. Kirk
West Virginia Department of Health and Human Resources
Office of Health Facilities Licensure and Certification

Tina Maher
West Virginia Department of Health and Human Resources

Michele Saxton
West Virginia Department of Health and Human Resources

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