

# **Aging in Place in Assisted Living: State Regulations and Practice**

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## Contents

Introduction.....	1
State assisted living policy directions.....	1
Assisted living models.....	2
State policies and practice.....	5
New Jersey.....	5
Oklahoma.....	6
Oregon.....	8
Vermont.....	9
Washington.....	11
Discussion.....	13

## **Introduction**

“I want to be independent and stay in my own home as long as I can. And I don’t want to go to a nursing home!”

It is a familiar statement from people who are aging and, due to chronic conditions and changes in functional abilities, need assistance to continue to live as independently as possible. Aging in place is a concept that allows people to receive services to live independently with supports that increase (or decrease) as needs change. The growth of assisted living offers more choices for people who live alone and do not have caregivers available, especially at night and on weekends. As a result, elders are now less likely to enter a nursing facility when they need oversight and assistance that cannot be scheduled. Long term care services are now being delivered in a variety of residential settings in part due to expanded civil rights protections afforded to people with disabilities and the emergence of home health, home care and assisted living across the country.

Elders moving to assisted living also want to age in place. While they may no longer live in a single family home or an independent apartment, many assisted living residences operate to promote independence, privacy, autonomy and decision making through an aging in place philosophy. The shifting focus to respond to consumer preferences is also supported by trends in state policy although each state has a unique approach to regulating aging in place. The purpose of this analysis is to highlight the varied approaches being used in several states committed supporting aging in place. Coleman<sup>1</sup> of AARP noted that more States are combining the financing and organization of long term care delivery systems to shift funds from nursing homes to services in residential and in-home settings. Coleman<sup>2</sup> reported that multiple strategies are being used to create more balanced systems including limiting the supply of nursing homes, expanding home and community based services, re-organizing State agencies to centralize responsibilities for allocating resources, creating single entry point delivery systems and increasing coverage for services in residential settings.

## **State assisted living policy directions**

State agencies responsible for licensing assisted living and other residential options have adopted regulations that allow a broader level of services to meet the needs of residents as they age in place. A 2004 study of state assisted living policy and practices by the National Academy for State Health Policy found that twenty-nine states and the District of Columbia include a philosophy in their regulations that supports resident autonomy and decision making in

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<sup>1</sup> Coleman, Barbara. “New Directions for State Long Term Care Systems: Second Edition.” AARP Public Policy Institute. Washington, DC. 1998.

<sup>2</sup> Coleman, Barbara. “New Directions for State Long Term Care Systems: Volume I: Overview.” AARP Public Policy Institute. Washington, DC. 1996.

residential settings. Assisted living in many states now represents a more consumer focused model which organizes the setting and the delivery of service around the resident rather than the residence. Inclusion of a statement of philosophy within the regulations often expands and gives more prominence to provisions that address resident rights. States that emphasize in their regulations the needs and desires of consumers typically stress independence, dignity, privacy, decision-making, and autonomy as a foundation of their policy.

Aging in place was examined in a 1999 report from the General Accounting Office which stated that:

Assisted living is often promoted as supporting the concept of “aging in place” that allows residents to remain in a residence as their health condition declines or their needs change. The ability of residents to age in place is reflected in a residence’s admission and discharge criteria or its rules governing who it will permit to move in and when they may be required to leave.

States typically use one or more of five factors to establish admission/retention policies in assisted living residences:

- General condition;
- Health related conditions;
- Functional capacity;
- Alzheimer’s disease and dementia; and
- Behaviors.

State rules usually set the parameters for admission and retention but allow individual residences to determine whom they will serve and what services will be provided within the parameters set by regulation. The GAO study reported that assisted living residences vary, both within and across states, in terms of the resident they will serve on admission and the criteria for retaining residents after admission.

This report examines the admission/retention criteria in selected states that allow residences considerable flexibility to support aging in place: New Jersey, Oklahoma, Oregon, Vermont and Washington. The report is based on a review of state regulations and interviews with state licensing officials and assisted living providers.

## **Assisted living models**

Like the answer to most questions about assisted living, aging in place policy and practices vary. For assisted living owners, aging in place is a risk. It may not reflect the company’s niche or business model. It may challenge their ability to recruit and retain the staff needed to serve people with greater functional dependency and health needs. To some, it has legal implications. It implies that a person may remain in a residence until they die which may not reflect either the

limits imposed by state regulations or the admission/retention policies established by specific companies within the parameters set by regulation in a state. Companies prefer to operationalize aging in place based on the answer to a fairly simple question: can we meet their needs? Some companies operate on a philosophy or business model that serves residents as long as possible. Others limit the services provided directly to residents whose service needs are somewhat less than what may be allowed by state regulation, but they frequently use outside agencies to serve residents with higher needs.

Providers described three different business models related to aging in place. The first seeks to admit and retain residents with high acuity levels. The criteria for admission among residences that admit residents with high service needs is, “Can we serve them effectively” rather than “How do their service needs affect our resident mix?” Regulations in some states allow and encourage residences to implement an aging in place approach to serving residents. This paper highlights five states whose regulations support this approach.

Two additional models were described in states that allow more flexibility. A second model is more focused on serving low to moderate acuity residents on admission but continues to serve residents as their needs increase. Acuity levels rise over time. Residences experience ‘acuity cycles’ in the second model. When buildings first open, residents tend to have fewer service needs. Retention policies allow residents to age in place and residences add direct care and nursing staff to meet additional needs. As acuity rises, less impaired applicants may be influenced by the number of residents with walkers and wheelchairs and may choose not to move in. Managers that try to maintain a mix of acuity levels are challenged when a larger percentage of the residents have higher needs. Lowering the acuity mix is sometimes easier when many frailer residents leave around the same time. Yet a higher acuity mix leaves the owner vulnerable to larger numbers of residents leaving within a short period of time and increasing the vacancy rate.

Several operators observed that resident acuity follows a three year cycle. Owners of new buildings attempt to recruit more independent residents. New residences serve less frail residents because marketing normally begins six months before the building is ready for occupancy. Consumers with higher and more immediate service needs are not able to wait until the residence opens. Over time, the residents’ needs have change and after three years, nearly all the initial residents die or move to a nursing facility.

The third model would admit residents with low to moderate needs and maintain policies that discharge residents as their needs increase regardless of the level of care allowed by the licensing regulations. However, over time, residences have allowed residents to remain and services are arranged with outside providers. In practice, this model has become more difficult to follow. Companies reported an increase in the average age of new residents and the acceptance of residents with higher needs on admission.

The latter two models highlight the flexibility available within state policy. Rules in states that limit who may be served create conflicts for owners, managers and consumers who prefer to age in place. Legislatures in Michigan, Mississippi and Texas have enacted laws that allow

residences to continue to serve residents who would be asked to move under the regulations as long as a physician, the residence, the resident and the family agree that the resident's needs can be met in the residence.

The aging in place philosophy directly affects staffing. Some larger, multi-state providers use a matrix to determine the number and type of staff per resident. One company noted that staff ratios do not always predict staffing needs. For example, a residence may have six residents that require assistance with transfer, but one resident needs assistance three times a day and another, eight or ten times a day. Resident to staff ratios that do not take differences in the type and frequency of assistance may not generate sufficient staffing patterns. The company develops and varies its staffing pattern based on discussions with the director of nursing and direct care staff about the needs of residents and their changes over time. The company has incentives to implement the correct staffing plan because it believes that residents will move if the service is not adequate.

### **Clear regulations**

Owners and managers indicated that clarity in the regulation and enforcement may be more important than the level of care permitted by the regulations. However, one key informant noted that Washington's criteria, which allows residences to serve residents with stable and predictable medical conditions, works well with their philosophy even though it may be open to interpretation.

New Jersey's categories were seen as the easiest to implement by one provider that operates in multiple states. Multi-state companies felt it is becoming easier to operate across states as surveyors receive more training and regulations are interpreted more uniformly.

Particularly in residences that limit acuity, operators develop admission and retention policies that function as risk management strategies. For example, some residences will not feed residents, provide two person transfers or provide subcutaneous injections. The process includes completing an assessment that fully identifies the resident's needs, the obligations and responsibilities of the residence's staff, the resident and family members. Residents are re-assessed after any incident or change in condition. The results of the reassessment are discussed with the resident, family members and the resident's physician.

During the admission process, residences use the resident agreement or contract as the primary vehicle to discuss changes or service needs that could result in a discharge. Some companies have developed a disclosure form that contains more information than the resident agreement. However, communication between the manager, professional and marketing staff is important to make sure that applicants are receiving accurate information about the residence's capacity to support aging in place. Price is another challenge for residences that support aging in place. On admission, residents indicate they want to stay as long as possible. However, as needs increase, the cost of care increases \$15 - \$50 a day, yet residents and their families often expect to receive more care at the same price.

## State policies and practices

### New Jersey

New Jersey supported aging in place when it first developed its regulations in the mid-1990s. The regulations allow residences to provide nursing services and also allow, but do not require, that residents must move if:

- The resident requires 24 hour, seven day a week nursing supervision;
- The resident is bedridden for more than 14 consecutive days;
- The resident is consistently and totally dependent in four or more of the following activities of daily living: eating, bathing, dressing, grooming, and toileting;
- The resident has a cognitive decline severe enough to prevent the making of simple decisions regarding activities such as bathing, dressing and eating and cannot respond appropriately to cueing and simple directions;
- The resident requires treatment of a stage three or four pressure sore or multiple stage two pressure sores;
- The resident requires more than assistance with transfer (verbal and physical cueing or the physical assistance of no more than two residence staff or both while the resident moves between bed and a standing position or between bed chair or wheelchair);
- The resident is a danger to self or others; or
- The resident has a medically unstable condition and/or has special health problems, and a regimen of therapy cannot be appropriately developed and implemented in the assisted living environment.

Residences in New Jersey are required to clearly specify on their admission agreement whether it will serve residents with one or more of the listed characteristics, the extent to which it will serve them and the associated costs. New Jersey's regulations do not allow residences to serve individuals who use a respirator or mechanical ventilator and residents with severe behavior management problems, such as individuals who are combative, aggressive, and exhibit disruptive behaviors.

The statute and regulations actually require some level of aging in place. Operators must include a statement in the licensing application that at least 20% of the residents will meet nursing home level of care criteria within three years of licensing.

One company executive who participated in the development of assisted living regulations supported the goal of offering consumers more choices to nursing homes. The aging in place philosophy was reflected in the regulations. He described regulations as, "very aggressive and requiring aging in place." Because the company owns a nursing home, residents with acute

conditions who need clinical nursing services move from assisted living and often return when their condition improves. Still, the aging in place philosophy has had a dramatic affect on admissions to the nursing home. Prior to the rules, the company had about 14 admissions in one year to a 92 bed residence. Five years ago, the same residence had 90 admissions and in 2004, 250 admissions. Nursing homes are now a short term, rehabilitative option and assisted living serves a significant number of people who would have entered a nursing home. Medicare accounts for payment for about 30% of the company's nursing home residents. This company had negligible Medicare stays before they developed assisted living and marketed their nursing home differently.

Because of the competitive assisted living market, including the growth of home delivered health and supportive services, assisted living residences are serving people at higher acuity levels than were anticipated 10-15 years ago. The trend is not a concern for residences that adopted the aging in place philosophy when they opened. However, residences that started by serving lower acuity residents began retaining residents longer and admitting residents with higher needs need to add staff and modifying training for staff.

## **Oklahoma**

Oklahoma's regulations for assisted living residences were designed to address the limitations of residential care facilities rules. Residential care homes serve residents who are ambulatory and essentially capable of managing their own affairs. They may not serve residents who need services provided in a skilled or intermediate care facility.

The assisted living center rules allow residences to serve residents with a range of needs but do not allow residences to serve residents who need 24 hour nursing services. Assisted living centers include their admission criteria in the licensing application and the resident service contract. The application has to include the population that will be served and the services provided to meet the following needs:

- Assistance with personal care;
- Nursing supervision;
- Intermittent or unscheduled nursing care;
- Medication administration;
- Assistance with cognitive orientation and care or service for Alzheimer's disease and related dementias; and
- Assistance with transfer or ambulation.

Services that will be provided to residents to meet their needs must also be described that address:

- Assistance with personal care, meals, housekeeping and laundry;
- Nursing supervision during nursing intervention;

- Intermittent or unscheduled nursing care;
- Medication administration;
- Assistance with cognitive orientation;
- Any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the residence intends to market;
- Assistance with transfer or ambulation;
- Planned programs for socialization, activities and exercise; and
- Provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.

Residences use a standard screening instrument to determine the appropriateness of the resident's placement in the assisted living center. Residents may not be admitted if they:

- Need care or services that exceed the care or services available in the assisted living center;
- Require physical or chemical restraints in situations other than emergencies;
- Pose a threat to self or others; or
- The residence cannot meet the resident's needs for privacy or dignity.

The admission/retention criteria were supported by the assisted living industry. Some residences initially set policies that did not allow residents with higher needs to be served. However, policies have changed over time. Key informants noted that referral patterns vary during the year. While assisted living residences often prefer to market to and admit residents who are less frail, the market affects actual practice. Referrals from hospitals and skilled nursing facilities are higher during the winter months while independent residents are more likely to move in during the summer.

The term “aging in place” is not generally used by operators in Oklahoma because of its legal implications. Operators feel it implies a legal obligation to serve residents regardless of their service needs and the residence’s ability to meet them. During the development of the regulations, the residential care industry interpreted aging in place to mean 24 hour nursing care. Residential care facilities were limited to serving residents who were ambulatory and could evacuate a building on their own or with mechanical assistance (cane, walker). They did not want to look like or appear to become a “nursing home.”

Within the context of a given state’s requirements and market competition, companies often focus on a specific group of consumers. One company noted that a “catch all” policy is difficult to manage. Physically impaired but cognitively intact residents are not likely to move into a residence that serves many residents with cognitive impairments. The company felt that residences should develop their own specialty. Serving either functional impaired or cognitively impaired residents is easier to maintain than variations within each population. Residences that

market to less frail residents must make a business decision as their customer's age. They must either ask residents to move when they become frailer, adjust staffing patterns to meet increasing service needs if they continue to serve them or arrange services through outside agencies.

One company described the difficulty dealing with consumers whose needs exceed what the company can meet. Despite the assertion that are not staffed to meet the person's needs, residents and family members usually asked, "What do I have to do to stay?" If the residence maintains its position, they often search all the assisted living residences in the area. Admission to a nursing home is generally the last resort for families and residents.

## **Oregon**

Oregon licenses assisted living residences and residential care facilities. Oregon's first assisted living regulations were effective in 1990 and allowed residences to serve anyone whose needs could be met by the residence. There were no other limitations.

The rules were revised in 1999 and 2002. The changes dropped a reference to aging in place, clarified when residences may ask a resident to move and set a minimum admission/retention threshold. The aging in place language was interpreted by administrators to prevent them from discharging residents. The Oregon Seniors and People with Disabilities Division encourages residences to support a resident's choice to remain in assisted living yet recognize that some residents may no longer be appropriate due to safety and services limitations. The revisions also clarified that residences were allowed, but were not required, to discharge residents if:

- The resident's needs exceed the level of ADL services the residence provides. The residence has to document efforts to provide or arrange for the services needed;
- The resident exhibits behavior or actions that repeatedly and substantially interfere with the rights or well being of other residents and reasonable interventions have failed to reduce the threat;
- The resident, due to severe cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express need or summon assistance;
- The resident has a complex, unstable or unpredictable medical condition and treatment cannot be appropriately developed and implemented;
- Non-payment of charges;
- The resident exhibits behavior that is an immediate danger to self or others;
- The resident has had a sudden change in condition that requires medical or psychiatric treatment outside the residence and when a return is planned, the residence determines that the resident's needs exceed the residence's level of service; or

- The resident requires 24 hour, seven day a week nursing supervision.

All licensed residences must provide assistance with ADLs. The language implies that residents who are totally dependent in an ADL may be asked to move. In practice, residents are not asked to move because they are totally dependent in an ADL but are likely to have other conditions that may exceed the residence's capacity to address. State officials report that most in-voluntarily moves are due to behavior. When a residence chooses to ask a resident to move involuntarily, the notice is reviewed by the licensing agency. The agency examines the reasons for the request and compares the request to the residence's disclosure statement to make sure the situation is consistent with the residence's policy.

A work group has been formed to review the regulations. State officials are concerned about rising acuity levels and care needs among residents. The regulations specify that residences must have sufficient staff to meet resident needs. They require that residences hire or contract with a registered nurse to conduct health assessments, monitoring, and assignment and delegation of basic nursing tasks. The amount of time is determined based on what is appropriate to meet the needs of residents. State officials note that providers and surveyors may disagree with what is "appropriate" but determining a number of hours is also difficult.

The state also licenses two types of residential care facilities. Class I facilities can assist with ADL needs. Class II facilities can provide the same level of care as assisted living residences. The primary differences are the structural requirements. ALFs must offer apartment units and RCFs may offer rooms. The state work group is considering merging the two sets of regulations.

## **Vermont**

Vermont licenses two types of residential settings – assisted living residences (ALR) and residential care homes (RCH). The ALR rules were adopted in March 2003. The ALR regulations supplement rules for residential care homes and "are intended to ensure that homes licensed as assisted living residences promote resident individuality, privacy, dignity, self-direction and active participation in decision-making." The rules were developed to encourage aging in place.

The state also licenses Residential Care Homes (RCHs). RCHs may not admit anyone who requires intravenous therapy, ventilators or respirators, daily catheter irrigation, feeding tubes, care of Stage III or IV decubitus; suctioning, or sterile dressings but may obtain a variance from the Department to retain residents who develop these needs. Variances are considered and issued on a case by case basis. A series of requirements are described for residences providing nursing overview, administration of medications, and nursing care. ALRs need a variance to admit residents with these conditions but not to retain them if the condition develops after admission.

During development of the regulations, policy staff were concerned that broad language may force residences to serve residents whose needs could not be met. The final language was designed to give property managers, consumers and family members realistic expectations of who could be served and what services were available.

Current residents who develop a serious, acute illness may be retained as long as their care needs are met by appropriate licensed personnel. To allow aging in place, residences “shall provide personal care and supportive services, which may include nursing services, to meet the needs and care plans of residents assessed who have an ADL score of 10 or less in the daily activities of eating, transfers, toileting and bed mobility, provided that the mobility, ambulation and transfer needs can be met by one staff person; a cognitive impairment at a moderate or lesser degree of severity; or behavioral symptoms that consistently respond to appropriate intervention.”

Residents may only be involuntarily discharged if they pose a serious threat to self or other residents that cannot be resolved through care planning and are not capable of entering into a negotiated risk agreement; are ordered by a court to move; or fail to pay rent, service, or care charges; the resident refuses to abide by the terms of the admission agreement; or the resident has care needs above the mandatory scope of aging in place and the assisted living residence can no longer meet the resident’s level of care needs or has a policy to discharge residents with such needs.

Residents who have an identified acute or chronic medical problem or who need nursing overview or supervision must be under the continuing general supervision of a physician of their choosing. The regulations state that “the expectation is that individuals will be permitted to age in place and not be required to leave an assisted living residence involuntarily. The residence is not allowed to discharge anyone because a resident’s choice might pose a risk if the resident is competent and the choice is informed and poses a danger or risk only to the resident.”

Stakeholders involved in developing the regulations want to monitor the implementation of the aging in place philosophy. The ALR regulations require that residences submit resident assessment data annually. The licensing agency developed the assessment form. The information will be used by the licensing agency to assess the conditions and needs of residents, whether residences are providing the full range of services required and the extent to which aging-in-place is being achieved. The regulations are new and few residences are licensed. Managing the assessment data is not seen as burdensome to the licensing staff. As the volume of assessment data increases, the licensing agency will have to add staff to manage the information which is submitted manually. It is not clear that the resources will be available to process and analyze the data. If the volume increases gradually and the data proves useful, it is more likely that additional resources may be approved. The licensing agency does not plan to require submission of assessment information on all RCH residents because of the larger number of residences and residents and the agency’s limited staff capacity.

## Washington

The state of Washington completed a lengthy four year review of its boarding home regulations in September 2004 and made extensive revisions to the regulations. Prior to the new regulations, boarding homes were not allowed to serve anyone who required respiratory ventilation, intravenous procedures, suctioning, feeding tube insertion or site maintenance, or were bed bound more than 14 consecutive days as a result of a medical condition. The rules did not allow residences to serve a resident returning from a hospital stay that had developed a decubitous ulcer that was healing and could be supported with available staff. The rules also prevented residences from serving stable bed bound residents that required routine care because the condition lasted more than 14 days. The working groups felt the diagnostically based requirements were too limiting and did not allow providers to serve higher acuity residents if they had the capacity to do so.

During its review, the licensing agency considered developing levels of care but found it was difficult to define each level and complicated to enforce them. As a result of discussions with the industry, the rules allow residences to serve a range of residents. Residences may choose to serve residents who do not need assistance with ADLs. When a residence chooses to provide, either directly or indirectly, assistance with ADLs, they must provide that assistance consistent with the reasonable accommodation requirements in state and federal laws. They must also provide at least minimal assistance with bathing, eating, personal hygiene, transferring, toileting, and mobility. Residences complete a uniform disclosure form that describes who they will serve, what services will be provided and the criteria for discharge. The new regulations state that:

A boarding home may admit and retain individuals only if:

- The boarding home can safely and appropriately serve the resident with appropriate staff and through the reasonable accommodation required by state or federal law, and provide any specialized training to caregivers that may be required;
- The person does not require the frequent presence and frequent evaluation of a registered nurse, excluding those persons who are receiving hospice care or persons who have short-term illness that is expected to be resolved within fourteen days as long as the boarding home has the capacity to meet the resident's identified needs;
- The individual is ambulatory, unless the boarding home is approved by the Washington state director of fire protection to care for semi-ambulatory or non-ambulatory residents; and
- The individual meets the acceptance criteria the boarding home described in the boarding home's disclosure information.

Prior to the new regulations, boarding homes were not able to provide respiratory ventilation, intravenous procedures, suctioning, feeding tube insertion or site maintenance, and care of

residents who are bed bound more than 14 consecutive days as a result of a medical condition. However, residents could arrange for these services if they reside in lockable quarters with a private toilet, sink, bathing fixture, and emergency power, if necessary, for life support equipment.

One operator with residences in multiple states reported that the changes made in Washington's move in/out criteria are clearer and more flexible. The new rules allow providers to determine the level of care they will offer within broad parameters. An early draft of the regulations set minimum criteria that all licensed boarding homes would have to meet. The final changes allow more flexibility. One multi-state provider offers a minimum to moderate level of care in keeping with its business plan and risk management strategy. The company is not staffed to serve residents with uncontrolled incontinence, moderate cognitive impairment, those who pose a safety threat to themselves, staff and other residents, and those with more than stage II pressure sores. They have maintained their admission/retention policy since the regulations were changed.

When a resident develops conditions or service needs that are not consistent with the disclosure statement, residences may develop "reasonable accommodation required by state or federal law." The company explained that 'reasonable accommodation' does not include adjustments that result in a change in the model and concept of the community, impose an adverse affect on their business or require a change in staffing. A resident that normally receives assistance from one staff member to take a bath would be accommodated if they needed full assistance from two staff members.

The company noted that the new regulations were clearer and easier to follow. However, it is not clear how the licensing agency will define and apply provisions that do not allow residences to serve residents who require the frequent services and evaluation from a registered nurse.

Another multi-state company stated that they did not change their admission and move out policies when the new rules took effect but the requirements for nursing support regardless of the acuity level means that residences with lighter acuity levels must hire nurses when their skills may not be needed. Residents who develop needs for nursing services, injections, catheter care are encouraged to move to a residence that offers this level of service or arrange for care from an outside agency. The residence focuses on residents who need support for ADLs, medication management, and assistance with ambulation.

Both Oregon and Washington require that residences disclose their move in-out criteria and service package. Washington established a uniform disclosure form.<sup>3</sup> Disclosures in Oregon must be approved by the licensing agency. Disclosures offer protections for residence since there is a record of information that was presented and discussed with the family and the resident upon admission. The disclosure form builds on the company's resident agreement which has been used for the past six years.

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<sup>3</sup> Available at: [http://www1.dshs.wa.gov/word/ms/forms/10\\_351.doc](http://www1.dshs.wa.gov/word/ms/forms/10_351.doc)

Washington's rules allow residences to change the level of care by changing the disclosure statement with 30 days notice if the changes are beyond the control of the residence or the changes do not require any current resident to leave the residence and with 90 day notice if residents would be forced to move due to the changes. State officials do not expect that residences will make many changes in their admission policies. More changes are expected in retention policies.

Company policies may be limited by the licensing rules and the state's nurse practice act. One company would prefer to administer insulin to better serve residents with diabetes but the rules require that injections be given by a registered nurse which affects the residence's staffing and cost structure.

## **Discussion**

This paper profiles regulations in five states with assisted living regulations that support and encourage aging in place. While there are variations among the states, all have established policies that allow assisted living providers to respond to the preferences of consumers and family members to receive additional services as conditions change. The importance of the regulations in these states is not how many residents require very high levels of service but that the flexibility to do so has been established. It may take several more years to implement the full extent of the regulations but the direction in recent years is heading in the intended direction.

Across the states, company representatives noted that supply, competition and consumer preferences all affect admission and retention policies. Residences that opened intending to serve less frail seniors are retaining residents who would have been discharged to another residence or to a nursing home. Some operators stated that because of their previous experience as a service provider, they are better able to change staffing patterns to meet rising needs.

One important variable regarding aging in place is the state policy on nurse delegation and medication administration. Oregon was viewed as the most flexible because the nurse practice act allows nurses to delegate injections. New Jersey requires that aides complete a medication administration training program while insulin injections in Washington must be given by nursing personnel. Assisted living providers in Washington face a choice: hire more nursing staff to administer insulin or discharge residents who could otherwise be served. One informant noted that the insulin administration policy has created a niche market for residences that specialize in serving people with diabetes.

Aging in place is a concept that is easier to articulate than to implement. Oversight agencies expressed general concern that residences are retaining residents that they are not adequately staffed to serve or that residences may be slow to adjust staffing patterns. Yet none of the states indicated that the concerns had prompted them to consider changing the admission/retention criteria. Regulators are considering steps that support the intent of the regulations and to support residences as they serve residents longer, eg., staffing, training, services. Operators acknowledge that competition from other providers affects their admission/retention policies but key

informants emphasized that they only retain residents whose needs they determine can met by the residence. Added pressure to remain comes from family members and residents who want to avoid entering a nursing home.

The tension between consumer preferences and public policy that supports aging in place and company policies and practices is likely to continue. State regulators continue to support flexible policies that allow residences to provide an array of services that individuals could obtain in their own single family home or apartment. Within a highly competitive assisted living environment, operators will strive to serve consumers and their family as long as possible.

<b>Comparison of state policies</b>					
<b>General approach</b>	<b>New Jersey</b>	<b>Oklahoma</b>	<b>Oregon</b>	<b>Vermont</b>	<b>Washington</b>
	Broad criteria that support aging in place	Allow up to 24 hour nursing care	Allow broad flexibility to serve any resident whose needs can be met	Allow admission of residents who could not be admitted under RCF rules	If provide assistance with ADLs, must offer minimum assistance with listed ADLs
<b>Criteria</b>	Residences indicate on their licensing application which of eight conditions they will meet	Cannot admit residents if:  Care exceeds capacity;  Require physical or chemical restraints;  Pose threat to self or others;  Needs for privacy or dignity cannot be met	Permit but do not require move out if:  Needs exceed capacity;  Unable respond to verbal instruction, avoid danger;  Complex, unstable medical condition;  24 hour, 7 day/week nursing supervision  Behaviors interfere with rights of others	Require a minimum level of care (personal care, nursing and supportive services) for people with:  ADL scores < 10;  moderate or lesser cognitive impairment;  behaviors that respond to appropriate intervention	Serve residents that :  Do not require the frequent presence and frequent evaluation of a registered nurse;  Are ambulatory, unless the boarding home is approved to care for semi-ambulatory or non-ambulatory residents; and  The individual meets criteria described in the disclosure information.
<b>Other provisions</b>	20% of the residents must meet nursing home level of care criteria within 3 years of licensure.	Admission criteria listed in the licensing application and service contract	Regulations clarify conditions that may require move out, at the option of the residence	No waiver required to retain someone who develops one of the listed conditions	Admission/retention criteria describe on a standard disclosure form

