LICENSING NEW BOARD AND CARE FOR THE ELDERLY

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INTRODUCTION

By the year 2030, there will be almost sixty-six million persons sixty-five years old or older in the United States, two and one-half times their number in 1980.¹ By the year 2000, persons sixty-five and older will represent thirteen percent of the population; by the year 2030, almost twenty-two percent.²

This graying of our population—unprecedented in the history of the United States—is forcing rapid changes in our approach to providing health care, housing and other social services to the elderly. Traditionally, older people moved in with their families or into board and care or nursing homes when no longer physically or economically capable of living in their own homes or in retirement communities. There were few alternatives. In the last decade, however, there has been a large increase in the number of assisted living options for the elderly, as both the public and private sectors attempt to respond to this major demographic shift.³ Between the extremes of independent living and nursing home care, there is now a variety of alternatives called “congregate care,” “assisted living,” “continuing care,” “life care” and “personal care” to list just a few. The ongoing struggle to define board and care facilities for licensing purposes pales in comparison to attempts to understand this new terminology. As one commentator noted, “[with] every newcomer claiming to have built a better mousetrap and coining a new phrase for his efforts, we are all becoming hopelessly

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¹ Staff Director, Commission on Legal Problems of the Elderly, American Bar Association.
² Assistant Staff Director, Commission on Legal Problems of the Elderly, American Bar Association.
³ American As of Retired Persons, A Profile of Older Americans (1990) (Pamphlet).
4 Id.
5 Harney, "Assisted Living" Concept Gains as Alternative for Elderly, Wash. Post, Feb. 25, 1989, at E3. (Data assembled by Moore Diversified Services, shows that 210 out of every 1000 seniors, 75 years or older, require some form of health related or physical assistance in coping with everyday life. Of those 210, only 75 have significant problems that can only be handled in an institutionalized setting).
mired in meaningless jargon.” He suggests, tongue-in-cheek, that we turn to state and local governing bodies for structuring definitions, since they need them for licensure and zoning purposes. He concludes, however, that governments are just as confused as we are, having relied on the industry for guidance.

This Article is designed to alert regulators to this new industry of assisted living for the elderly and to suggest that many of the services being offered in facilities other than the traditional licensed board and care facility do indeed fall under board and care licensure statutes. A secondary—yet critical—concern is the misleading advertising concerning many of these facilities, and the fact that many older people may erroneously believe they will be getting assisted living as part of this package.

“Assisted living” is a term primarily used by the housing industry as a term to advertise and to sell to the general public a new type of housing for the elderly. In the last several years the term has begun to appear in the housing industry literature concerned with types of housing for the elderly. During the last few years there has been increased attention paid to reaching wealthier older persons and in turn to develop housing schemes to meet their needs.

I. TRADITIONAL BOARD AND CARE

Board and care describes a “publicly or privately operated residence that provides personal assistance, lodging and meals to two or more adults who are unrelated to the licensee or administrator.” They also are known by a variety of other names such as “group homes,” “adult foster care homes,” “personal care homes,” “domiciliary care homes,” “residential care facilities” and “homes for the aged.” Many of these homes also house individuals with mental or physical impairments that prevent them from living independently.

A recent survey identified forty-one thousand board and care facilities housing five hundred sixty-three thousand residents throughout the country. These range from small operations with two or more residents in a private home to larger facilities for as many as one hundred residents operated by private non-profit corporations. In addition to meals

5. Id. at 32.
6. Id.
7. See Harney, supra note 3.
and housekeeping, residents in traditional board and care generally receive help with activities of daily living such as: shopping, bathing and dressing; supportive services such as financial management and transportation; and protective oversight.

Although each state licenses some types of board and care facilities, it is impossible to generalize about the extent of coverage because it varies so greatly from state to state. For purposes of the following discussion, this Article analyzes board and care statutes in New Jersey, Maryland, Connecticut, Ohio and Oregon. These statutes will be used to suggest that many of the new "assisted living" facilities in those states fall within their respective statutory board and care frameworks and, therefore, should be licensed as such.

Amendments to state legislation for board and care have been numerous over the past several years. States such as Ohio enacted their first comprehensive licensing act in 1989 with an effective date of November 1990. As is typical of most of the legislation, the Ohio statute includes three levels of homes based on size. The statute also requires that the facilities provide "personal care services" for a minimum number of residents. In the larger homes (seventeen or more unrelated adults), there is an additional requirement that the facility distribute medication and provide for special diets. These special requirements apply when three or more people in the facility have a need for the service. The Ohio statute is typical of what other states have enacted over the last fifteen years. Recent amendments fall into several categories of change. These generally include zoning overrides in order to place small facilities in neighborhoods, applying intermediate enforcement mechanisms on violations of regulations and on applying the investigative mechanisms present in adult protective services legislation.

II. THE NEW ASSISTED LIVING INDUSTRY

The new term "assisted living" is simply a more palatable and appealing way to describe board and care, a term which conjures up images of frail older people with bed sores living in dilapidated old houses. While many types of assisted living offer a great deal more in terms of services and assistance than do most traditional board and

12. OHIO REV. CODE ANN. §§ 3721.01(G), 3722.01(A)(7), 3722.01(A)(8) (Baldwin Supp. 1990).
13. Id.
15. OHIO REV. CODE ANN. § 3731.01(G) (Baldwin Supp. 1990).
care facilities, the level of allowable care is the same. This “allowable care” generally is defined as, “assistance with routine daily activities and seeks to include such activities or functions as ambulation, bathing, dressing, eating, grooming and other personal hygiene activities.” This definition is similar to most states’ definitions of board and care facilities. The criteria for classifying these facilities, therefore, is the level of care provided, and not the label. The terms “adult congregate care,” “residential care,” “personal care,” “perpetual care,” and variations on that theme are meaningless for the purposes of evaluating the level of care offered and the appropriateness of licensure.

Assisted living also includes the burgeoning industry of “life care” or “continuing care” (also “life lease,” “perpetual care,” “residence and care,” but most commonly referred to as “continuing care retirement communities” (CCRCs)). CCRCs are conventionally defined as retirement facilities that provide shelter, care and services, including nursing home services, for as long as the resident lives in the facility, in return for a one-time entrance fee and monthly fees. Originally sponsored by non-profit religious or fraternal organizations, the CCRC industry is now experiencing a marked growth and change because of the entry of private, for-profit corporations who see the tremendous potential of these facilities. Currently, there are approximately seven hundred CCRCs—both non-profit and for-profit—serving between one hundred thousand and two hundred thousand individuals. One estimate states that by the end of 1990, there will be one and a half thousand CCRCs serving more than four hundred fifty thousand elderly residents.

The regulation of CCRCs varies widely among states. Thirty states have enacted legislation in an effort to regulate these facilities,
in part a response to a rash of bankruptcies in the 1970s. The thrust of these statutes is to ensure financial stability through disclosure requirements and long term solvency assurances, although a few states regulate minimum contract terms, such as refund and termination policies. Additionally, a CCRC's nursing facility must be licensed by the state. If that nursing facility is receiving Medicare or Medicaid reimbursement, it must also be licensed by the federal government. Efforts at self-regulation have emerged in the form of the Continuing Care Accreditation Commission, an independent body sponsored by the American Association of Homes for the Aging (AAHA). Thus far the decision to submit to accreditation is voluntary; logically those facilities with something to hide may not seek accreditation. By the end of 1990 about one hundred of these seven hundred facilities had been accredited.

CCRC accreditation is voluntary. The AAHA initiated the process within the last five years. The initial standards for accreditation have recently been revised and will be used in 1991 for facilities which seek accreditation for the first time and those which seek re-accreditation. CCRCs must pay for the accreditation. It is not used for any substituted regulatory process and the facilities must be convinced that the cost and the peer review add value or why would they endure the rigors of inspection.

The changing nature of the CCRC industry has made it difficult to both accredit as well as to regulate. Over the last several years the


24. See generally Fisher, Continuing Care Retirement Communities: Promise Falling Short, 8 Geo. Manson U. L. Rev. 47, 49 (1985); Topolnicki, The Broken Promise of Life-Care Communities, Money, Apr. 1985, at 150; Sterns, Netting & Wilson, supra note 21, at 255-56.
25. See Sterns, Netting & Wilson, supra note 21, at 260-63.
market has dramatically changed and grown with private for profit corporation entering the CCRC market. The definition of CCRCs is also becoming increasingly fluid as developers manipulate the conventional earmarks of CCRCs by doing away with the entrance fee or relying more on a fee for service approach. Even traditional rental facilities and condominiums have begun to “look” more like CCRCs by adding long-term health care packages purchased through service agreements on “memberships.”

One of the draws of CCRCs is that assisted living—at whatever level necessary—will be readily available. One commentator noted that “[t]he need [for assisted living] has been so real within the life care communities that seldom will one permit entry directly from outside of the community.” Consequently, life care has jealously guarded its assisted living and nursing care as needed without having to leave the facility. Most residents enter these facilities fully capable of independent living. As they age, they may find it necessary to move to a different level of care depending on physical and health needs. For example, a senior may at different times need help with ambulation, eating, dressing, bathing, grooming or other personal hygiene activities; or a brief period of mental incompetence may necessitate the need for assistance with personal affairs. CCRC licensing statutes in most states do not address this middle ground of assisted living, although much of the assistance may in fact be regulated in a state’s board and care statute.

III. NEW BOARD AND CARE

This Article suggests that the new assisted living industry is simply an expansion of the traditional board and care industry. If that is the case, then should these new facilities be regulated?

Regulators and the public should take a close look at the new assisted living industry because: (1) Many facilities’ promotional materials contain misleading information about the nature and extent of the assisted living they provide; and (2) As suggested in this Article, much of the assisted living being provided is not licensed but in fact is—or should be—covered by state board and care licensure statutes. This is particularly true of CCRCs, which may or may not be licensed, and whose assisted living services are not covered by licensure, yet who provide assisted living as a significant part of their service packages. The following discussion illustrates these problems by way of specific state examples:

30. Id. at 131.
A. New Jersey

A New Jersey facility advertises itself as a “unique adult residence where many opportunities exist to make the next years the best years of your life” and that it “provide[s] for your special needs and security.” It furnishes room, board, housekeeping, transportation, and a number of recreational and social activities and facilities. Although billing itself as a congregate living facility for the “well” elderly who are capable of independent living, the literature misleads the reader into believing that these “special needs” indeed include assisted living. For example: “Although certain physical standards are required for residence, the fact of aging is known and accepted by [the facility]. Generally, the ability to help one’s self (that is, to dress, wash, be able to walk to the dining room and other areas of the facility) is essential. Also, one should be reasonably well oriented mentally. A medical certificate is required for tenancy.”

This description raises a number of questions: What happens when one cannot walk to the dining room unassisted? Will a client be kicked out? What are the procedures for asking someone to leave? What do the words “generally” and “reasonably” imply with respect to physical and mental fitness? Are wheel chairs available? What happens if a resident can walk some days and not others? What does “affiliated nursing homes” mean? Are residents simply referred to the nursing homes? Do residents get priority over non-residents? Can the resident return to the facility after spending time in a nursing home?

This is not a CCRC, which would be licensed in New Jersey. So what is it? New Jersey’s board and care statute defines “boarding house” as “any building, together with any related structure, accessory building, any land appurtenant thereto ... which contains two or more units of dwelling space arranged or intended for single room occupancy ... and wherein personal or financial services are provided to the residents, including any residential hotel or congregate living arrangement. ...” “Personal services” means “any services permitted or required to be furnished by an owner or operator to a resident, other than shelter, including, but not limited to meals or other food services and assistance in dressing, bathing or attending to other personal needs.”

The New Jersey licensing scheme is not unique but rather is mirrored across the country. The CCRC licensing regulations rarely require oversight of the personal care aspects of the facilities. CCRC

31. Id. at 129-31 (emphasis added) (at most facilities a health and financial screening are a prerequisite for admission).
statutes attempt to regulate the financial solvency of the facilities rather than the levels of care provided with the exception of the nursing homes units which are covered under a different state statute.\textsuperscript{35}

The facility could certainly argue that it is not required to provide “personal needs,” although that is undefined. Nonetheless, the facility appears to offer more than gardening and field trips by virtue of its veiled promise of personal assistance for “the next years” (whatever that means) and certainly a perusal of the contract itself would establish whether it fits squarely into the board and care statute. Suffice it to say that the literature is at best unclear and at worst misleading; and it is the type of facility that should be regulated.

B. Maryland

Similar to the New Jersey facility’s brochure is a community in Maryland designed for “retirement living.” It provides individual apartments, a community dining room (optional), housekeeping (optional), transportation, and a wealth of recreational and social activities. While there are no veiled promises of assisted living in this literature, it does advertise emergency response systems and audio-visual systems in each room and personnel coverage on-site twenty-four hours a day. Similar questions arise: What happens when a resident needs a change in level of care? Can the onsite personnel deal with medical emergencies? Why is there an audio-visual system, if not to check up on people who may need assistance? Again, a true analysis of this facility’s services would not be complete without an examination of the contract; nonetheless these types of facilities for the “well” elderly raise troubling questions about the procedures for changes in levels of care and the extent of personal assistance that residents can reasonably expect as they grow older and more frail.

CCRC contracts may or may not speak to all of the considerations that an individual needs to have in order to make an informed decision. Most likely the contracts are written to favor the facility and are not consumer friendly. There are certain provisions which need to be included that consultation with an attorney would be advisable. The categories to be concerned with are: solvency and expertise of the provider; entrance fees and monthly fees; health care; and residents’ rights.\textsuperscript{36} Although the upfront costs for most CCRC’s are not included in the assisted living facility many of the same contractual questions remain.

Maryland’s CCRCs are licensed. The statute defines “sheltered housing for the elderly” as a form of residential environment consisting of independent living assisted by congregate meals, housekeeping, and

\textsuperscript{35} Id. at 153-54.

\textsuperscript{36} Fairbanks, Lifetime Care Contracts: Are Senior Citizens Putting All Their Eggs in Basket?, PROB. & PROP., Mar./Apr. 1990, at 5-9.
personal services, for: (1) "An individual at least sixty-two years old who has temporary or periodic difficulty with one or more essential activities of daily living, like feeding, bathing, grooming, dressing, or transferring. . . ."37

The October 25, 1989, Business Section of the Montgomery County Journal contained an article about a new facility being built by Marriott Corporation for availability in Spring 1991.38 It will have two hundred thirty one- and two-bedroom "independent living" apartments; seventy-five of those will have "minimum nursing assistance" available. There will also be forty-six nursing home beds available to the residents. There is no large entrance fee; monthly fees range between $1,600 and $2,500 for one person. Thus far, eight hundred and five people have each put down a $1,000 deposit for the two hundred thirty apartments. Query: Is this a CCRC? Probably not, because there is no large entrance fee. But there is nursing care—so it looks like a CCRC. Generally, where there is nursing care, there is also some type of assisted living; therefore it may in fact fall under the board and care statute for licensing purposes.

While most states have revised their board and care statutes to eliminate the "old folks home" stereotype and to make them age-neutral, a few states have retained the distinction. In those few states it is particularly appropriate to evaluate whether an elderly assisted living facility—or a facility with an assisted living component—falls within the statutory definition of board and care. Examples include: Connecticut, Ohio, and Oregon.

C. Connecticut

Connecticut licenses "Homes for the Aged" and "Rest Homes," which are establishments which furnish, "in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provide[s] services which meet a need beyond the basic provisions of food, shelter and laundry."39

D. Ohio

The Ohio "Homes for the Aging" statute makes an important distinction between personal care services and skilled nursing care. It states that the "part or unit of the home for the aging that provides personal care services, that may administer medication and that may supervise special diets is licensed as a rest home . . . [t]he part of unit that provides skilled nursing care is licensed as a nursing home."40

37. MD. ANN. CODE art. 70B §1(e) (Supp 1990).
39. CONN. GEN. STAT. ANN. § 19a-490(c) (West 1988).
40. OHIO REV. CODE ANN. § 3721.01(H)(2) (Baldwin Supp 1990).
“Personal care services” is further defined as services including . . . "assisting residents with; activities of daily living self-administrating of medication, and preparing special diets."

E. Oregon

The Oregon Administrative Rules for “Residential Care Facilities/Assisted Living Facilities” specifically addresses the crossover between board and care and assisted living. The regulations call for individual apartment living, much closer to what is advertised as “assisted living” in other jurisdictions. It is Oregon’s intention to regulate facilities which provide for the autonomy of individuals while also addressing residents increased need for assistance with the activities of daily living. The Oregon regulations attempt to meet these apparent goals of autonomy and protective oversight in one set of regulations. This approach seems to be much better than the vacuum which most states have left.

CONCLUSION

The new industry of assisted living for the elderly is growing and changing at a rapid pace, with the private market in particular looking to accommodate an increasingly older, more independent population. The traditional retirement community is more and more like a traditional board and care facility; states must review these new facilities to ensure they comply with applicable statutes and, most importantly, that they provide their residents with the assistance they expect to receive.

41. Id. at § 3721.01(E).
42. OR. REV. STAT. § 418.950 (SUPP. 1990).
43. Id.
44. Id.