11-1-2012

"Homelike" Characteristics of Maine's Residential Services: A Survey of Maine's Residential Service Settings (2010)

Julie T. Fralich MBA
University of Southern Maine, Muskie School of Public Service

Eileen Griffin JD
University of Southern Maine, Muskie School of Public Service

Catherine McGuire BS
University of Southern Maine, Muskie School of Public Service

CHARTBOOK

"Homelike" Characteristics of Maine's Residential Services

A Survey of Maine's Residential Service Settings (2010)

MUSKIE SCHOOL OF PUBLIC SERVICE

UNIVERSITY OF SOUTHERN MAINE

"Homelike" Characteristics of Maine's Residential Services

A Survey of Maine's Residential Service Settings (2010)

November 2012

This document was prepared by the Muskie School of Public Service at the University of Southern Maine for the Maine Department of Health and Human Services.

Muskie School Project Staff

Julie Fralich
Cathy McGuire
Eileen Griffin

DHHS Lead

Jay Yoe, Director
Office of Continuous Quality Improvement

Funding for this document is through cooperative agreement CA-CO-11-228 between the Maine Department of Health and Human Services and the University of Southern Maine. The cooperative agreement was funded under grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement of the Federal Government.

Table of Contents

Tables

Figures

Acknowledgements

This chartbook is the product of a combined effort of Maine's Department of Health and Human Services (DHHS), the Muskie School of Public Service, and Maine's community residential service providers.

We acknowledge and extend our gratitude to DHHS' State Profile Tool Project Team current and former members, particularly Jay Yoe, Romaine Turyn, and Gary Wolcott for their enthusiastic support for conducting the survey and assistance with selecting the survey sample, reviewing and editing the survey instrument, and commenting on the results and findings. Cathy Cobb, the former director of the Maine Division of Licensing and Regulatory Services provided important expertise in developing the survey instrument and lent her support to the fielding of the survey.

We credit a number of people for the impressive response rate obtained during the survey administration phase. Danny Westcott ably oversaw the administration of the survey including supervising interview staff. Muskie graduate students and part-time interviewers Aziz Mambetkarimov, Birgitta Polson, Celeste Bard, Emily Shaw, Nona Tsotseria and Tim Diomede possessed the right combination of qualities that assured the survey's successful completion, including creativity, persistence, maturity, friendliness, and camaraderie. Stuart Bratesman developed an exceptional survey-status tracking tool and database and Adam Bowman designed the impressive web-based survey tool and database used by the interviewers and research staff.

Also we'd like to express our gratitude to those who helped us pre-test the survey instrument, including: Meg Dexter and Mary Dunn at Charlotte White Center; Harry Lowd at Wiscasset Green, Elder Care Network of Lincoln County; and Matt Hickey and David Babin at Goodwill Industries of Northern New England.

Finally our heartfelt thanks go to the staff of all of the residential provider organizations who willingly spent their valuable time to complete the survey.

Data Highlights

Facilities with Apartments and Private Bedrooms

- The facilities with only apartments or private bedrooms represent 2205 beds, or 33%, of the total number of beds available among the facilities participating in the survey.
- Facilities with all private bedrooms tended to be small and numerous. They have an average 5.4 beds but they represent 66% of all facilities and 54% of the total number of beds available among the facilities.
- A total of 326 facilities, or 61%, of the facilities responding to the survey were facilities with six or fewer beds offering only apartments or private bedrooms. These facilities represent a total of 1345 of beds, or 20% of the total beds represented by the facilities participating in this survey.
- Of those facilities with all private bedrooms, 65% said all or most of their residents had a common bathroom (defined to include a bathroom shared by three or more people) as their primary bathroom.

Facilities with Shared Bedrooms

- The facilities with at least some shared bedrooms represent 4435 beds, or 67%, of the total number of beds available among the facilities participating in the survey.
- Those facilities with predominantly shared bedrooms tended to be the largest facilities, with an average of 36.6 licensed beds. A total of 86 facilities, or 16%, were facilities with seven or more beds with fewer than 50% private bedrooms. The number of licensed beds in these facilities totaled 1392 beds, or 21% of the total beds represented by the facilities participating in this survey.

Population Groups Served

- The majority of the facilities participating in the survey served persons with developmental disabilities. Facilities serving persons with developmental disabilities tended to be smaller: of the 290 facilities providing services to persons with developmental disabilities, 97% have six or fewer beds. The remaining facilities have between 7 and 15 beds.
- Older adults and adults with disabilities tend to be served in larger facilities. Of the 155 facilities serving older adults, only 13% have six or fewer beds. Seventy percent have 16 or more beds.

Other Characteristics

- Amenities related to meal preparation (stove, microwave and refrigerator) were more commonly available in facilities with all private apartments or all private apartments and private bedrooms

- Facilities serving older adults and adults with disabilities tended to have more intrusive features than other types of facilities.

- Facilities with primarily shared bedrooms tended to have more intrusive features than other types of facilities.

Control Over Environment, Movement and Activities, and Meals

- 62% of facilities allowed residents to lock the doors to their rooms; 81% of facilities serving residents with mental illness permit locks compared to 34% for facilities serving older adults and adults with disabilities.

- 49% of facilities allow residents to control the temperature of their room

- 21% of facilities allow residents to have pets.

- 80% of facilities said residents are allowed to enter and exit without restrictions.

- 78% of facilities allowed visitors at any time.

- 92% of facilities allowed residents to store their own food.

- 90% of all facilities offer residents menu options at meal time.

- 80% of all facilities allow residents to prepare their own meal compared to 41% of those serving older adults and adults with disabilities.

- 74% of the facilities allowed residents to participate in preparing common meals; only 32% of facilities serving older adults and adults with disabilities provided that option.

- 78% of facilities serving older adults and adults with disabilities allowed residents to choose where to sit, compared to 92% overall.

Introduction

Over the last several decades, federal and state policies have accelerated efforts to shift the balance of funding and services from nursing home care to community-based long term services and supports (LTSS). The 2009 Affordable Care Act promotes further progress through a variety of programs including the Balancing Incentive Payment Program, the Community First Choice Option, the Money Follows the Person Rebalancing Demonstration, and the Medicaid State Plan Home and Community-Based Option. These initiatives are part of a broader and longer campaign to support states' efforts to comply with the "integration mandate" under the American with Disabilities Act, which requires states to provide services in the most integrated setting appropriate to an individual's needs.

In 2007, DHHS received a State Profile Tool Grant from the U.S. Centers for Medicare and Medicaid Services (CMS) to document how far Maine has come in shifting its balance of services from institutional to home and community-based long term services and supports. Completed in 2009, this profile documents Maine's LTSS system and the distribution of service utilization and expenditures across institutional, residential, and private home settings (Muskie School 2009). As noted in the report, Maine was not able to satisfactorily categorize its residential services as more like a home or institutional care. Residential settings vary widely in their size and characteristics. Some residential settings are small family style residences, part of a family home while others are larger and are sometimes one of multiple facilities on a larger campus. To better understand the nature of the residential facilities serving more than 19 percent of Maine's LTSS population, DHHS commissioned the Muskie School to conduct a survey of residential facilities as part of its update to Maine's LTSS profile.

"Most Integrated Setting"

Federal regulations implementing the ADA require states to provide public services in the "most integrated setting" appropriate to the needs of the individual. The most integrated setting is one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[1] In *Olmstead v. L.C.*,[2] the U.S. Supreme Court affirmed the integration mandate, holding that the ADA requires states to provide community-based services to persons with disabilities when such services are appropriate; the affected persons do not oppose community-based treatment; and community-based services can be reasonably accommodated, taking into account the resources available and the needs of others who are receiving disability services.

In June 2011, the U.S. Department of Justice issued a new statement on enforcement of the "integration mandate" under the ADA and Olmstead.[3] DOJ states that a public entity may be in violation of the ADA when it: (1) directly or indirectly operates facilities or programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.

Under DOJ's enforcement statement "most integrated setting" is defined to include:

> ...those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the

[1] 28 C.F.R. Part 35, Appendix A (addressing § 35.130).

[2] 527 U.S. 581 (1999).

[3] U.S. Department of Justice (June 22, 2011). Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* Accessed from: http://www.ada.gov/olmstead/q&a_olmstead.htm#_ftn1.

> opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

CMS views the Medicaid program as an important vehicle for supporting state compliance with *Olmstead*. To that end, since *Olmstead* CMS has been incrementally providing greater clarity on how it defines the "home and community-based services" that can be paid for through a Medicaid §1915(c) home and community-based services (HCBS) waiver program. Current federal regulations do not define the setting in which §1915(c) home and community-based waiver services may be provided except to say that they may not be provided to persons who are inpatients of a hospital, nursing facility or ICF-MR.[4] However, CMS requires that states applying for a waiver describe how facilities that serve four or more individuals will maintain a "home and community character," including how "the facility is community-based, provides an environment that is like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy and easy access to resources and unscheduled activities in the community. In addition, residents should have the opportunity for visitors at times of preference and convenience to them. Waiver services should not be provided in institution-like settings except when such settings are employed to furnish short-term respite to individuals."[5]

In April 2011 CMS proposed an amendment to its regulations that would further limit the setting in which HCBS services may be provided.[6] Under the proposed rule, HCBS may only be provided in settings that are:

> …[H]ome and community based, integrated in the community, provide meaningful access to the community and community activities, and choice about providers, individuals with whom to interact, and daily life activities.[7]

Under the proposed rules, a setting is not "integrated in the community" if it is:

- Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care;
- In a building on the grounds of, or immediately adjacent to, a public institution;
- Or a housing complex designed expressly around an individual's diagnosis or disability, as determined by the Secretary.

The amendment would also permit the Secretary to determine that a facility "has qualities of an institutional setting" and prohibit provision of waiver-funded services in that setting. CMS proposes that it would not exclude the provision of HCBS services in an assisted living facility (such as a congregate setting serving older adults) if the following conditions are met:

- The resident has a lease
- The setting is in an apartment (with individual living, sleeping, bathing and cooking areas, and individuals can choose whether to share a living arrangement and with whom).

---

[4] 42 CFR §441.302(b)(ii).

[5] CMS Instructions, Technical Guide and Review Criteria for §1915(c) HCBS Waiver [version 3.5].

[6] These proposed rules generated significant comment and CMS has not yet promulgated final rules.

[7] Medicaid Program; Home and Community-Based Services (HCBS) Waivers, Proposed Rules, 76 Fed. Reg. 21311-21317.

- Residents have lockable access to and egress from their own apartments
- Residents are free to receive visitors and leave the setting at times and for durations of their own choosing.
- Aging in place, or allowing individuals to remain where they live as they age and/or support needs change, is common practice.
- Leases do not reserve the right to assign apartments or change apartment assignments.
- Access to the greater community is easily facilitated based on individual needs and preferences.
- An individual's compliance with their person centered plan is not in and of itself a condition of the lease.

Federal regulations relating to institutional and HCBS have also played a role in DHHS discussions with CMS regarding its Private Non-Medical Institution Services (PNMI), Maine's funding mechanism for residential services in its MaineCare program. CMS has identified a number of concerns relating to PNMIs. For example, CMS is concerned that some of the facilities meet the federal definition of an Institution for Mental Disease (IMD), which cannot be paid for through the Medicaid program. In addition, CMS objects to DHHS' bundling personal care and rehabilitation services into PNMI reimbursement. Bundling limits residents' choice of providers for those services, which are not contingent on residency in the PNMI: these services must be provided to residents in the same way they are to persons living in the community. Member eligibility and provider qualifications must be comparable.[8]

Measuring "Homelike" Characteristics

While Maine's Residential Settings Characteristics Survey was conducted prior to CMS' proposed rules, DOJ's guidance, and elevation of CMS' concerns about Maine's PNMI services, the survey was designed to capture many of the dimensions and underlying principles embedded in DOJ's and CMS' statements "most integrated setting" and "home and community-based setting."

The goal of the survey was to measure the "homelike" characteristics of residential settings. Measuring "homey-ness" is an imprecise science (Cutler). Part of the challenge is the complexity of defining "home," which includes both physical and abstract concepts, defined by cultural norms as well as personal and emotional needs and preferences. Cosmetic design features meant to represent "hominess" are inadequate; environmental features that have personal meaning create a greater sense of belonging, self-esteem and self-actualization (Cutler).

In the context of disability policy, both the physical and abstract aspects of home are strongly connected to the concept of "autonomy." In the political sphere, autonomy is tied to independence of action, speech and thought, and freedom from oppression. According to Agich, this concept of autonomy does not adequately address the social and interdependent experience of actual autonomy. In daily life, autonomy and dependence are not inconsistent as long as an individual's independent sense of self and personal values are respected.

The concept of choice is also embedded in autonomy. However, offering an array of choices does not necessarily support autonomy. According to Agich, "choice that enhances autonomy is choice that is meaningful for individuals and allows them to express and develop their own individuality."

Applicable to any adult receiving LTSS, Lidz and Arnold describe three necessary elements of a complete theory of autonomy for older adults:

> *The Freedom to Act*: Actions are intentional and voluntary. Implicit in the freedom to act is having a choice to act upon.

[8] Maine Department of Health and Human Services (September 1, 2011). Memorandum from Commissioner Mary Mayhew to Providers of MaineCare Private Non-Medical Institution (PNMI) Services Regarding Reimbursement Chances Required for PNMI to be in Federal Compliance. Accessed from: http://www.maine.gov/dhhs/oms/provider/pnmi.html.

Effective Deliberation: Decisions are made based on an adequate understanding of a situation and the possible alternative courses of action. Effective deliberation is embodied in the informed consent process, in which a person is informed about an action, its consequences and possible alternatives.

Consistency: The autonomous character of a person's action is measured by its consistency with a person's past actions and values, current values, and future goals. This understanding of autonomy requires that an action be consistent with a person's commitments, values and life plans, or more generally, the individual's self.

Privacy is an element of autonomy: an individual right to privacy is in essence the right to control access to information about oneself (Kane *et al.*). Private bedrooms and private bathrooms are highly valued and may lead to better psychological, social and physical outcomes; in a series of focus groups, participants perceived a lack of privacy as compromising a wide range of everyday life activities (Kane *et al.*).

Researchers studying facility characteristics have found that facilities that provide a high level of services also offer less privacy for residents (Hawes et al.); larger facilities tend to have policies that support a higher level of resident autonomy (Sikorska-Simmons 2006), although little is known about how much autonomy residents actually have (Sikorska-Simmon 2007). One study found the availability of personal space and a moderate level of amenities were the only organizational factors found to be significant predictors of resident satisfaction (Sikorska 1999).

Methodology

- The survey was conducted between July 27, 2010 and September 30, 2010.
- Survey questions collected information about the facilities' physical characteristics and features, services, resident characteristics, and policies relating to autonomy and privacy.
- The survey sample comprised all licensed residential care facilities or private non-medical institutions licensed, totaling 636 facilities.
- Facilities serving older adults and adults with disabilities, adults with developmental disabilities (waiver homes and PNMIs), adults with mental illness and adults with brain injury were included in this group.
- Substance abuse treatment facilities and residential child care facilities are not included in this group. Apartment-style assisted living programs were excluded from the sample.
- The survey response rate was 82.9% (527 facilities).
- We developed two key facility groupings. "Population Groups Served" groups the facilities by the major subpopulations they predominantly serve. "Type of Housing Offered" provides a measure of the privacy of housing units.

Survey Instrument

The survey tool was developed in collaboration with DHHS staff and informed by survey tools developed by Hawes and others. It was designed to capture both physical characteristics of the setting as well as policies and procedures that influence autonomy and privacy.

Table 2 on page 16 groups select survey questions into three primary domains: autonomy, privacy, and the physical characteristics, or "look and feel" of the facility.

We also wanted to find out if the characteristics of the residents had an impact on privacy and autonomy. A resident's needs could have a legitimate impact on the privacy and autonomy a facility is able to provide. For example, a person with impaired cognitive function may not be able to make some decisions or choices independently or staff may need to monitor their activities. A person with a significant physical impairment or medical condition may depend on the assistance of staff in order to act on a choice; or facility staff may also need to closely monitor their condition. We also collected information about staffing. Categories of other questions are listed on page 17.

A pretest was conducted in late May and June 2010; the draft survey was administered in face-to-face interviews with program managers for three facilities. Based on this pretest, the survey was revised to clarify wording. Following the pretest the survey was converted to a web-based format that interviewers would use to conduct phone interviews.

Survey Sample

The survey sample comprised all residential facilities licensed by DHHS' Division of Licensing and Regulatory Services pursuant to the Department's regulations governing assisted housing programs.[9] Assisted living facilities, or congregate, apartment-style housing, were excluded. DHHS defines four levels of residential facilities. The primary difference between levels relates to the number of people the facility may serve and the level and type of staffing a facility may be required to have:

Level I. A Level I facility is licensed to serve two or fewer residents. Facilities of this size are not required to have a license, but may voluntarily.

Level II. A Level II facility is licensed to serve three to six residents. A Level II facility is a family-operated facility having fewer than three employees who are not related to the owner.

Level III. A Level III facility is licensed to serve three to six residents and employs three or more employees who are not related to the owner. A Level III facility is held to higher standards than the Level II facility for medications and health services.

Level IV. A Level IV facility is licensed to serve more than six residents. The Level IV facility has higher standards for administration, programming, staffing, kitchen services, and physical plant.

At each level, facilities can be licensed as a Residential Care Facility or a Private Non-Medical Institution which is a Residential Care Facility that accepts MaineCare members. Included in this sample are residential facilities licensed to provide services to older adults and adults with disabilities, adults with mental illness, adults with brain injury and adults with developmental disabilities.[10] Licensure as a Level I facility is voluntary and would include small residential settings funded under the MaineCare Home and Community Based Waiver program for adults

[9] 10-144 CMR Chapter 113, Regulations Governing the Licensing and Functioning of Assisted Housing Programs.
[10] MaineCare funding for services provided in these facilities would come under the MaineCare Benefits Manual, Section 2, Adult Family Care Services; Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder; Section 97, Private Non-Medical Institutional Services, Appendices C, E and F.

with intellectual disability or autistic disorder and adult foster care programs for adults in protective custody. Apartment style assisted living facilities were excluded from the sample. Substance abuse treatment programs, residential child care facilities, and family foster home for children are not licensed as residential care facilities and are not included in the sample.

DHHS provided a list of 628 eligible facilities derived from the Quality Improvement and Evaluation System (QIES). Forty-four additional eligible facilities were identified by providers and DHHS management staff and were added to the study population. The survey team supplemented and updated the facility contact information for the facilities. Of the original 673 facilities, 37 facilities were removed from our list as closed or not in service.

The survey team contacted each facility to identify the right person to respond to the survey. The Department issued a letter to the facilities informing them of the survey and requesting their participation. The Division of Licensing and Regulatory Services also posted information about the survey on its home page. Each facility received a paper copy of the survey in advance of the telephone survey.

Survey Administration

The phone survey was conducted beginning July 27, 2010 and ending on September 30, 2010. Most surveys were completed by phone. In some instances facility staff, particularly those with multiple facilities, reported that they preferred to complete the paper surveys. In some cases the survey team, followed up with the facility to complete the survey when the paper survey had missing information.

Survey Response

A total of 527 surveys were completed out of 636 facilities; 26 facilities refused to participate and 85 could not be reached. The response rate was calculated to be 82.9%.

Table 1. Response Rate by License Level

License Level	Not Reached	Refused	Survey Completed**	Total	Response Rate
Level I: 1-2 beds	14	3	32	49	65.3%
Level II: 3-6 beds family-operated	16	4	28	48	58.3%
Level III: 3-6 beds	30	10	300	339	88.5%
Level IV: >6 beds	25	9	167	200	83.5%
Total	85	26	527	636	82.9%

Below are notes on the survey response and adjustments we have made to account for inconsistencies in the data collected:

- Eight facilities were marked survey completed, although there was not a completed survey in the database.
- Our survey asked facilities to confirm our record of their license including whether they were licensed as an RCF (*i.e.,* facilities eligible for private pay only) or PNMI (*i.e.*, eligible to provide MaineCare services). The survey team found that facilities were often not familiar with the distinction between the PNMI and RCF label. Because of that confusion, we do not distinguish between the PNMI or RCF in this report.

- Level IV facilities may be licensed to have "distinct parts," that provide distinctly different levels of care. Because we were interested in finding out if the level of care has an impact on privacy and autonomy, if a facility reported that it had multiple distinct parts, we asked the facility to answer the questions separately for each "distinct part." Only five facilities indicated that they had a distinct part, although data from other sources indicated the number is much higher. This report uses 532, the total number of units (527 complete surveys and 5 distinct parts) as the unit of analysis.

- Two facilities in our survey are licensed under New Hampshire law. Given their size, these facilities were coded as Level IV facilities.

Facility Groupings

Population Groups Served

Facilities were assigned to one of the following population groups:

Brain Injury

Facilities that specialize in serving persons with brain injury. These facilities receive funding for MaineCare services as Private Non-Medical Institutional Services under Section 97, Appendix F of the MaineCare Benefits Manual.

Developmental Disabilities

Facilities that provide services to adults with intellectual disabilities and autistic disorder under the MaineCare's Home and Community-Based Benefits, Section 21 in the MaineCare Benefits Manual.

DD-PNMI

Facilities that provide services to adults with intellectual disabilities and autistic disorder under Section 97, Appendix F of the MaineCare Benefits Manual. People served in this program are likely to be people who are not eligible for Section 21 services or are on the waiting list for those services.

Older Adults & Adults with Disabilities

Facilities that provide services to older adults and adults with disabilities who have a functional need for services but are not otherwise eligible for services provided in the other programs. People served in these facilities may pay out of their own pocket or are receiving Private Non-Medical Institutional Services under Section 97, Appendix C of the MaineCare Benefits Manual.

Mental Health

Facilities that provide services to adults with serious and persistent mental illness. People served in these facilities receive Private Non-Medical Institutional Services primarily under Section 97, Appendix E of the MaineCare Benefits Manual, although some are also funded under Appendix F.

We used several methods for assigning facilities to population groups included obtaining lists from DHHS staff; assignment based on billing for Private Non-Medical Institutional Services, Appendix C; contacting the facility or reviewing their marketing materials.

Type of Housing Offered

Facilities were asked about the number of different types of units they had currently occupied or set up for occupancy. An apartment was defined as a unit with an individual or private bathroom, bedroom, and food preparation area. A private bedroom was defined as a bedroom with single occupancy, and a shared bedroom

was defined as a bedroom with double occupancy. (Licensing requirements prohibit residential care facilities from having more than two people share a bedroom.)

We used the type of units offered by a facility to group facilities based on the type of housing offered, whether it be apartments, private bedrooms, or shared bedrooms, or a combination. See Table 6 on page 22 for more information.

Table 2. Measures of Autonomy, Privacy and Facility "Look and Feel"

Autonomy	Measured in Survey Questions:
Resident Control Over Environment	Can residents lock the door to their bedroom or apartment? Do any residents bring their own furniture? Do any residents decorate their bedroom or apartment with personal items? Are residents allowed to control the temperature for their bedroom or apartment? Are residents allowed to control the lighting in their personal area? Do any residents have their own pet?
Resident Control Over Activities and Movement within the Facility	Can residents choose to do their own laundry? Are residents allowed to move about all common areas without restriction? Are residents allowed to enter and exit the Facility without restriction? Are residents allowed to choose when to wake up, dress, and go to bed? Are residents required to participate in activities arranged by the Facility? Are residents allowed to participate in planning activities arranged by the Facility? Are residents who are capable of administering their own medications allowed to self-administer their medications? Does the Facility arrange opportunities for community outings or activities (*e.g.*, provide transportation)? Are residents visitors permitted at any time, during visitor hours, or with other limitations?
Resident Control Over Meals and Mealtime	Are residents allowed to store their own food and snacks? Do residents participate in menu planning? Are residents given menu options at each meal? Are residents allowed to prepare their own meals? Do residents participate in preparing common meals? Do residents eat their meals (check all that apply): • In a common dining area? • In a separate dining area that may be reserved for private use? • In their own room or apartment? Are residents allowed to choose where to eat their meals? Do residents who eat in a common dining area choose where to sit?
Privacy	
Bedrooms	Of those units set up for occupancy or currently occupied, how many are: a. Apartments? (By "apartment," I mean a unit with an individual or private bathroom, bedroom, and food preparation area.) b. Private bedrooms? (A private bedroom is a bedroom with single occupancy.) c. Shared bedrooms? (A shared bedroom is a bedroom with double occupancy.) d. Bedrooms sleeping more than two people?
Bathrooms	Do All, Most, Some or None of the residents in this [part of the] Facility have as their primary bathroom… a. A private bathroom (used by only one person)? b. A shared bathroom (shared bathroom with just one other person)? c. A common bathroom (shared by three or more people)?

Look and Feel	Measured in Survey Questions:
Intrusiveness	Does this [part of the] Facility: a. Use audible bed, chair or floor alarms? b. Use silent bed, chair or floor alarms? c. Use a bracelet wander alert systems? d. Use a visible call system? e. Use overhead paging or a public address system? f. Pipe music into residents' bedrooms or apartments? g. Have a nursing or staffing station? Would you say the nursing or staffing station is prominent or readily noticeable? Inconspicuous or not readily noticeable?
Common Areas	For this [part of the] Facility, is there a.... a. Common dining area? b. Common living area to gather or for group activities? c. Outdoor seating (on Facility premises or in easy walking distance)? d. Lawns or other outdoor park or green space (on Facility premises or in easy walking distance)? e. Places for residents to garden (on Facility premises or in easy walking distance)? f. Outdoor recreational space (on Facility premises or in easy walking distance)?
Physical Characteristics	How many licensed beds does this facility have? Is this Facility part of a campus with other licensed facilities or programs? What other types of facilities or programs are part of this campus?
Amenities	For the bedrooms or apartments in this [part of the] Facility, do All, Most, Some or None have... a. A stove, range, or oven? b. A microwave? c. A refrigerator? d. Cable TV hook-up (whether paid for by the facility or separately by the resident)? e. Landline telephone access (whether paid for by the facility or separately by the resident)? f. Internet access (whether paid for by the facility or separately by the resident)? g. Private space for visiting with family and friends or taking private phone calls? h. Will the Facility provide furnishings if the residents needs or asks for furnishings?

Table 3. Other Information Collected

Type of Information	Categories of Survey Questions
Population Served	Specialty Units Admission and Retention Policy Residents' Needs Residents' Age
Facility Staffing	Types of Personal Assistance Available Nursing Staffing Clinical Social Worker Staffing Types of Medical and Therapy Professional Staff Available On Site Types of Alcohol and Drug Counselors Available On Site Types of Mental Health Professional Staff Available On Site Type of Direct Service Staff

Facility Characteristics

Capacity

We asked facilities a number of questions about the type of license they have, their census and occupancy and the type of bedroom units they offer. This information captures basic descriptive information about facility capacity, licensing status and occupancy.

Facilities were also asked about the number of apartments, private bedrooms, and shared bedrooms currently set up for occupancy. "Apartment" was defined as a unit with an individual or private bathroom, bedroom, and food preparation area.

Table 4. Population Group Served by License Level

License Level	Population Group Serviced					TOTAL
	Brain Injury	DD	DD-PNMI	Older Adult	MH	
Level I: 1-2 beds	1	21	2	1	8	33
Level II: 3-6 beds family-operated	0	28	1	1	3	33
Level III: 3-6 beds	5	213	17	18	47	300
Level IV: >6 beds	5	5	3	135	18	166
TOTAL	11	267	23	155	76	532

- The majority of residential facilities served persons with developmental disabilities (n = 290). The majority of these facilities were licensed as Level III facilities. (See page 13 for more information about license levels.)
- 155 facilities served older adults and adults with disabilities. The majority of these facilities (n = 135) were licensed as Level IV facilities.

Table 5. Type of Units Offered by License Level

License Level	Type of Unit					
	Apartments		Private Bedrooms		Shared Bedrooms	
	Number of Facilities	Average Number of Units	Number of Facilities	Average Number of Units	Number of Facilities	Average Number of Units
Level I: 1-2 beds	3	2	30	2	3	1
Level II: 3-6 beds family-operated	3	2	30	3.1	11	1.7
Level III: 3-6 beds	12	2.6	297	3.9	26	1.8
Level IV: >6 beds	9	19.8	150	9.8	117	11.9
TOTAL	27	8.2	507	5.7	157	9.32

- A total of 27 facilities offered apartment units, 507 offered private bedrooms, and 157 offered shared bedrooms. (Some facilities are counted more than once since some offer more than one type of living arrangement or unit.)

Table 6. Type of Housing Offered

Type of Housing Offered	N	Percent
All Apartments	4	1 %
All Apartments or Private Bedrooms	19	4 %
All Private Bedrooms	352	66 %
>50% but <100% Private Bedrooms	60	11 %
< 50% Private Bedrooms	97	18 %
Only Shared Bedrooms	0	0%

We created a hierarchy that grouped facilities according to how much privacy their housing units offered. Facilities were grouped according to whether they offered all apartments, a combination of apartments or bedrooms, all private bedrooms, or combinations of private and shared bedrooms.

- Most facilities (66%) offered private bedrooms exclusively.
- 29% offered either a combination of private bedrooms and shared bedrooms
- Five percent offered apartments or a combination of apartments and private bedrooms.

Table 7. Occupancy Rates by License Level

License Level	Occupancy Rates		
	Average	Minimum	Maximum
Level I: 1-2 beds	97%	50%	100%
Level II: 3-6 beds family-operated	83%	25%	100%
Level III: 3-6 beds	93%	33%	100%
Level IV: >6 beds	95%	65%	100%

Table 8. Occupancy Rates by Population Group Served

Population Group Served	Occupancy Rates		
	Average	Minimum	Maximum
Brain Injury	100%	98%	100%
Developmental Disability	92%	25%	100%
Developmental Disability-PNMI	97%	67%	100%
Older Adults & Adults with Disabilities	94%	65%	100%
Mental Health	97%	50%	100%

The facilities were asked about their census on the date they were interviewed and the number of licensed beds.

- The average census on the day of the survey was 11 residents, with a range of one in a Level I facility and 176 in a Level IV facility.
- Occupancy rates average 93% and ranged from a low of 25% in a Level II facility to a high of 100% for all levels of facilities.
- The lowest occupancy rate was for Level II facilities (with three to six beds and operated by a family), which had an average occupancy rate of 83%.

Table 9. Geographic Distribution of Facilities by County and Population Group

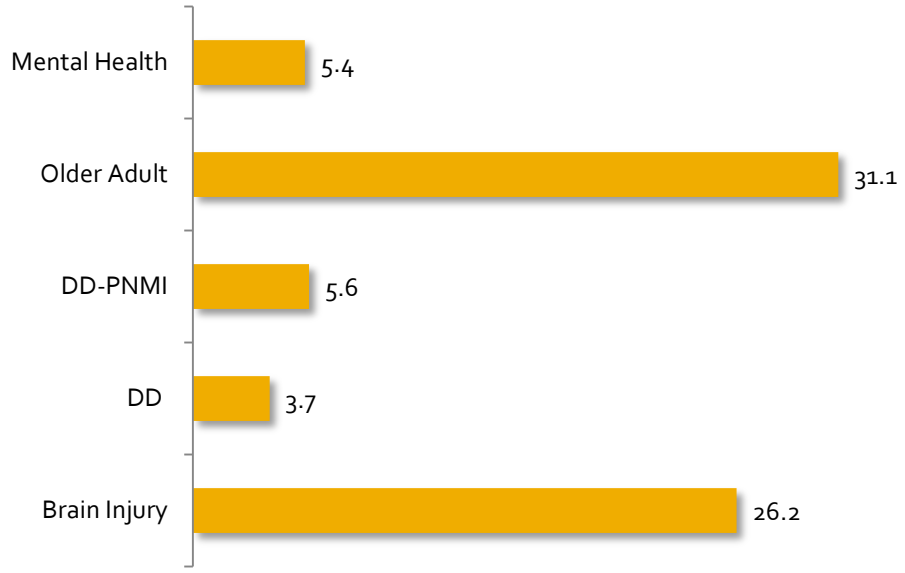
County	Brain Injury	DD	DD PNMI	Older Adults & Adults with Disabilities	MH	All
Androscoggin	1	26	1	12	14	54
Aroostook		23		15	4	42
Cumberland	6	58	3	20	7	94
Franklin		4		4		8
Hancock		8		5	2	15
Kennebec		23	6	13	17	59
Knox		8	1	6	4	19
Lincoln		2		9		11
Oxford		11	4	8	3	26
Penobscot	1	34		23	18	76
Piscataquis		2		2	1	5
Sagadahoc		7		1		8
Somerset		16	3	5	1	25
Waldo		3	2	4		9
Washington		5	2	15	1	23
York	1	37	1	10	4	53
New Hampshire	1					1
Total	**10**	**267**	**23**	**152**	**76**	**528**

- Facilities serving adults with developmental disabilities and older adults and adults with disabilities were distributed across all 16 counties.
- Facilities serving persons with brain injury are limited to only 5 counties, with one in Penobscot County, one in Aroostook County and the remainder in southern Maine or New Hampshire.
- Facilities serving persons with mental illness are available in 12 of 16 counties, with Franklin, Lincoln, Sagadahoc, and Waldo counties not having residential mental health facilities.

Facility Size

Facilities were asked about the number of licensed beds they had. The number of licensed beds ranged from 1 to 180, with an average of 11.6.

Figure 1. Average Number of Licensed Beds by Population Group Served



- Facilities serving persons with developmental disabilities tended to be smaller: 72% of the facilities with six or fewer beds served persons with developmental disabilities (DD and DD-PNMI).

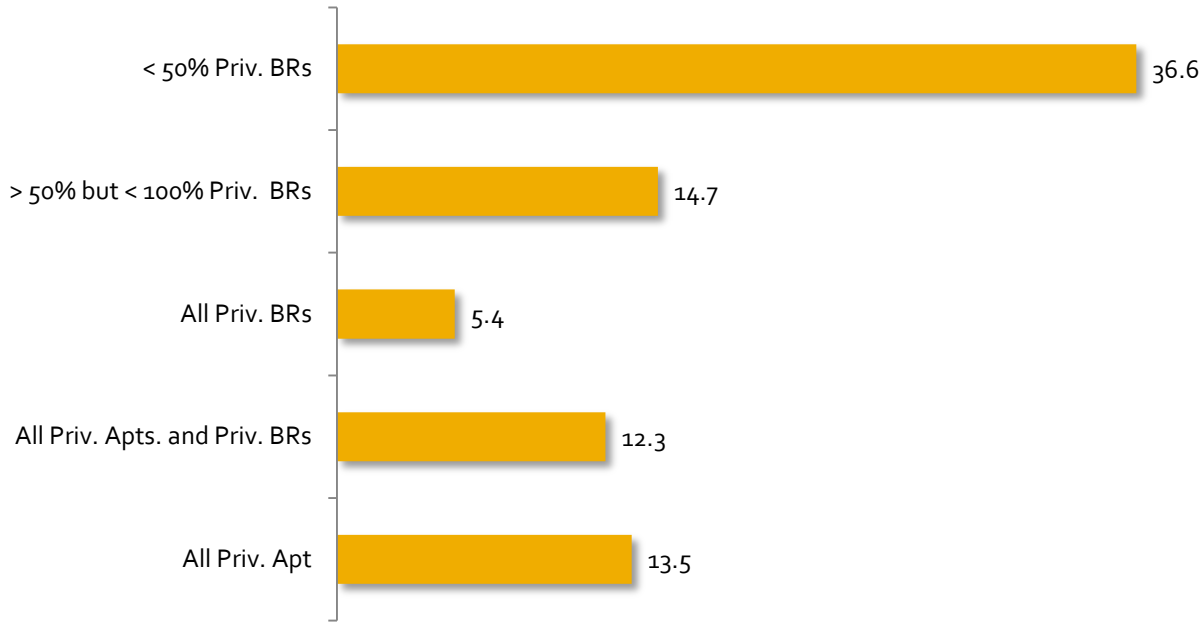
- Although the average number of licensed beds for residential facilities serving people with brain injury (n = 11) was over 26, two large facilities skewed the average. The other 9 facilities had 15 or fewer licensed beds. See Table 10.

Table 10. Number of Beds by Population Group Served

Number of Beds	Brain Injury		DD		DD-PNMI		Older Adults & Adults with Disabilities		Mental Health		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
0-2	1	9%	27	10%	1	4%	0	0%	10	13%	39	7%
3-6	5	45%	236	88%	19	83%	20	13%	48	63%	328	62%
7-15	3	27%	4	1%	3	13%	26	17%	16	21%	52	10%
16-30	0	0%	0	0%	0	0%	54	35%	2	3%	56	11%
31-50	0	0%	0	0%	0	0%	35	23%	0	0%	35	7%
51-100	0	0%	0	0%	0	0%	16	10%	0	0%	16	3%
100+	2	18%	0	0%	0	0%	4	3%	0	0%	6	1%
TOTAL	11	100%	267	100%	23	100%	155	100%	76	100%	532	100%

- Persons with developmental disabilities are served in smaller facilities. Of the 290 facilities providing services to persons with developmental disabilities, 97% have six or fewer beds. The remaining facilities have between 7 and 15 beds.
- Older adults and adults with disabilities tend to be served in larger facilities. Of the 155 facilities serving older adults, only 13% have six or fewer beds. Seventy percent have 16 or more beds.
- Of the six facilities with 100 or more beds, four serve older adults and adults with disabilities.
- Facilities serving persons with mental illness also tend to be smaller. Only 23% of the facilities have 7 or more beds.

Figure 2. Average Number of Licensed Beds by Type of Housing Offered



- Those facilities with predominantly shared bedrooms tended to be the largest facilities, with an average of 36.6 licensed beds.
- Facilities with all private bedrooms tended to be the smallest with an average of 5.4 licensed beds.

Table 11. Number of Beds in Facility by Housing Type Offered

Number of Beds	All Private Apartments		All Private Apartments and Private Bedrooms		All Private Bedrooms		More than 50% but less than 100% Private Bedrooms		Less than 50% Private Bedrooms		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
0-2	1	25%	3	16%	32	9%	1	2%	2	2%	39	7%
3-6	1	25%	12	63%	277	79%	29	48%	9	9%	328	62%
7-15	1	25%	1	5%	25	7%	13	22%	12	12%	52	10%
16-30	0	0%	0	0%	15	4%	8	13%	33	34%	56	11%
31-50	1	25%	1	5%	2	1%	8	13%	23	24%	35	7%
51-100	0	0%	2	11%	1	0%	0	0%	13	13%	16	3%
100+	0	0%	0	0%	0	0%	1	2%	5	5%	6	1%
TOTAL	4	100%	19	100%	352	100%	60	100%	97	100%	532	100%

- A total of 326 facilities, or 61%, of the facilities responding to the survey were facilities with six or fewer beds offering only apartments or private bedrooms. These facilities represent a total of 1345 of beds, or 20% of the total beds represented by the facilities participating in this survey.

- A total of 86 facilities, or 16%, were facilities with seven or more beds with fewer than 50% private bedrooms. The number of licensed beds in these facilities totaled 1392 beds, or 21% of the total beds represented by the facilities participating in this survey.

Table 12. Average and Total Number of Beds by Housing Type

Number of Beds	All Private Apartments	All Private Apartments and Private Bedrooms	All Private Bedrooms	More than 50% but less than 100% Private Bedrooms	Less than 50% Private Bedrooms
Average	13.5	12.3	5.4	14.7	36.6
Total	54	233	1918	880	3555

- The facilities with only apartments or private bedrooms represent 2205 beds, or 33%, of the total number of beds available among the facilities participating in the survey.
- The facilities with at least some shared bedrooms represent 4435 beds, or 67%, of the total number of beds available among the facilities participating in the survey.
- Facilities with all private bedrooms tended to be small and numerous. They have an average 5.4 beds but they represent 66% of all facilities and 54% of the total number of beds available among the facilities.

Amenities

Facilities were asked about the amenities they offer to residents in their bedrooms and apartments. Certain amenities may be perceived as contributing to personal comfort and a more "homelike" experience by some residents.

Table 13. Type of Amenities by Population Group Served (Number and Percent)

Type of Amenities	Brain Injury		DD		DD-PNMI		Older Adults & Adults		Mental Health		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Stove	1	9%	19	7%	1	4%	1	1%	4	5%	26	5%
Microwave	2	18%	19	7%	1	4%	7	5%	4	5%	33	6%
Refrigerator	1	9%	19	7%	1	4%	9	6%	4	5%	34	6%
Cable TV Hook-Up	8	73%	203	76%	21	91%	136	88%	55	72%	423	80%
Landline Phone Access	1	9%	101	38%	7	30%	114	75%	33	43%	256	48%
Internet Access	2	18%	67	25%	4	17%	68	44%	26	34%	167	31%
Visiting Space	9	82%	264	99%	23	100%	130	84%	73	96%	499	94%
Facility Provides Furnishings	11	100%	235	88%	23	100%	143	93%	73	96%	485	93%

- A majority of facilities offered cable TV hook-up (80%) and visiting space (94%). Landline phone access (48%) and internet access (31%) were less commonly available.
- Amenities related to meal preparation (stove, microwave and refrigerator) were much less common.
- The availability of amenities across population groups varied most for landline phone access and internet access.

Table 14. Type of Amenities by Type of Housing Offered (Number and Percent)

Type of Amenities	All Private Apartments		All Private Apartments and Private Bedrooms		All Private Bedrooms		More than 50% but less than 100% Private Bedrooms		Less than 50% Private Bedrooms		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Stove	3	75%	10	53%	10	3%	1	2%	2	2%	26	5%
Microwave	4	100%	12	63%	12	3%	3	5%	2	2%	33	6%
Refrigerator	4	100%	13	68%	12	3%	3	5%	2	2%	34	6%
Cable TV Hook-Up	3	75%	17	89%	272	77%	49	82%	82	85%	423	80%
Landline Phone Access	3	75%	14	74%	146	42%	30	50%	63	66%	256	48%
Internet Access	2	50%	8	42%	99	28%	19	32%	39	41%	167	31%
Visiting Space	4	100%	19	100%	347	99%	53	88%	76	79%	499	94%
Facility Provides Furnishings	3	75%	18	95%	316	90%	58	98%	90	94%	485	92%

- Amenities related to meal preparation were more commonly available in facilities with all private apartments or all private apartments and private bedrooms.

Multiple Licenses and Multiple Facility Campuses

- Facilities were asked if they had more than one type of license. The majority of respondents (88%) had only one type of license; 57 facilities said they had multiple levels of licenses; 6 respondents did not answer this question. The most common combination of license levels was nursing facility and License Level IV.

- Level IV facilities were asked to indicate if they had a "distinct part." A "distinct part" is a term used in licensing regulations to define a physically separate unit that is clearly identifiable from the remainder of the facility. A distinct part provides distinctly different levels of care. For example, a facility might have a distinct part that serves persons with Alzheimer's or dementia or a distinct part that serves people with certain behavioral impairments. Of the 167 facilities that said they had a distinct part, 48 were facilities with multiple levels of licenses and 119 were facilities with a single license level.

- Facilities were asked if they were part of a campus with multiple facilities. Of the 91 facilities indicating they were part of a campus, 46% indicated that they shared the campus with a nursing facility; 14% shared the campus with an assisted living facility; and 15% had a licensed adult day program on campus.

Non-Intrusive Features

Facilities were asked a number of questions to gauge the facility's efforts to minimize institutional features such as audible alarms, nursing stations, overhead public address systems or music. We used these responses to develop a "non-intrusiveness" score to compare "non-intrusiveness" across facility groups.

Table 15. Percent of Facilities Not Having Select Institutional Features

Institutional Features	Percent
Facility does not use audible bed, chair or floor alarms	83%
Facility does not use silent bed, chair or floor alarms	98%
Facility does not use bracelet wander alert systems	91%
Facility does not use visible call system	75%
Facility does not use overhead paging or public address system	91%
Facility does not pipe music into residents rooms	99.6%
Facility does not have a nursing station	43%
Facility does not have a nursing or staffing station that is prominent or conspicuous	58%

- Over half of the facilities (56%) indicated that they had a nursing station; however most of those were described as inconspicuous or not readily noticed.
- 19% of facilities serving persons with developmental disabilities indicated the presence of a nursing station.
- 49 facilities (less than 10%) indicated that they have overhead address systems. Where these features were present, the facilities were predominantly serving older adults and adults with disabilities.
- Audible alarms were not common. Only 17% of the facilities indicated that they used audible alarms. Across population groups served, the audible alarms were more common in facilities that served older adults and adults with disabilities; 30% said they used audible alarms.
- 2 facilities indicated that they pipe music into residents' rooms.

Table 16. Number and Percent of Facilities by Composite Non-Intrusiveness Score

Total Points	Number of Facilities	Percent
0	9	2
1	20	4
2	39	7
3	89	17
4	200	38
5	175	33

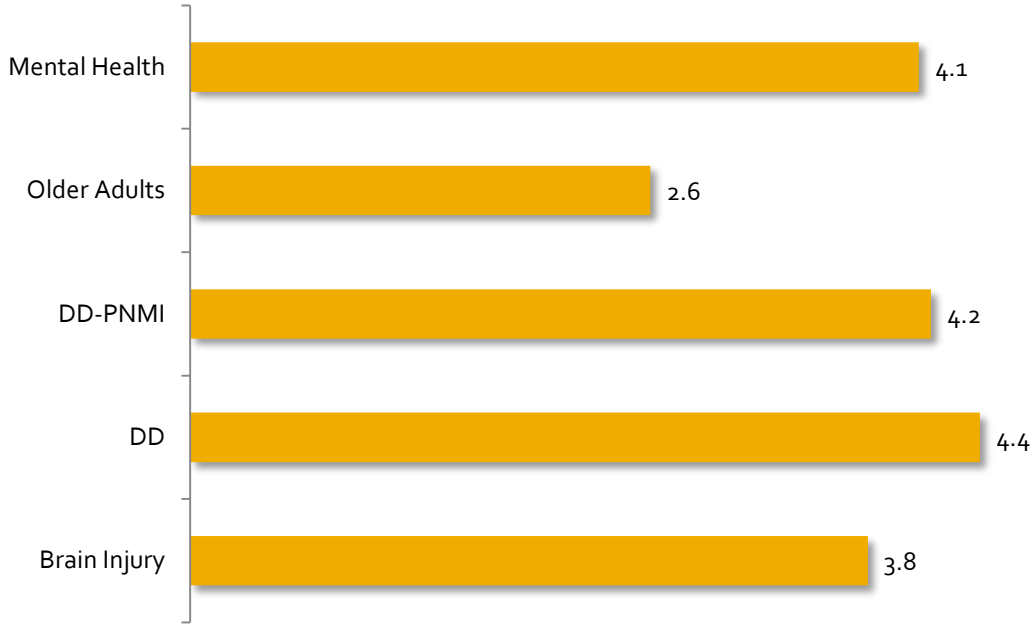
Using facilities' responses to these questions, we created a composite "non-intrusiveness" score. Because there was little variation in facility response to two questions (use of silent alarms and piped in music), we eliminated these questions from our composite score.

The composite score was based on scoring for the:

- Audible alarms
- Wander alert
- Nursing station
- Overhead paging or public address system.

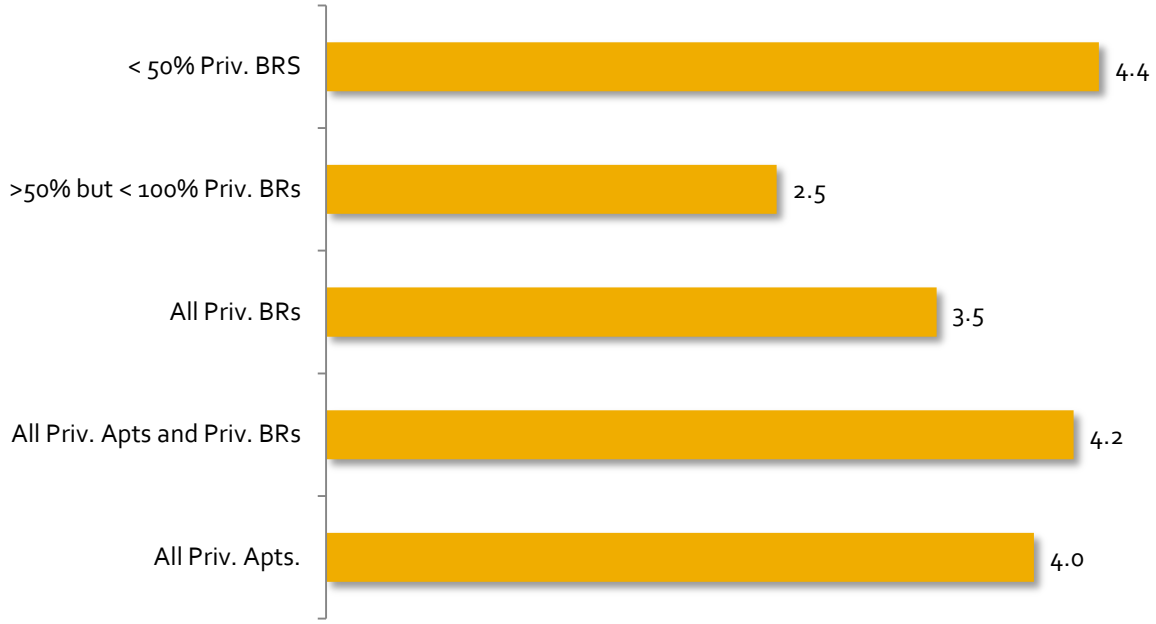
Facilities with a higher score have fewer intrusive features, making them more "homelike" by our definition.

Figure 3. Non-Intrusiveness Score by Population Group Served



- Facilities serving older adults and adults with disabilities tended to have more intrusive features than other types of facilities.

Figure 4. Non-Intrusiveness Score by Type of Housing Offered



- Facilities with primarily shared bedrooms tended to have more intrusive features than other types of facilities.

Privacy

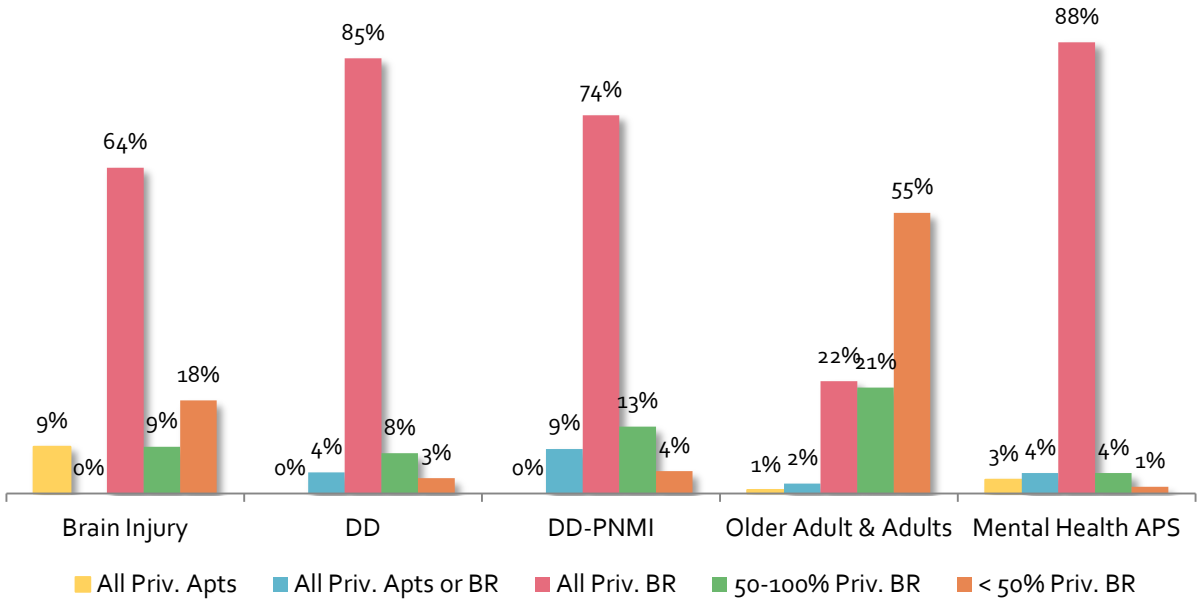
Bedroom Privacy

We used Type of Housing Offered as a measure of bedroom privacy. (See discussion on page 15 and Table 6 on page 22 for more information.) We crosswalked Type of Housing Offered with Population Group Served to identify disparities in bedroom privacy.

The facilities serving Older Adults and Adults with Disabilities tend to offer less bedroom privacy than facilities serving other population groups.

.

Figure 5. Type of Housing Offered by Population Group (Percent)



- Most facilities serving persons with brain injury, developmental disabilities or mental illness offer all private bedrooms. The percent ranges from 64% for facilities serving persons with brain injury (n = 11) to 88% for facilities serving persons with mental illness (n = 76).

- Facilities serving older adults and adults with disabilities were more likely to offer shared bedrooms: only 22% offered only private bedrooms, 21% had between 50-100% private bedrooms and 55% offered less than 50% private bedrooms.

Table 17. Type of Housing Offered by Population Group Served

Population Group Served	All Private Apartments	All private apartments or private bedrooms	All private bedrooms (100%)	More than 50% but less than 100% private bedrooms	Less than 50% private bedrooms	Total
Brain Injury	1	0	7	1	2	11
DD	0	11	227	21	8	267
DD-PNMI	0	2	17	3	1	23
Older Adult & Adults	1	3	34	32	85	155
MH	2	3	67	3	1	76
All	4	19	352	60	97	532

- 85 of the 97 facilities (88%) with more than 50% shared bedrooms served older adults and adults with disabilities.

- 227 of the 352 facilities (64%) with all private bedrooms serve persons with developmental disabilities. The next largest group with all private bedrooms, serving adults with mental illness, comprises 20% of the facilities.

Bathroom Privacy

Facilities were also asked whether all, most, some or none of their residents have a private bathroom, shared bathroom or common bathroom as their primary bathroom.

- A shared bathroom was defined as a bathroom shared with just one other person
- A common bath was defined to include a bathroom shared by three or more people

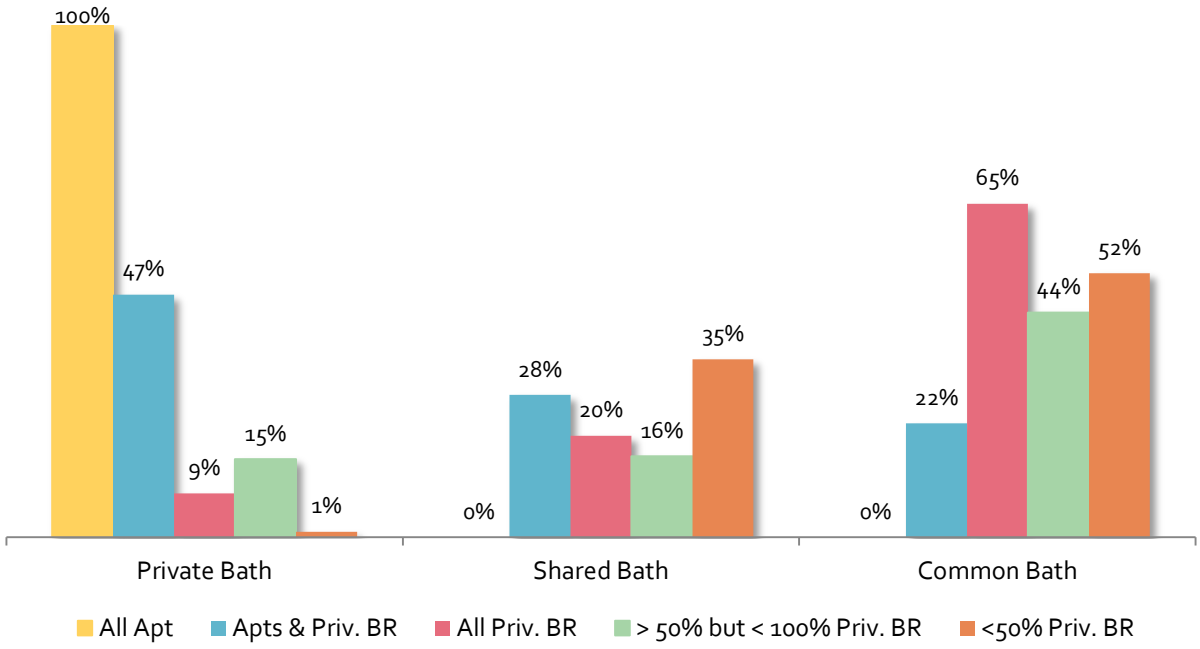
We also created a composite privacy score for bathrooms to compare bathroom privacy across facility groupings.

Table 18. Privacy of Resident's Primary Bathroom

Resident's primary bath is:	All	Most	Some	None
Private bathroom	43	10	118	358
Shared bathroom	72	44	96	309
Common bathroom	268	38	52	165

- Of the 532 facilities responding to this survey, 306 or 58% said all or most of its residents had a common bath as their primary bathroom. Only 53, or 8%, indicated that all or most of their residents had a private bathroom and 22% indicated that all or most had a shared bathroom.

Figure 6. Percent of Facilities with All or Most Residents Having Private, Shared or Common Bathroom, by Type of Housing Offered



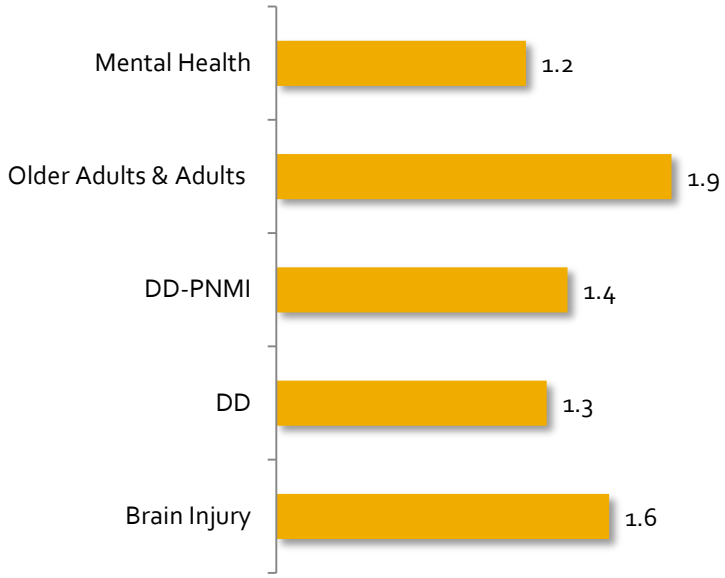
- Of those facilities with all private bedrooms, 65% said all or most of their residents had a common bathroom as their primary bathroom.

Table 19. Number and Percent of Facilities by Bathroom Privacy Score

Residents with Private Bath as Primary Bath	Score	N	Percent
All	4	43	8%
Most	3	10	2%
Some	2	118	22%
None	1	358	68%

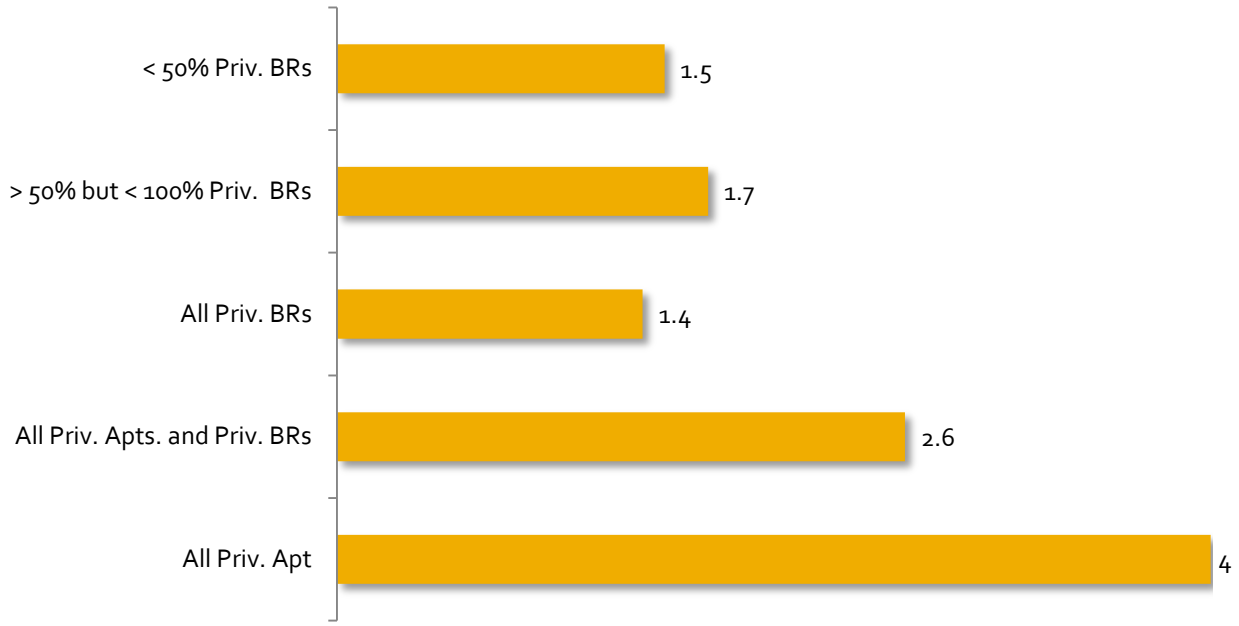
We calculated a composite score for bathroom privacy. Facilities reporting that their residents have a private bath as their primary bath were awarded points, giving facilities a higher score for having a larger share of residents with private baths.

Figure 7. Bathroom Privacy Score



- Facilities serving persons with mental illness had lowest bathroom privacy score.
- Facilities serving older adults and adults had the highest bathroom score.

Figure 8. Bathroom Privacy Score by Housing Type Offered



- Facilities with apartments and private bedrooms (n = 19) had a higher average privacy score for bathrooms.
- Facilities with only private bedrooms had the lowest scores.

Combined Bedroom and Bathroom Privacy Score

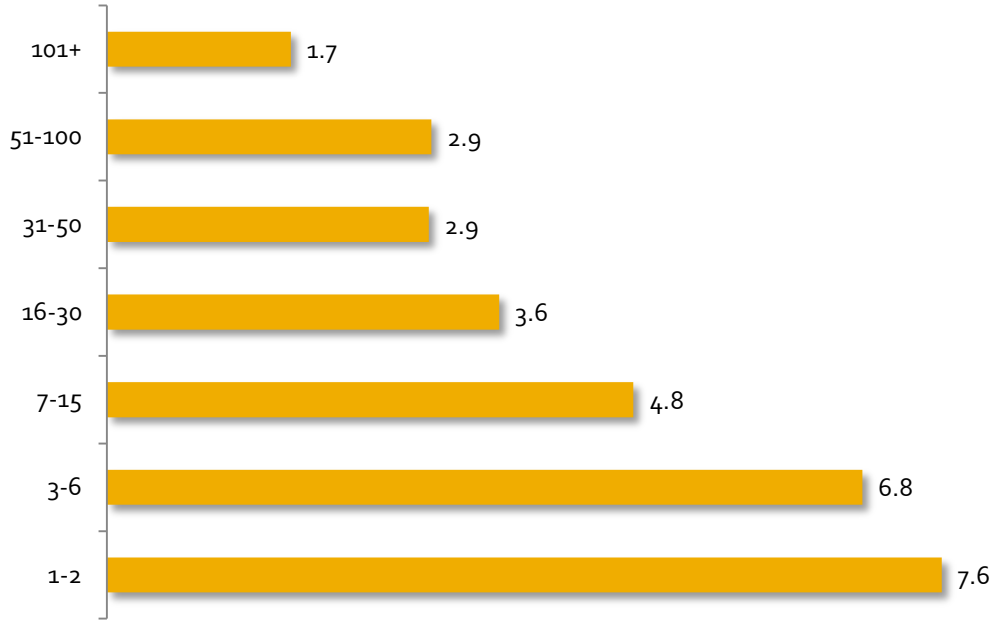
We combined bathroom and bedroom characteristics to develop a combined composite privacy score. Facilities having only apartment units were given the highest score. Facilities having apartments or private bedrooms were scored depending on the privacy of the bathrooms. If all or most had private bathrooms then they were scored more highly than those having shared bathrooms. For facilities having common bathrooms, those in smaller facilities were scored more highly than those in larger facilities, giving a higher score to facilities that were more likely to be "family-style." Facilities that had shared and private bedrooms were scored lower, depending on the characteristics of the bathroom.

Table 20. Scoring for Combined Bedroom and Bathroom Privacy Scores

Housing Type	Bathroom Privacy	Other Criteria	Score	Frequency	Percent
Apartment	NA		10	4	1%
Any Private Bedroom/ No Shared Bedroom	Private Bathroom (All/Most)		9	39	7%
	Shared Bathroom (All/Most)		8	110	21%
	Common Bathroom (All/Most)	License Level I, II, or III	7	203	38%
	Common Bathroom (All/Most)	License Level IV	6	19	4%
50-100% Private Bedroom	Private Bathroom (All/Most)		5	9	2%
	Shared Bathroom (All/Most)		4	22	4%
	Common Bathroom (All/Most)		3	29	5%
0-50% Private Bedroom	Private or Shared Bathroom (All/Most)		2	60	11%
	Common Bathroom (All/Most)		0	37	7%

- 38% of facilities fell into the small, most likely "family style" facility, with private bedrooms and common bathrooms.
- 21% were in facilities with private bedrooms and shared bathrooms.
- 11 % had fewer than 50% private bedrooms and private or shared bathrooms.

Figure 9. Combined Composite Privacy Score by Number of Licensed Beds in Facility



- The combined bedroom and bathroom privacy score corresponded to facility size with the smallest facilities having the most privacy (most likely to have private bedrooms and private bathrooms) and the largest facilities having the least privacy (more likely to have shared bedrooms and shared or common bathrooms).

- Although our combined score only directly relied on the relative size of the facility in a limited way (by using Licensing Level to score facilities with common bathrooms), indirectly our scoring rewarded smaller facilities. By ranking facilities with only private bedrooms and shared or common bathrooms more highly than facilities that had some shared bedrooms and some private bathrooms, in effect we were ranking smaller facilities more highly since we know that larger facilities were more likely to have shared bedrooms. However, the decision to rank private bedrooms over private bathrooms is consistent with the choices made in private housing – private housing usually provides for individual bedrooms and shared bathrooms, rather than the reverse.

Autonomy

Resident Control Over Their Environment

The facilities were asked about a number of policies and procedures that supported resident control over their environment. The questions addressed resident control over room temperature, lighting, and personal items and whether residents were allowed to lock the door to their rooms and bring their own furniture.

We used facility responses to develop a composite score in order to compare residents' control over their environment by different facility groupings.

Table 21. Facilities Policies Related to Resident Control Over Their Environment

Questions about Residents Control Over Environment	Percent Yes
Residents can lock doors to room	62%
Residents bring furniture	96%
Residents decorate room with personal items	99%
Residents allowed to control the temperature of their room	49%
Residents allowed to control lighting in personal area	99.6%
Residents have pets	21%

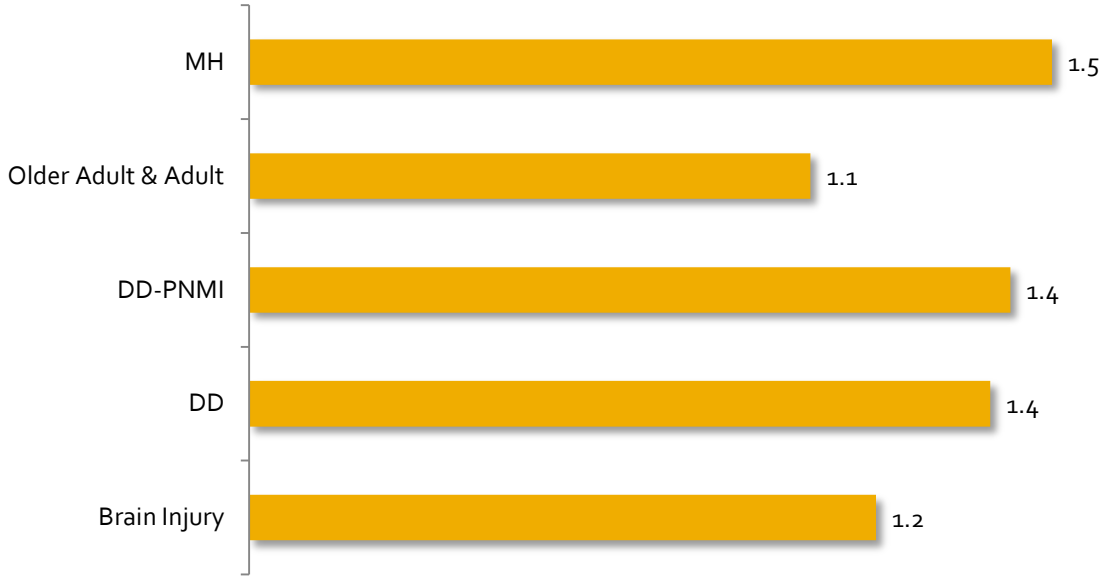
- The facilities were fairly consistent in indicating that residents could decorate their own room, bring in their own furniture, and control the lighting in their personal area.
- 62% of facilities allowed residents to lock the doors to their rooms; 81% of facilities serving residents with mental illness permit locks compared to 34% for facilities serving older adults and adults with disabilities.
- 49% of facilities allow residents to control the temperature of their room
- 21% of facilities allow residents to have pets.

Table 22. Number and Percent of Facilities by Composite Control Over Environment Score

Total Points	Number of Facilities	Percent
0	90	17
1	223	42
2	182	34
3	37	7

We developed a composite score for residents' control over their environment. This composite relied on those questions where there was greater variation in responses: residents can lock doors to room; residents allowed to control the temperature of their room; residents have pets. Each facility was given a point for each of these features, up to three. The table above shows the distribution of facilities across the possible range of points 1 to 3.

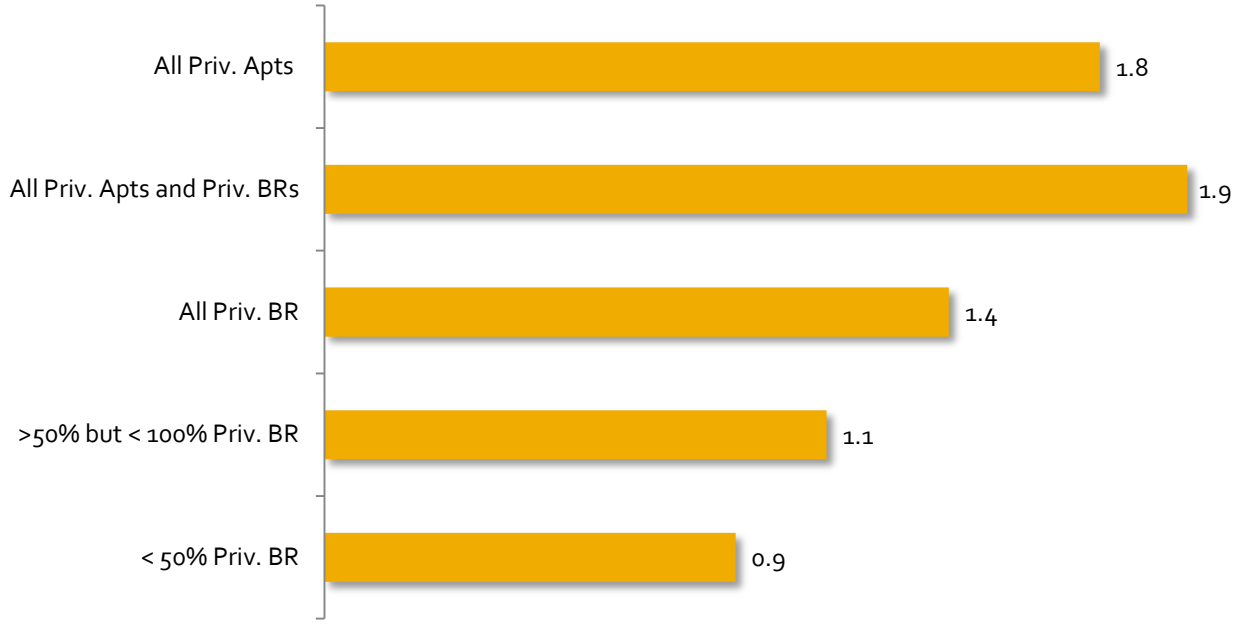
Figure 10. Average Control over Environment Score by Population Group Served



- On average, facilities serving older adults and adults with disabilities have the lowest average composite score, indicating this group has less control over their environment.

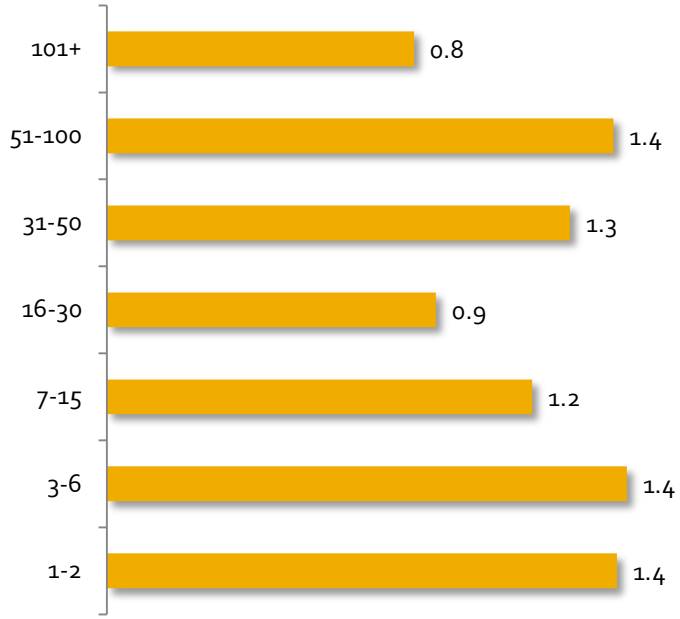
.

Figure 11. Average Control over Environment Score by Type of Housing Offered



- On average, facilities with fewer than 50% of private bedrooms had the lowest average composite score indicating residents had less control over their environment.
- On average, facilities with all private apartments or all private apartments and private bedrooms had the highest composite score, indicating residents had more control over their environment.

Figure 12. Average Composite Score for Control Over Environment by Facility Size



- On average, facility size did not appear to be related to how facilities ranked on our composite score for control over environment.

Resident Control Over Movement and Activities

The facilities were asked a number of questions about resident control over their activities, including whether or not residents could leave the facility at will, decide when to wake or get out of bed and whether or not participants were required to participate in facility-sponsored activities.

We used facility responses to develop a composite score in order to compare resident control over their activities and movement across facility groupings.

Table 23. Percent of Facilities with Select Policies Governing Resident Control Over Movement and Activities

Questions about Residents Control Over Activities	Percent Yes
Residents allowed to enter and exit without restrictions	80%
Visitors allowed at any time	78%
Residents allowed to move around common areas without restrictions	97%
Residents choose when to wake or go to bed	95%
Residents not required to participate in activities	91%
Residents who are capable are allowed to self-medicate	75%

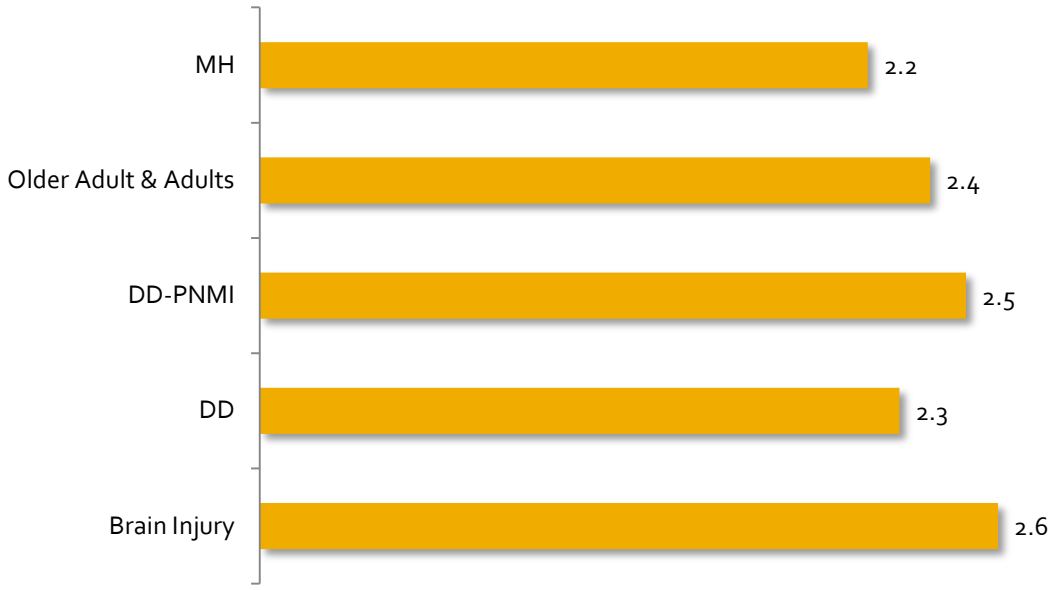
- 80% of facilities said residents are allowed to enter and exit without restrictions.
- 78% of facilities allowed visitors at any time.
- 75% of facilities allow capable residents to self-medicate.
- 91% of facilities do not require residents to participate in activities.

Table 24. Facility Composite Score for Control Over Movement and Activities (Number and Percent)

Total Points	Number of Facilities	Percent
0	7	1%
1	72	14%
2	198	37%
3	255	48%

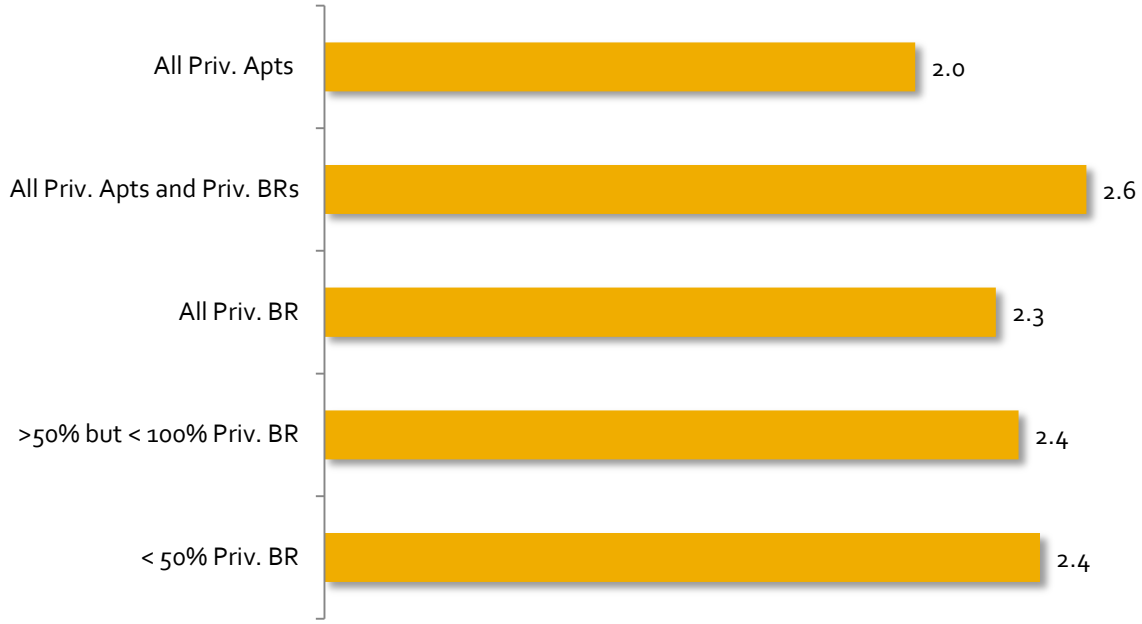
We developed a composite score for residents' control over movement and activities within the facility. This composite relied on those questions where there was greater variation in responses: residents allowed to enter and exit the facility without restrictions; visitors allowed at any time; residents who are capable are allowed to self-medicate. Each facility was given a point for each of these features, up to three. A higher score indicates greater resident control over activities and movement. The distribution of facilities across the range of points 1 to 3 can be found in the table above.

Figure 13. Average Control over Movement and Activities Score by Population Group Served



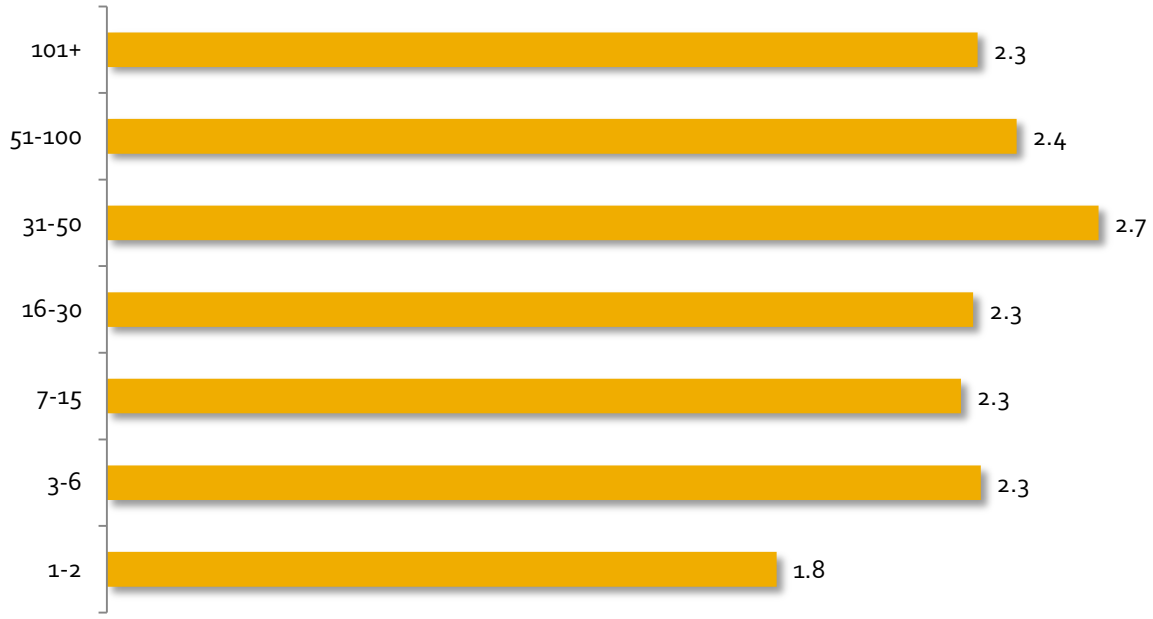
- On average, facilities serving persons with brain injury and PNMIs serving persons with developmental disabilities had a higher composite score for residents' control over movement and activities, indicating these facilities allowed greater control over movement and activities than other facilities.

Figure 14. Average Control over Movement and Activities Score by Type of Housing Offered



- On average facilities with all private apartments or private bedrooms had a higher composite score for control over movement and activities, indicating these facilities allowed residents greater control over their movements and activities.

Figure 15. Average Composite Score for Control Over Movement and Activities by Facility Size



- On average, midsize and large facilities had a higher composite score for control over movement and activities, indicating these facilities allowed residents greater control over their movements and activities.

Resident Control Over Meals

The facilities were asked a number of questions about resident control over meals, including whether or not residents could store their own food, participate in menu planning, prepare their own meals and choose where to eat.

We used facility responses to develop a composite score in order to compare resident control over meals across facility groupings.

Table 25. Facilities Policies Governing Meals

Questions about Residents Meal Options	Brain Injury	DD	DD-PNMI	Older Adult	MH	TOTAL
	N=11	N=267	N=23	N=155	N=76	N=532
Residents allowed to store their own food and snacks	100%	88%	96%	92%	100%	**92%**
Residents participate in menu planning	100%	91%	96%	75%	97%	**88%**
Residents have menu options at each meal	91%	88%	100%	90%	95%	**90%**
Residents allowed to prepare their own meals	100%	95%	96%	41%	96%	**80%**
Residents participate in preparing common meals	100%	89%	96%	32%	97%	**74%**
Residents allowed to choose where to eat their meals	64%	79%	87%	77%	79%	**79%**
Residents who eat in common dining area choose where to sit	100%	98%	100%	78%	97%	**92%**

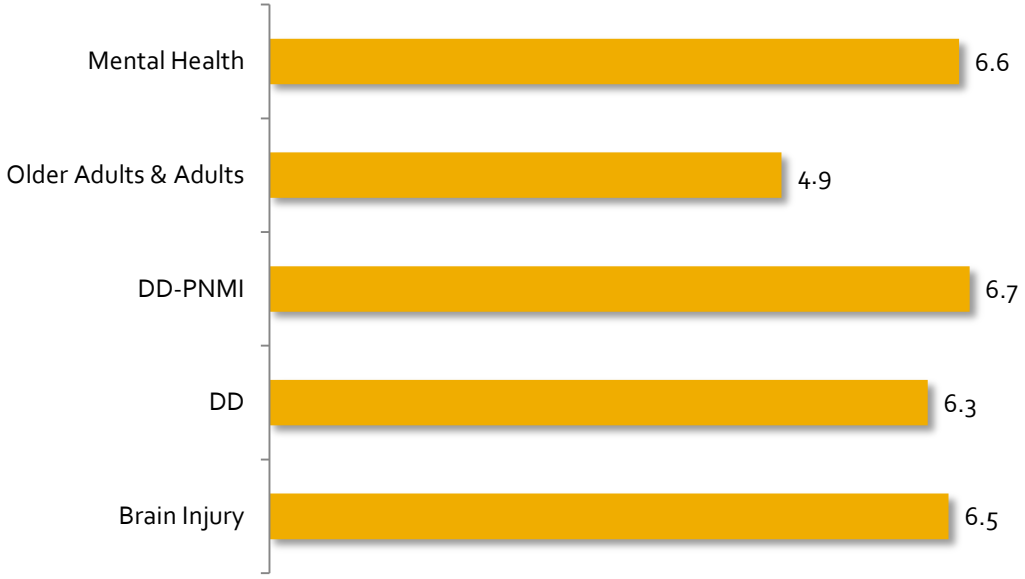
- 92% of facilities allowed residents to store their own food.
- 90% of all facilities offer residents menu options at meal time.
- 80% of all facilities allow residents to prepare their own meal compared to 41% of those serving older adults and adults with disabilities.
- 74% of the facilities allowed residents to participate in preparing common meals; only 32% of facilities serving older adults and adults with disabilities provided that option.
- 78% of facilities serving older adults and adults with disabilities allowed residents to choose where to sit, compared to 92% overall.

Table 26. Number and Percent of Facilities by Composite Meal Score

Total Points	Number of Facilities	Percent
0	8	2%
1	41	8%
2	76	14%
3	120	23%
4	287	54%

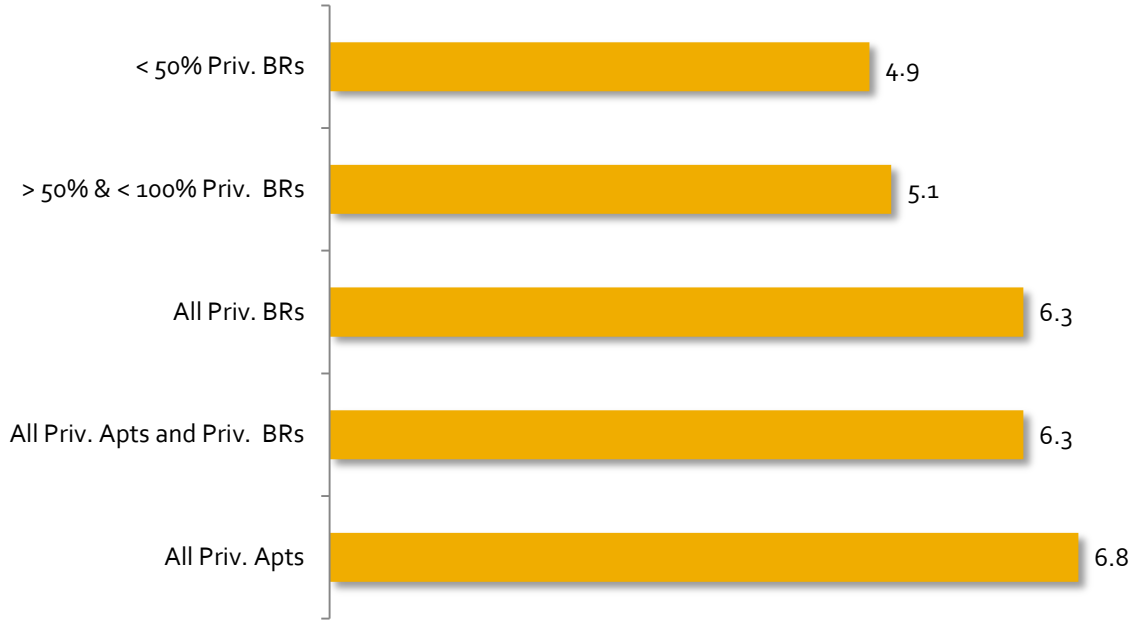
We developed a composite score for residents' control over meals and mealtime. This composite relied on those questions where there was greater variation in responses: residents participate in menu planning; residents allowed to prepare their own meals; residents participate in preparing common meals; residents allowed to choose where to eat their meals. Each facility was given a point for each of the meal choices it offered, up to four. The distribution of facilities across the range of points 1 to 4 can be found in the table above.

Figure 16. Average Composite Meal Score by Population Group Served



- On average, facilities serving older adults and adults with disabilities had the lowest composite score for resident control over meals, indicating these facilities allowed residents less control over their meals than facilities serving other population groups.

Figure 17. Average Composite Meal Score by Type of Housing



- On average, facilities with shared bedrooms had the lowest composite score for resident control over meals, indicating these facilities allowed residents less control over their meals than facilities offering more private bedrooms or apartments.

Overall Composite Score

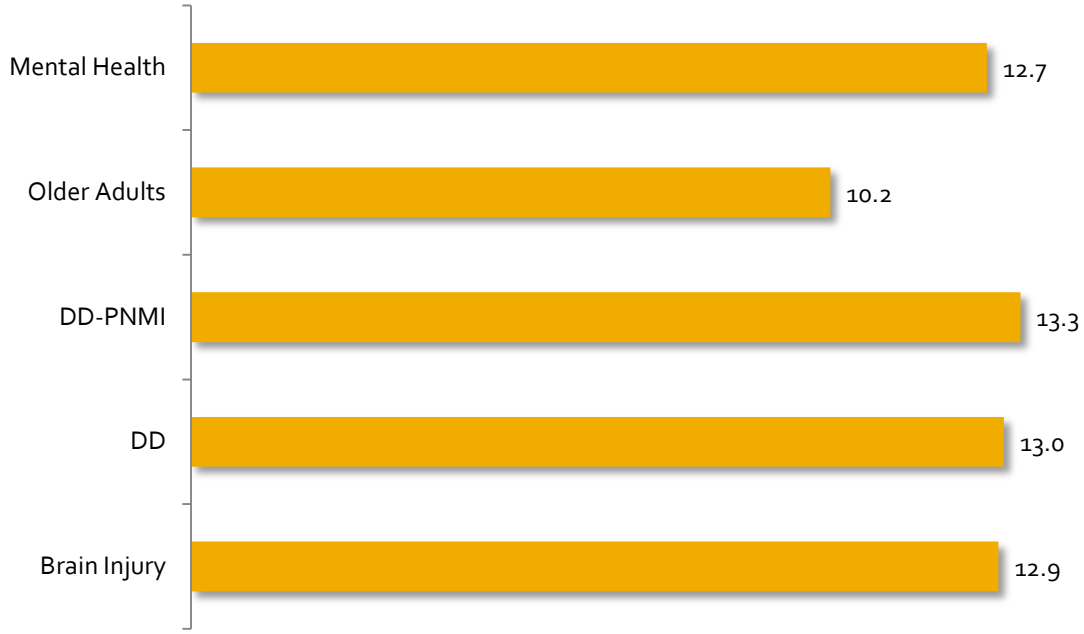
We used the elements identified in the individual composite scores to develop an overall composite score for each facility. The overall composite score does not weight the importance of each of these elements, so that our measures of privacy and autonomy are given equal weight regardless of how individual residents would measure their importance. However, these composite scores do provide some measure of how Maine's facilities compare when it comes to offering residents privacy and autonomy.

Table 27. Number and Percent of Facilities by Overall Composite Score

Total Points	Number of Facilities	Percent
4	1	0
5	4	1
6	3	1
7	15	3
8	21	4
9	30	6
10	48	9
11	80	15
12	71	13
13	87	16
14	93	17
15	45	8

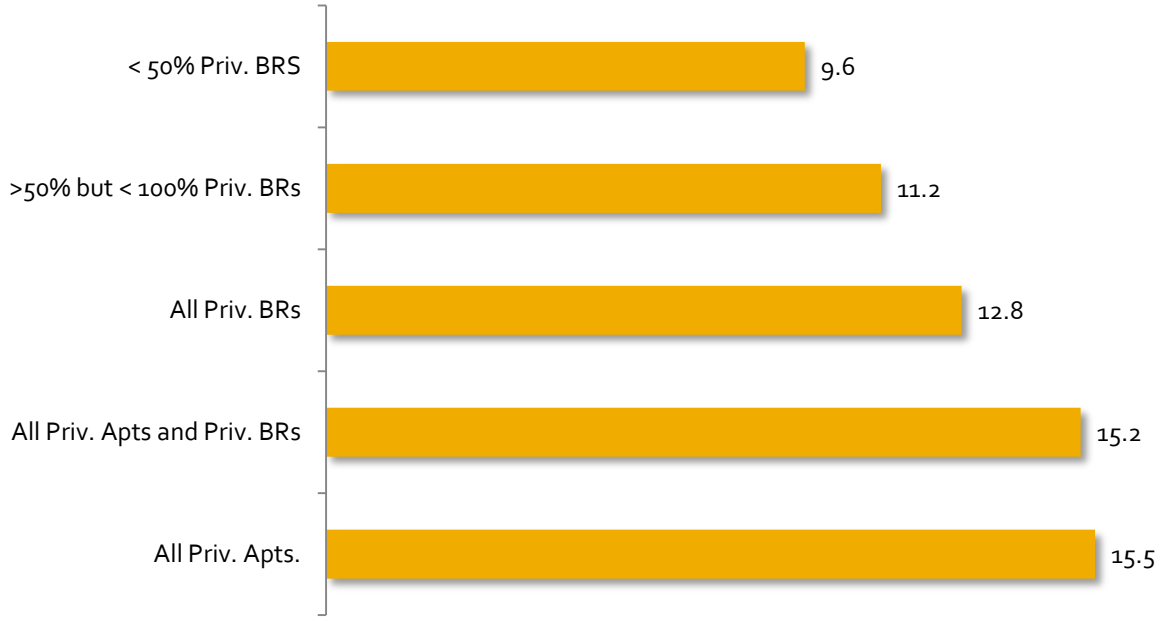
We developed a composite autonomy and privacy score by totaling each facility's score on the elements used to develop the individual composite score. (Those elements were the questions where the facilities' responses varied the most. See the discussion of each composite scores for more information about these elements.) The distribution of facilities across the range of possible points 0 to 16 can be found in the table above. A higher score indicates the facility offers greater resident autonomy and privacy, according to our measures.

Figure 18. Overall Composite Score by Population Group Served



- Facilities serving older adults tended to have lower overall composite scores than other population groups, indicating that these facilities had lower scores on measures of resident privacy and autonomy.

Figure 19. Overall Composite Score by Type of Housing Offered



- Facilities offering private bedrooms and apartments tended to have lower overall composite scores, indicating that these facilities were also more likely to score better on measures of resident privacy and autonomy.

Resident Characteristics

Admission Criteria

Facilities were asked about the admission criteria they use for deciding who is appropriate for their facility. The questions focused on particular functional and behavioral criteria including the need for and level of required physical assistance with certain activities of daily living; cognitive and communication impairments and behavioral impairment and risk of harm to self or others.

Table 28. Facilities Admitting Persons by Type of Need (Percent)

Will the facility admit a person who…	Yes	Depends
	Percent	Percent
Requires special food preparation?	96.0	1.9
Requires cueing/monitoring for eating?	95.2	1.9
Needs partial assistance with toileting?	91.6	3.8
Has moderate or severe communication impairment?	89.6	5.5
Has moderate or severe cognitive impairment?	85.1	9.2
Needs total assistance with toileting?	76.1	7.4
Needs to use wheelchair to get around?	68.4	9.1
Needs weight bearing physical assistance for transfer?	65.2	12.7
Has another behavioral impairment?	60.9	15.7
Requires total assistance with eating?	49.0	17.4
Has medical need requiring delegation of nursing tasks to staff?	45.4	27.8
Has medical need requiring on-site delivery of services by nursing staff?	42.2	27.9
Needs full staff performance for transfer?	40.8	17.7
Is at significant risk of hurting themselves or others?	37.4	19.0

- Most facilities reported that they would admit persons who need special food preparation, cueing or monitoring for eating, and partial assistance for toileting.
- Facility admission criteria were more likely to differ for people at significant risk of harming themselves or others, persons needing full staff performance of toileting, persons needing nursing, and persons needing full assistance with eating.

Residents' Age

The facilities in this survey are licensed to serve persons age 18 and up. The facilities were asked to identify whether all, most, some or none of their current residents fell into a certain age group. Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

Among the 351 facilities reporting that all or most of their residents fall into a particular age group, 82% (n = 289) serve predominantly younger adults.

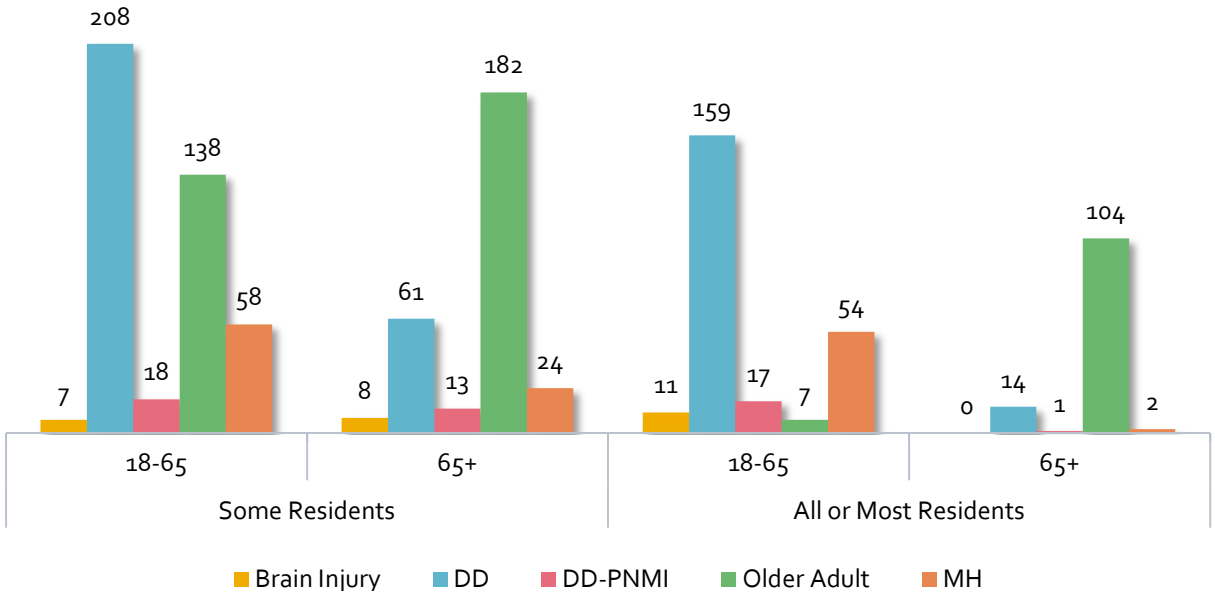
Table 29. Number of Facilities by Portion of Residents Falling into a Specific Age Group by Population Group Served

Age Group	Brain Injury		DD		DD-PNMI		Older Adult & Adult		MH		TOTAL	
	Some	All or Most	Some	All or Most	Some	All or Most	Some	All or Most	Some	All or Most	Some	All or Most
18-54		10	93	139	6	16	45	4	20	49	169	222
54-65	6	1	115	20	12	1	93	3	38	5	176	67
65-85	1	0	54	13	12	1	72	77	23	2	92	115
85+	0	0	7	1	1	0	110	27	1	0	9	29
TOTAL	-	11	-	173	-	-	56	111	-	56	-	351

Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

- Of the 111 facilities serving older adults and adults with disabilities that said all or most of their residents fell into a specific age group, 94% percent (n = 104) said that all or most of their residents were age 65 or older.
- Of those 119 facilities indicating that some residents were over 85 years of age, 98% (n = 110) were facilities that were classified as serving Older Adults and Adults with Disabilities; of the remaining 9 facilities, 8 serve persons with developmental disabilities.

Figure 20. Reported Age of Residents by Population Served (Number of Facilities)



Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

- Of the 121 facilities reporting that all or most of their residents are age 65 or older, 86% (n = 104) are facilities classified as serving Older Adults and Adults with Disabilities.
- Of those 248 facilities reporting that all or most of their residents are age 18 to 65, 64% (n = 159) are classified as serving persons with Developmental Disabilities; only 3% (n = 7) are classified as serving Older Adult and Adults.

Table 30. Number of Facilities by Portion of Residents Falling into Specific Age Group by Type of Housing Offered

Age Group	All Private Apartments		All Private Apartments and Private Bedrooms		All Private Bedrooms		More than 50% but less than 100% Private Bedrooms		Less than 50% Private Bedrooms	
	Some	All or Most	Some	All or Most	Some	All or Most	Some	All or Most	Some	All or Most
18-54	0	3	2	14	116	177	14	17	33	7
54-65	2	0	5	1	159	24	33	3	65	2
65-85	1	0	6	1	89	24	21	22	45	46
85+	0	1	2	1	26	8	24	8	67	12
TOTAL	-	4	-	17	-	233	-	50	-	67

Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

- Of the 233 facilities reporting that all of their units are private bedrooms, 201 facilities (86%) said all or most of the residents of that facility were age 65 or younger.
- Of the 67 facilities with fewer than 50% private bedrooms, 58 facilities (87%) said all or most of their residents were age 65 or older.

Figure 21. Reported Age of Residents by Type of Housing Offered (Number of Facilities)

Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

- Of the 121 facilities reporting that all or most of their residents are over age 65, 48% (n = 58) were facilities with fewer than 50% private bedrooms.
- Of the 248 facilities reporting that all or most of their residents are age 18 to 65, 81% (n = 201) were facilities with all private bedrooms.

Residents' Needs

The facilities were asked to report whether all, most, some or none of their current residents have functional needs related to mobility, behavioral impairment (*e.g.*, wandering), cognitive capacity, communication impairment, and medical needs requiring nurse staffing. Facilities were permitted to provide multiple responses.

Facilities with all private rooms served persons with the highest level of need as measured by the composite score.

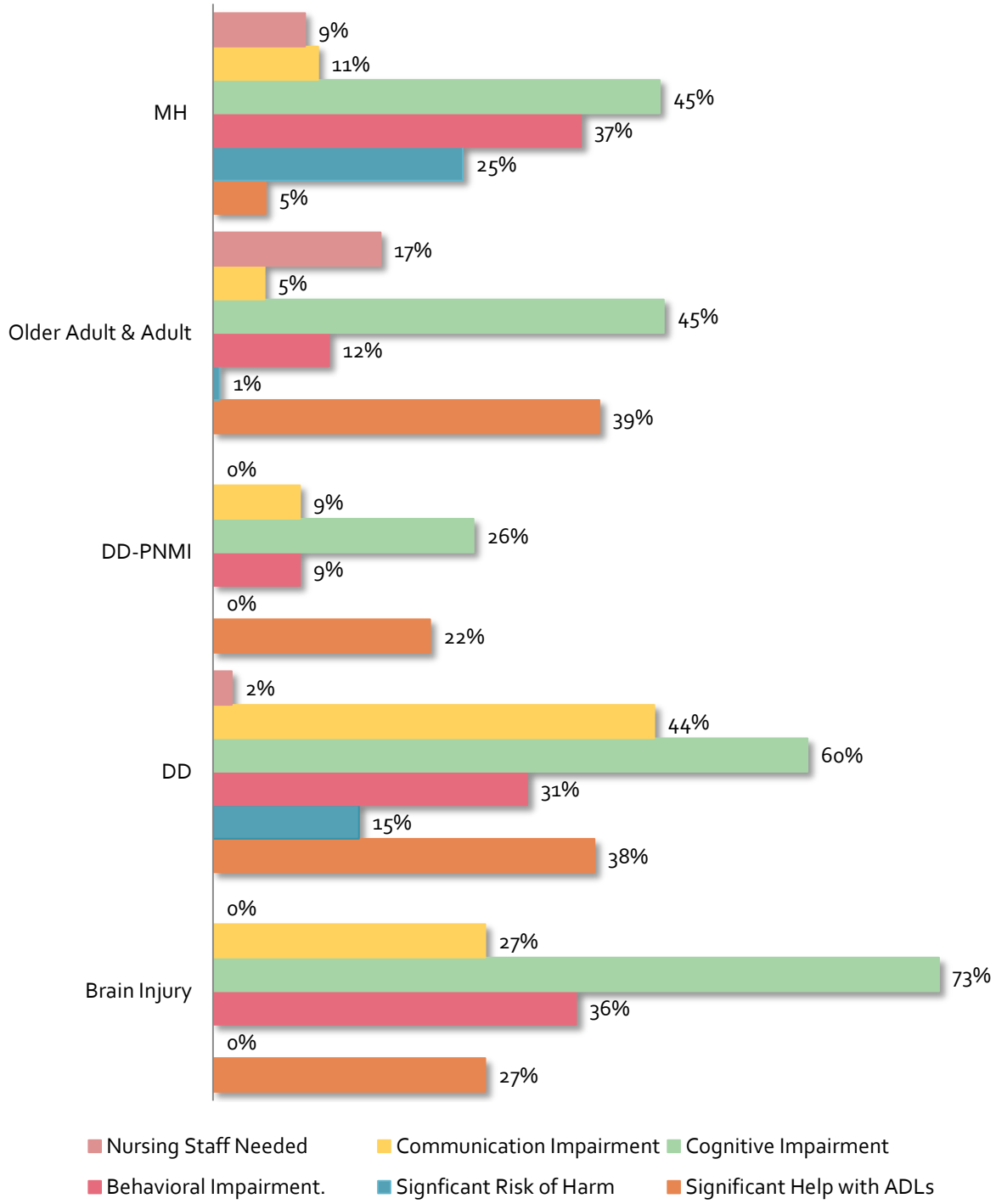
Table 31. Number of Facilities by Portion of Residents with Select Type of Need by Population Group Served

Type of Resident Need	Brain Injury		DD		DD-PNMI		Older Adult & Adult		MH		Total	
	n = 11		n = 267		n = 23		n = 155		n = 76		n = 532	
	Some	All/ Most	Some	All/ Most	Some	All/ Most	Some	All/ Most	Some	All/ Most	Some	All/ Most
Significant Help with Activities of Daily Living	6	3	84	102	10	5	84	60	25	4	209	174
Significant Risk of Harm to Self or Others	5	0	98	39	9	0	26	1	41	19	179	59
Moderate or Severe Behavioral Impairment	6	4	130	84	11	2	97	18	42	28	286	136
Moderate or Severe Cognitive Impairment	3	8	87	159	12	6	79	70	38	34	219	277
Moderate or Severe Communication Impairment	6	3	109	118	16	2	109	8	35	8	275	139
Medical Need Requiring Nursing	3	0	14	5	1	0	43	26	13	7	74	38

Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

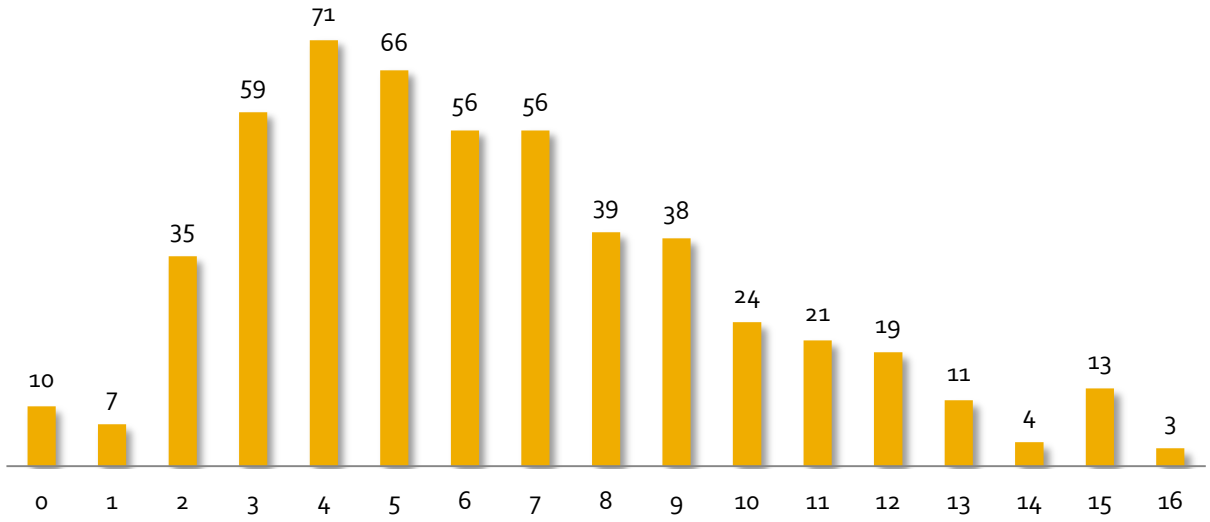
- Of 532 facilities, 277 (52%) said all or most of their residents had a moderate or severe cognitive impairment.
- 41% of the 290 facilities serving persons with developmental disabilities said all or most of their residents had a moderate to severe communication impairment (n = 165).
- Those 59 facilities that said that all or most of their residents were at significant risk of harm to themselves or others were most commonly serving persons with mental illness (n = 19) or developmental disabilities (n = 39).
- Facilities serving people with brain injury and persons with mental illness were more likely to have residents with a moderate or severe behavioral impairment.
- 7% of all facilities said all or most residents had a medical need for nursing compared with 17% for facilities serving older adults and adults with disabilities.

Figure 22. Percent of Facilities Reporting All or Most Residents Have Select Need by Population Group Served



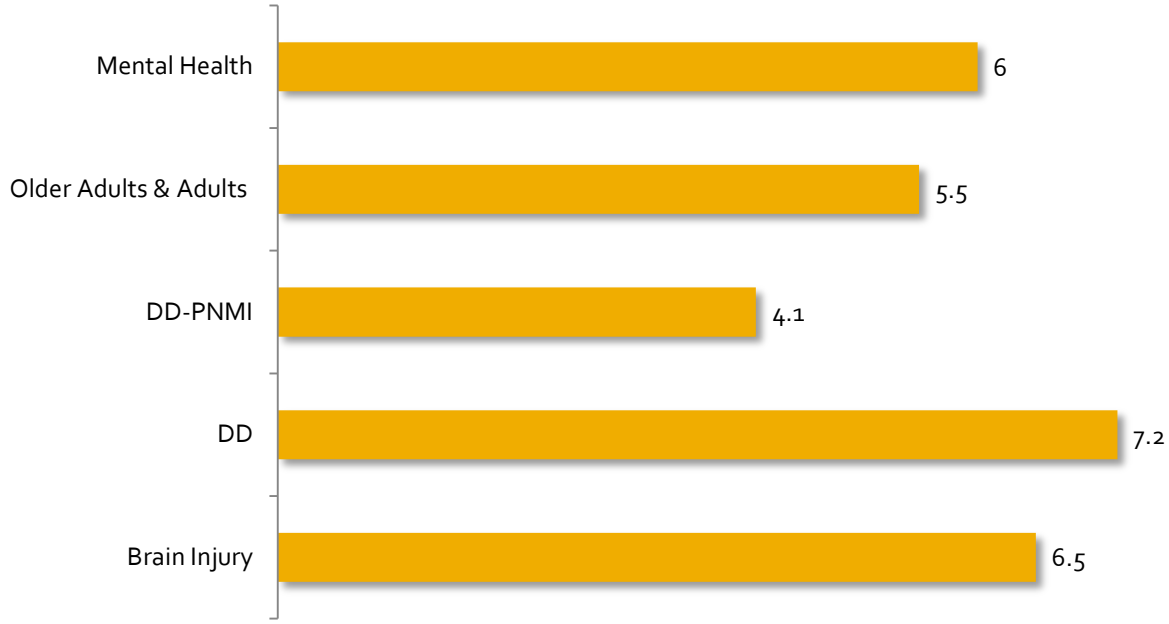
Because facilities could respond "some" for multiple age groups, the total number of facilities responding "some" exceeds the total number of facilities responding to the survey.

Figure 23. Distribution of Resident Service Need Composite Score



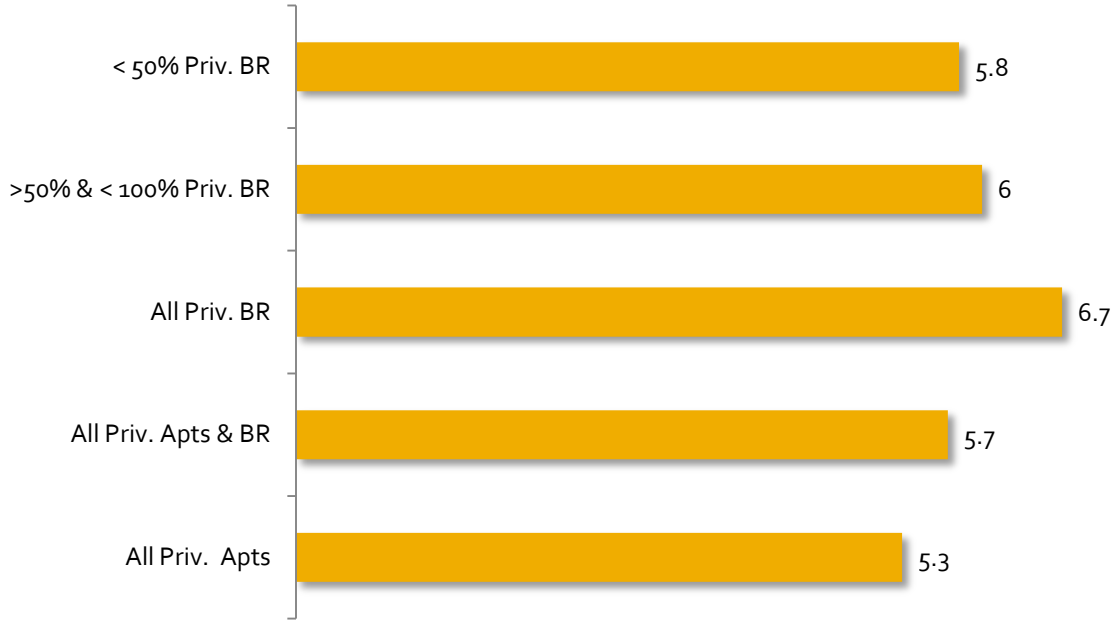
A composite score for resident need was developed by weighting each identified resident need by 3 if the facility said all residents had that need, by 2 if the facility said most residents had that need, and by 1 if the facility said some residents had that need. (See Table 31 on page 84 for the types of resident needs facilities were asked to identify.) The resident level of need score ranged from 0 to 18 with an average score of 6.4. The figure above represents the distribution of the composite resident service need score across facilities.

Figure 24. Composite Resident Need Score by Population Group Served



- Facilities serving persons with developmental disabilities under the HCBS waiver program have residents with the highest composite score of resident need. Conversely, DD-PNMI facilities (serving persons with developmental disabilities under §97 of the MaineCare Benefits Manual) had the lowest composite score or resident need.

Figure 25. Composite Resident Need Score by Housing Type



- Facilities with all private bedrooms had the highest average score for resident need; this higher composite score may be explained by the fact that people with developmental disabilities have a higher composite need score and people with developmental disabilities are predominantly served in facilities with all private bedrooms.

Facility Staffing

Direct Service Staff

Facilities were asked to identify the credentials of the unlicensed direct service workers that they have on staff.

Table 32. Type of Direct Service Workers on Staff

Type of Staff	Number of Facilities with Staff Available	Percent
Certified Residential Medication Aide (CRMA)	497	93%
Direct Support Professional (DSP)	317	60%
Personal Support Specialist (PSS) or Personal Care Attendants (PCA)	162	31%
Certified Nursing Assistant (CNA)	147	28%
Mental Health Rehabilitation Technician-1 (MHRT-1) or Mental Health Support Specialist (MHSS)	110	21%
Other	34	6%
Behavioral Health Professional	25	5%
Home Health Aide	15	3%
Certified Brain Injury Specialist	9	2%
Alcohol/Drug Counseling Aide	5	1%

.

- Almost all facilities (93%) indicated that they have a direct service worker with a Certified Residential Medication Aide (CRMA) on staff; CRMA certification is required for unlicensed assistive personnel under licensing standards for residential care facilities.

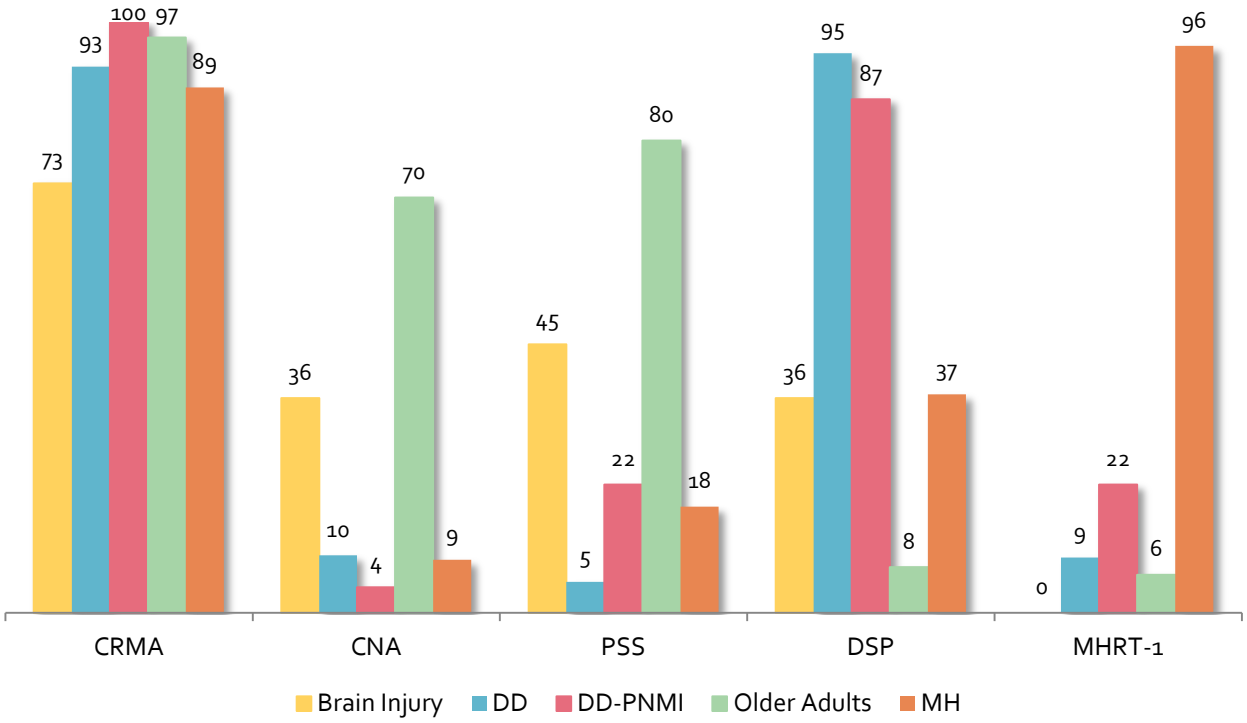
- 60% of facilities said they had a Direct Support Professional (DSP) on staff; DSPs are trained to serve adults with developmental or intellectual disabilities.

- 31% of facilities said they had a Personal Support Professional (PSS) and 28% said they had a Certified Nursing Assistant (CNA) on staff; these direct service workers primarily serve older adults and adults with disabilities.

- 21% said they employed a Mental Health Rehabilitation Technician-1 (MHRT-1), serving persons with mental illness.

- Because residential child care facilities and substance abuse treatment residential programs were not included in this survey it is not surprising that only 5 facilities indicated that they have alcohol & drug counseling aides. Only 25 facilities indicated they had a Behavioral Health Professional on staff; the BHP is trained to serve children. Only 9 facilities indicated that they have at least one Certified Brain Injury Specialist on staff; the Certified Brain Injury Specialist is a voluntary certification given by the Academy of Certified Brain Injury Specialist. A Home Health Aide is a CNA with the additional training and orientation for providing services in an individual's home; only 3% of facilities indicated they had a Home Health Aide on staff. Some facilities (6.4%) indicated that they had another type of direct service worker.

FIGURE 26. SELECT DIRECT SERVICE WORKER JOB TITLES BY POPULATION GROUP SERVED (PERCENT)



- CRMAs were common across facilities serving all population groups. Facilities serving persons with brain injury (n = 11) were the least likely to have a CRMA on staff, with 73% reporting that they had a CRMA on staff.

- Otherwise the credentials of the direct service workers tended to vary by the population group served by the facility. For example, 70% of facilities serving older adults and adults had a Certified Nursing Assistant on staff and 80% had a Personal Support Specialist, compared to 36% and 45% respectively for facilities serving persons with brain injury. Similarly, facilities serving persons with developmental disabilities were much more likely to a Direct Support Professional on staff and facilities serving persons with mental illness were much more likely to have Mental Health Rehabilitation Technician-1 on staff.

Professional Services Available On Site

Facilities were asked to identify the type of credentials of licensed or certified professionals who routinely provide services in the facility, either on staff, or as needed and arranged by the facility, including medical and therapy professionals, mental health professionals, and substance abuse treatment professionals. Facilities could indicate more than one professional.

Table 33. Facilities Reporting Medical or Therapy Professionals Available on Site by Population Group (Percent)

Type of Professional	Brain Injury	DD	DD-PNMI	Older Adult & Adult	MH	Overall
	n = 11	n = 267	n = 23	n = 155	n = 76	n = 532
Physician	18%	7%	4%	55%	0%	21%
Physician Assistant	18%	5%	0%	30%	0%	13%
Registered Nurse	55%	38%	22%	71%	1%	51%
Licensed Practical Nurse	18%	5%	0%	40%	0%	15%
Nurse Practitioner	18%	4%	0%	39%	0%	15%
Other Nurse	18%	4%	17%	8%	0%	6%
Occupational Therapist	55%	15%	9%	65%	0%	31%
Physical Therapist	45%	15%	9%	70%	0%	30%
Speech/Language	55%	9%	4%	47%	0%	20%
Other Medical/ Therapy	18%	4%	0%	10%	0%	6%
No Medical/Therapy	36%	49%	70%	10%	0%	36%

- Registered nurses are the most commonly available professionals: 51% of facilities reported that registered nurses routinely provide services in the facility.
- 90% of facilities serving older adults offer access to medical and therapy professionals, compared to 74% overall.
- 55% routinely made physician services available on site compared to 21% overall, 70% offered physical therapy compared to 30% overall, and 65% offered occupational therapy compared to 31 overall.
- 36% of the facilities indicated that they do not routinely provide or arrange for access to medical or therapy professionals. Facilities serving persons with developmental disabilities were least likely to arrange access to medical or therapeutic services on a routine basis.

Table 34. Facilities Reporting Mental Health Professionals Available on Site

Type of Professional	Brain Injury	DD	DD-PNMI	Older Adult & Adult	MH	Overall
	n = 11	n = 267	n = 23	n = 155	n = 76	n = 532
Psychiatrist	27%	14%	9%	25%	28%	19%
Psychologist	18%	21%	4%	9%	5%	14%
Neuropsychologist	55%	1%	4%	3%	0%	3%
Psychiatric Nurse	9%	4%	0%	11%	14%	7%
Licensed clinical social worker	27%	15%	13%	30%	46%	24%
Licensed Marriage/ Family Therapist	9%	0%	0%	3%	1%	1%
Licensed Clinical Professional Counselors	36%	2%	13%	8%	18%	7%
MHRT/C	18%	4%	4%	6%	74%	15%
MHRT/Crisis	9%	2%	4%	5%	24%	6%
Other MH	18%	5%	9%	3%	5%	5%
No MH	36%	60%	48%	49%	12%	49%

- Just over 50 percent of facilities indicated that they routinely provided or arranged access to mental health professionals, compared to 88% of facilities serving people with mental illness.
- 24% of facilities provided access to licensed clinical social worker services; 19% provided access to psychiatrists; and 15% provided access to mental health rehabilitation technicians with a community certification.
- Over half of the facilities serving persons with brain injury offered access to neuropsychologists (n = 6).

Table 35. Facilities Reporting Alcohol and Substance Abuse Professional Available on Site by Population Group (Percent)

Type of Professional	Brain Injury	DD	DD-PNMI	Older Adult & Adult	MH	Overall
	n = 11	n = 267	n = 23	n = 155	n = 76	n = 532
Licensed Alcohol Drug Counselor	9%	0%	0%	3%	0%	2%
Certified Alcohol Drug Counselor	0%	0%	0%	1%	0%	1%
Other Alcohol or Drug Staff	18%	0%	0%	1%	0%	1%
No Alcohol or Drug Staff Available	82%	97%	100%	94%	1%	95%

- 95% of facilities do not provide or arrange access to substance abuse treatment professionals.

References

Agich, G.J., (1990). Reassessing autonomy in long-term care. *Hastings Center Report*, 20(6), 12-17.

Cutler, L. (2007). Physical environments of assisted living: research needs and challenges. *Gerontologist*, 47(Special Issue III), 68-82.

Hawes, C., Rose, M., and Phillips, C. (1999). A national study of assisted living for the frail elderly: results of a national survey of facilities. Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Kane, R.A., Baker, M.O., Salmon, J. and Veazie, W. (1998). Consumer perspectives on private versus shared accommodations in assisted living services. Washington, D.C.: American Association of Retired Persons.

Lemke, S. and Moos, R.H. (1986). Quality of residential settings for elder adults. *Journal of Gerontology*, 41(2), 268-276.

Lidz, C.W. and Arnold, R.M. (1993). Rethinking autonomy in long term care. *University of Miami Law Review* **47, 603-623.**

Moloney, S.L., McDonald, D.D., and Palmisano-Mills, C. (2007). Psychometric testing of an instrument to measure the experience of home. *Research in Nursing & Health*, 30, 518-580.

Rubin, S. and Millard, R., (1991). Ethical principles and American public policy on disability. Journal of Rehabilitation, 57, 13-16.

Sikorska, E. (1999). Organizational determinants of resident satisfaction with assisted living. *Gerontologist*, 39(4), 450-456.

Sikorska-Simmons, E. (2006). The effects of organizational context on autonomy-enhancing policies in assisted living. *Journal of Aging Studies*, 20(3), 217-226.

Sikorska-Simmons, E., & Wright, J. (2007). Determinants of resident autonomy in assisted living facilities: a review of the literature. *Care Management Journals*, 8(4), 187-193.