AMERICAN SOCIETY OF PLANNING OFFICIALS
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NURSING HOMES

The increase in the number and proportion of the aged is making an impact on our cities. ASPO Planning Advisory Service Information Report No. 148, Planning and an Aging Population (July 1961), summarized population trends that are resulting in an increase in the number of older people and discussed some of the planning implications of these trends. Statistics concerning this growth have been quoted often enough to be implanted in the reader's mind and need not be repeated here. Similarly, planners are aware of how the change in age distribution can influence planning programs and land use controls. The recent interest in special housing facilities for the aged, and the special zoning and subdivision provisions to allow the facilities, is one example of the planning problem created.

This report will examine one small facet of the problem that planning agencies must face in dealing with an aging population -- the nursing home. The number of nursing homes in our cities has been steadily increasing. With this increase has come friction, particularly in the location of nursing homes as controlled by zoning ordinances. Traditionally, zoning ordinances have either been silent on the subject or have allowed the nursing home in high-density residential districts or in commercial districts. Recently there has been some discussion and rethinking of the special needs of this kind of facility. This report will summarize some basic characteristics of nursing homes, examine changes in the facilities, and will present excerpts from zoning ordinances that deal with nursing homes on more than a perfunctory basis.

A word of caution is in order. A nursing home is a medical-related facility. Regulation of many of the operational and administrative characteristics are outside the area of competence and responsibility of the typical planning agency. Consequently, the report will discuss only those aspects of nursing homes that are related to land use controls. There is a great deal of literature on the general subject and anyone seeking more detailed information should consult the bibliography at the end of this report.

Prepared by Frank S. So.

Definitions

Definitions and classification of facilities were developed by the U.S. Public Health Service and used in a 1961 inventory of nursing home facilities.[1]

First, there are definitions of the type of care provided:

Skilled Nursing Care -- Provides, in addition to room and board, those nursing services and procedures employed in caring for the sick which require training, judgment, technical knowledge, and skills beyond those which the untrained person possesses. It involves administering medications and carrying out procedures in accordance with the orders, instructions, and prescriptions of the attending physician or surgeon.

Personal Care -- Provides, in addition to room and board, personal services such as help in walking and getting in and out of bed; assistance with bathing, dressing, and feeding; preparation of a special diet; and supervision over medications which can be self-administered.

Residential Care -- Provides primarily room and board with limited services such as laundry, personal courtesies such as occasional help with correspondence or shopping, and a helping hand short of routine provision of "personal care" described above.

In addition, there are classifications of facilities by kind of facility and type of care provided:

KIND OF FACILITY*

Nursing Homes -- Includes nursing homes, convalescent homes, special service nursing homes, children's convalescent homes, and nursing home units of hospitals.

Homes for Aged -- Includes homes for the aged, county homes, county infirmaries, county poor farms "poor homes", public homes, aged home residences, and state veterans' homes for aged.

Boarding Homes for Aged -- Includes boarding care homes.

Rest Homes -- Includes rest homes, sheltered care homes, adult care homes, and personal care homes.

*As classified by the States, generally for licensure purposes.

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[1]This and subsequent references are listed at end of report.

TYPE OF CARE PROVIDED**

Skilled Nursing Home
Provides "skilled nursing care" as its primary and predominant function.

Personal Care Home With Skilled Nursing
Provides some "skilled nursing care" but only as an adjunct to its primary "personal care" function.

Residential Care Home With Skilled Nursing
Provides some "skilled nursing care" but only as an adjunct to its primary "residential care" function.

Personal Care Home Without Skilled Nursing
Provides "personal care" with no "skilled nursing care."

Residential Care Home Without Skilled Nursing
Provides "residential" or "sheltered" care with no "skilled nursing care."

**According to definitions above.

For licensing purposes, the definitions will vary from state to state. The planning agency should become conversant with state and local definitions and classifications since they are important to health and medical authorities. However, they may or may not be suitable for zoning ordinance definitions.

Growth Trends

The 1961 nursing homes inventory conducted by the Public Health Service counted 23,000 non-hospital facilities in the United States and territories providing nursing or supportive care to the aged and chronically ill of all ages. This total is 2,000 less than the figure reported in a similar survey undertaken in 1954. However, the resident capacity increased from 450,000 beds to 592,800 -- a 32 per cent increase.[2]

In terms of kind of facility, there were an estimated 11,600 nursing or convalescent homes with 369,300 beds; 11,400 other facilities for the aged with 223,500 beds. The latter category included homes for the aged, boarding homes for the aged, rest homes, and similar facilities.

About nine out of ten of the nursing homes, providing about three-fourths of all the beds, are operated commercially. Their median size is 24 beds. Other kinds of facilities such as homes for the aged, are also under proprietary auspices. These homes are generally small, with the following median size: homes for the aged, 19 beds; boarding homes, 8 beds; and rest homes, 13 beds.

Personal care is the primary function of nearly 90 per cent of all homes for the aged, boarding homes for the aged, and rest homes. In homes for the aged and rest homes, skilled nursing care is available either as a primary or as an

adjunct service to more than 1/2 the resident bed capacity. Nursing services are available in only one out of 8 beds in boarding homes for the aged.

The 23,000 homes are broadly grouped by primary type of service as follows: 9,700 skilled nursing care homes; 11,100 personal care homes; 2,200 residential care facilities.

The greatest growth has occurred in skilled nursing care homes. Since 1954, they have increased from a total of 7,000 to 9,700 homes -- an increase of 39 per cent. Total bed capacity has nearly doubled from the 180,000 beds in 1954 to 338,700 in 1961. Almost all of these beds were reported to have skilled nursing service.

The number of personal care homes has grown from 9,000 with 190,000 beds to 11,000 with 207,100 beds. However the number of residential care facilities has decreased from 9,000 homes with 80,000 beds to 2,200 homes with 47,000 beds.

The survey showed a wide variation among the states in the supply of skilled nursing care beds. In general, the bed-population ratio increases with the average state per capita income, the amount of old age assistance payments, the relative number of persons aged 65 and over, and the proportion of the population living in urban areas. The following tables, which summarize the PHS survey results by each of these characteristics, can be quite useful in determining the potential market for nursing home facilities:

POPULATION AGED 65 YEARS AND OVER

Per Cent Population Aged 65 and Over	Number of States*	Skilled Nursing Care Beds per 1,000 Population Aged 65 and Over
Less than 6.0	4	6.7
6.0 - 6.9	5	7.4
7.0 - 7.9	6	14.8
8.0 - 8.9	7	15.8
9.0 - 9.9	12	24.0
10 and over	18	24.9

PER CAPITA INCOME

Per Capita Income of State	Number of States	Skilled Nursing Care Beds per 1,000 Population Aged 65 and Over
Less than $1,750	11	9.7
$1,750 - 1,999	11	15.8
$2,000 - 2,499	19	25.4
$2,500 and over	10	24.0

*Includes territories.

RURAL AND URBAN DISTRIBUTION

Per Cent Rural Population	Number of States	Skilled Nursing Care Beds per 1,000 Population Aged 65 and Over
50 and over	18	11.7
40 - 49	11	23.9
30 - 39	14	23.3
Less than 30	9	22.4

OLD-AGE ASSISTANCE PAYMENTS

Annual OAA Payments per Recipient, 1960	Number of States	Skilled Nursing Care Beds per 1,000 Population Aged 65 and Over
Less than $500	4	8.9
$500 - 699	11	12.3
$700 - 899	15	22.2
$900 - 1,099	15	23.6
$1,100 and over	7	28.4

Skilled nursing homes are larger than they were about a decade ago, according to the survey. The median size is approximately 25 beds, compared to 19 beds in 1954 and varies from small establishments of less than 10 beds to a few large facilities of 500 beds and over. The percentage frequency distribution of skilled nursing care facilities in terms of the proportion of facilities in each size category as well as the proportion of beds, in each size category are shown in the following tables:

FACILITIES

Under 10 beds	10.3
10 - 24.	39.7
25 - 49.	33.5
50 - 99.	12.2
100 - 249.	3.7
250 beds and over.	.6
Total.	100.0 per cent

BEDS

Under 10 beds	1.9
10 - 24.	19.8
25 - 49.	33.1
50 - 99.	23.3
100 - 249.	15.0
250 beds and over.	6.9
Total.	100.0 per cent

Size also varies according to ownership. Publicly owned facilities are the largest with an average of 61 beds. Skilled nursing homes under proprietary ownership average 24 beds. Homes connected with church groups average 50 beds while other types of nonprofit homes average 39 beds. Approximately 87 per cent of the skilled nursing homes are owned by proprietary interests. However, while proprietary homes account for nearly 9 out of 10 homes, they provide little more than 7 out of 10 beds.

Finally, nearly 9 out of 10 skilled nursing homes have at least one full-time registered professional nurse or licensed practical nurse.

LOCATION FACTORS AND ZONING PROVISIONS

Although there are many standards for construction and interior facilities of nursing homes, there are few standards useful to planners. Almost all sources consulted in the preparation of this report contain general, rather than specific location standards. A typical example is found in the Public Health Service's Nursing Home Standards Guide:[3]

> Home Standards Guide:[3]
>
> The site of a nursing home should be reasonably accessible to the center of community activities, physicians services and medical facilities and located within the service area of fire department. There should be good drainage, adequate sewerage, water, electrical, telephone, and other necessary facilities available on or near the site. Public transportation should be available within a reasonable distance. Adequate roads and walks and parking areas should be provided within the lot lines. Sufficient space suitable for outdoor recreation also should be available. Compliance with all zoning codes and regulations should be required.
>
> The requirements of older people for a quiet environment vary and some patients prefer an area in which sounds of people and movement are present. However, proximity to sources of loud, continuous, or impact noise should be avoided. In general, the home should be remote from railroads, factories, airports, or similar noise sources. The outdoor noise level at a nursing home site should not exceed 50 decibels.
>
> Nursing homes should generally be located in areas reasonably free from noxious and hazardous smoke and fumes.

The small amount of literature available on location factors emphasizes that nursing homes ought not to be located out in the country, but in the city where community activities go on. In the words of one observer, a nursing home should be located on land that is evaluated by the front foot rather than by the acre. Most of our elderly have lived in cities all their lives and do not want to be shipped off to the country. Unfortunately, there is a shortage of nursing home facilities in neighborhoods close to friends and families in the city. In general, the facilities in such locations are the ones with long waiting lists.

While there is unanimous agreement that residential types of environments are most desirable for nursing homes, this objective may appear to conflict with an important principal of planning: a residential neighborhood should be protected against uses that are detrimental or incompatible with a desirable living environment. This conflict is perhaps the central issue when zoning provisions for nursing homes are discussed. The conflict has come about because traditional zoning seeks to segregate residential uses and to protect single-family areas as the most desirable areas in a community. Because of this, the great majority of zoning ordinances have always placed nursing and convalescent homes in the highest density, multi-family districts, as well as in commercial districts. An unpublished study of the Los Angeles Welfare Planning Council (1959) showed that only 6 out of 46 cities in the greater Los Angeles area permitted nursing homes or related facilities in R-1 zones. Although the trend is by no means universal, there is evidence of a growing acceptance of the principle that these uses should be more freely dispersed throughout residential areas.

The influence and impact of nursing homes on single-family neighborhoods was studied in Richmond, California. Following a number of heated public hearings on the subject, the planning commission listed the major reasons given by various people who claimed that a nursing home would adversely affect the neighborhood.[4] It was believed that a nursing home would:

a. Change the character of the neighborhood -- it would no longer be a uniform single-family area.

b. Introduce commercialism -- after the first care home would come another and then business and stores.

c. Lower property values.

d. Produce a traffic hazard -- increase traffic volumes.

e. Create parking problems -- people would not be able to park in front of their own homes.

f. Necessitate street widenings.

g. Result in ambulance traffic and blowing sirens.

h. Transform the neighborhood into a "Quiet Zone" restricting the children's play activities.

i. Raise taxes or special assessments for street widening and paving.

The planning commission took these arguments and tested them by studying the residential areas surrounding three small nursing homes. Two homes contained bed patients; the other, ambulatory patients. A questionnaire was used to sample neighborhood opinion. In addition, an analysis of various kinds of public records was also made.

When neighborhood residents were asked if they were aware of the existence of a care home in the neighborhood, approximately 90 per cent were aware of the home. About one-fourth stated that they had lived in the neighborhood for

periods varying from six months to two years before learning that the care home existed. All agreed that the present care home residents were very quiet. None of the neighbors had noticed a siren being used. About half had never noticed an ambulance calling at the home, and the other half had noticed an ambulance only at infrequent intervals. When asked about traffic problems respondents stated that in general there were "no problems." The only exceptions were two next-door residents, who said that occasionally visitors to the homes would park in front of their homes. However, there was no complaint in one case where off-street parking was provided. Neighbors unanimously stated there was no effect at all on the play of their children. Ninety-five per cent of the neighbors said there had been no effect at all on property values, and the remainder said that they did not know. When asked whether or not they had become acquainted with the residents of the care home, neighbors of the two care homes with bed patients responded that there was little contact. But in the case of the home with ambulatory residents, most of the respondents had often observed the people taking walks about the neighborhood, and chatting with both children and adults.

The trend of the comments clearly indicated that the neighborhood had experienced no difficulty or deterioration because of the care home. Some surprise was expressed that the city should be investigating the matter as a "problem." Many people mentioned the fact that the way the home was conducted seemed to be important. Neighborhood residents were of the opinion that there might be problems with a very large nursing home, or if several small homes were located close together.

Other sources of information, including assessor's records, city traffic and engineering offices, and the only ambulance service, were investigated. The planning commission concluded:[5]

> Small care homes of six or fewer residents have no noticeable effect on neighborhood character.
>
> Larger care homes might have some visual affect, although this could be minimized by attention given to the architectural treatment of the structure.
>
> A care home is not a forerunner of commercial development.
>
> Although the operator may make his living from it, the care home operation is not a commercial business like a store, but is rather a home occupation like taking in sewing or teaching piano lessons. It is a much less intense use than a hospital, which is permitted in residential zones.
>
> A care home for six or fewer people generates no more traffic than an ordinary home, and therefore the usual off-street parking regulations should suffice.
>
> Care homes for more than six people will require extra off-street parking facilities to maintain equity with neighbors in the use of street parking space.
>
> There is no basis for the ambulance-siren apprehension. This may have arisen from confusing a care home with a hospital where people do go for emergency treatment.

Other planners and public agencies have also given careful thought to the location of nursing homes. Appendix A contains a policy statement prepared by the California chapter of the American Institute of Planners in cooperation with the Welfare Planning Council of the Los Angeles Region. This statement essentially states that boarding homes for the well-aged are comparable to boarding homes for persons of any age and should be permitted in the same locations that any boarding homes may be permitted. The policy statement concluded that it is appropriate for nursing facilities to be in multiple-residential zones. In this sense, the policy statement does not go as far as some recent zoning ordinances in permitting nursing homes in lower density residential zones. Other points may be found in the policy statement in Appendix A.

Zoning Trends and Characteristics

Appendix B contains the zoning text provisions covering nursing homes from eight selected zoning ordinances. These ordinances go into more than usual detail, and with one exception, have been adopted within the past four years. Many of the ordinances contained similar provisions, but differ somewhat in treatment of details.

The significant trend in zoning for nursing homes is to permit them in single-family residential districts. The zoning ordinance of Richmond, California, includes nursing homes as a permitted use in its R-1 single-family district. However, these homes may have a maximum capacity of only six persons. Homes for seven or more persons are permitted in the R-2 multiple-family district, the next zoning district after the R-1 single-family district. At the same time, a larger home may be permitted in any zoning district as a conditional use, if it meets certain requirements imposed by the commission.

Other zoning ordinances also permit nursing homes in single-family districts. However, they are not permitted as a matter of right but are handled through special permit or conditional use provisions. The zoning ordinances of Baltimore, Seattle, Santa Rosa, and the Maryland-Washington District fall into this category.

Two of the ordinances, Minneapolis and New Haven, do not permit nursing homes in the first single-family districts. Minneapolis first permits them as a conditional use in the second, multi-family (R-4) district. New Haven treats them as a special exception in the R-1 low-medium density district. This is the third residential district, following two single-family districts.

Another approach is used in Tacoma. The Tacoma ordinance has a special medical center transitional district which can be combined with various other districts. Nursing homes are a permitted use in this district. Details of the ordinance can be found in Appendix B.

Most of the ordinances in Appendix B contain reasonably detailed definitions of nursing and convalescent homes. The definitions vary considerably, depending upon whether the ordinance is attempting to differentiate by size of institutions, whether nursing care is permitted, whether it is desired to differentiate between nursing homes and lodging homes or other homes for the aged, whether mental disorders are considered, and whether hospitals and various kinds of clinics are specifically excluded.

In drafting definitions, it is desirable to differentiate between nursing homes and hospitals and other medical facilities. In addition, the definition should be related to state and local health and welfare definitions, as well as to those kinds and capacities of nursing homes that are being operated. Two problems seem to be evident. First, although it may be desirable to regulate on the basis of bed capacity, it appears as if the majority of nursing homes may fall into the upper limits of the breakdowns that are contained in definitions of size. For example, an ordinance may permit nursing homes of less than six beds in a particular district. Yet these may only be a handful that are this small, and in effect would exclude nursing homes as permitted uses. Ordinance drafters need to be careful not to encourage or give favorable treatment to marginal operators. Second, it may be undesirable, in the long run, to differentiate between lodging homes for the aged and nursing homes. More than one authority has pointed out that if the average age of the resident of a lodging home for the aged is now between 65 and 70, ten years hence many of the same residents will still be residing in the lodging home. Often they will require extensive nursing care. Many operators of nursing homes originally operated lodging homes and found that it was necessary to add nursing care as their residents became older.

Most of the ordinances also contain minimum lot size and dimension requirements. In general, the provisions have two characteristics. First, as the number of beds increases, the lot area requirements increase. Second, as the land use intensity of the zoning district increases, the lot size requirements decrease. Although a few ordinances have no minimum lot areas that are specifically required for nursing homes, the smallest encountered is 6,000 square feet and the largest is 40,000 square feet. It would not be useful to try to determine an average; however, 10,000, 15,000 and 20,000 square feet appear most frequently as minimum lot area requirements.

While yard requirements also vary considerably, the tendency is to require greater yards that for residential uses in the same zoning district. In addition, landscaping and screening requirements are required in a number of ordinances. These kinds of requirements serve two purposes. First, to protect the adjacent residential uses, by some visual barrier and second, to provide an outdoor privacy for nursing home residents.

One of the knottiest problems in zoning regulations for nursing homes has been the problem of conversion of existing large dwellings. Although none of the ordinances examined contain completely adequate provisions in this regard, a few of them do have some pertinent provisions. For example, the Baltimore ordinance contains minimum floor space requirements for sleeping rooms. This kind of requirement can prevent overcrowding. The Baltimore ordinance also requires that a nursing home be a completely detached structure (presumably to exclude row houses), no part of which is used for any other purpose. The building must also be accessible for fire fighting purposes and evacuation at all levels of the structure and on three sides.

Depending on state and local health regulations, some of these aspects of building and interior design may be regulated in other laws. However, the planning agency ought to be aware of what is covered in other legislation. To insure adherence to such regulations before passing on the zoning, the Baltimore ordinance provides that written approval from the State Department of Health, the

City Health Department, the Fire Department, and any other legally responsible agency must be received before the Board of Adjustment will make its decision. An indirect regulation to control conversions is the limitation of the height of nursing homes to one story. This requirement would generally rule out the older, large single-family residences.

Parking requirements for nursing homes vary considerably. (See Appendices B and C.) Some requirements are based on floor area. The majority are based on a ratio of parking spaces to beds. Many ordinances also gear their requirements on a combination of the number of beds, employees, and doctors.

It is difficult to arrive at a single standard for parking facilities for such a specific use as nursing homes. However, in addition to the provisions cited in the Appendix, two recommendations have been made by other sources. The Highway Research Board in Bulletin No. 24, Zoning for Parking Facilities, published in 1950, suggested that one parking space be provided for each six patient beds, plus one space for each staff or visiting doctor, plus one space for each four employees, including nurses. More recently, the American Nursing Homes Association suggested that generally, one parking space for each four beds is sufficient. The Association expressed concern with some municipalities that require parking ratios similar to hospital requirements. The Highway Research Board study concluded that all other things being equal, the convalescent home requires fewer parking spaces on a unit basis than a hospital because the number and frequency of visitors is substantially less.

CONCLUSIONS

The problem of appropriate zone locations for nursing homes is by no means solved. In the past the nursing home was relegated to high-density residential and commercial districts. Now there is the recognition that they were often inappropriately located and that perhaps certain kinds of homes can be located in single-family residential areas. A number of zoning ordinances now permit this. One study has concluded that small nursing homes have a negligible impact on single-family areas and neighbors have few or no objections. However, this is the only study and it does not test impact or reaction to larger homes.

The question of whether nursing homes should be permitted in single-family areas is also influenced by a number of other, perhaps intangible, factors. The impression the public has of a nursing home is influenced by the fact that many nursing homes in the past (and in the present, too) were old, run-down, ill-maintained, fire-traps. In addition, the public sees a nursing home and a boarding house as much alike. Not only does the prospect of a boarding house bring anxiety to neighbors, but, quite correctly, they saw the existence or conversion of a dwelling to a rooming house as a sure sign that the neighborhood was going downhill.

With the growth in the number of nursing homes, the quality of maintenance, operation and construction has improved considerably. Increasing interest in all aspects of housing and caring for the aged has brought suggestions from health and welfare officials to the effect that is is desirable to locate facilities for the aged in a normal residential environment.

The typical zoning ordinance deals with the nursing home in very general fashion. A few now set up requirements in some detail. In response to the recommendations from various planners and health authorities that nursing homes be permitted in single-family districts, some cities have amended their ordinances to permit this. However, they are seldom permitted directly without special review. The approach is to permit them as a conditional or a special permit use if they meet certain size and development requirements.

As yet there are no generally accepted standards, but a range of them are in use in various combinations. Items of regulation and control include: definitions, size, ownership, minimum sleeping room sizes, minimum lot area and dimensions, height, site plans, distance from other kinds of zoning districts, exclusion from commercial and industrial areas, access for fire fighting, approval of health officials, screening and landscaping, and off-street parking.

In addition to zoning requirements, there are many other regulatory agencies with various functional areas of interest that should be consulted before drafting new zoning controls.

Finally, this report should be looked upon as a progress report rather than any statement of recommendations that ought to be followed in every city. If the report encourages more critical thinking about the proper place of the nursing home in the community, then it will have served its purpose.

REFERENCES

1. Nursing Home Standards Guide, U. S. Department of Health, Education and Welfare, Public Health Service, Public Health Service Publication No. 827, 1961, pp. 33-34.

2. Hugh B. Speir, Characteristics of Nursing Homes and Related Facilities: Report of a 1961 Nationwide Inventory. U. S. Department of Health, Education and Welfare, Public Health Service, Division of Hospital and Medical Facilities, 1963.

3. Ibid., pp. 1-2.

4. Care of Homes in Richmond, City Planning Commission, Richmond, California, July, 1958. pp. 3-4.

5. Ibid., pp. 5-8.

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APPENDIX A

CALIFORNIA CHAPTER, AMERICAN INSTITUTE OF PLANNERS, OCTOBER, 1956
STATEMENT OF PRINCIPLES ON ZONING FOR SHELTER CARE FACILITIES SERVING THE AGING

Prepared by the Committee on Zoning for Shelter Care Facilities Serving the Aging, of the Southern Section, California Chapter American Institute of Planning in Cooperation with the Committee on Problems of the Aging of the Welfare Planning Council, Los Angeles Region. Approved for publication by the Executive Board, California Chapter, American Institute of Planners, October 7, 1956.

1. Boarding homes for the well-aged are comparable to boarding homes for persons of any age, and in general should be permitted to the extent that board and room service and facilities are permitted in any zone.

   Small boarding homes with one through six guests are not normally institutional in character, being private homes in which limited facilities are offered and, as such, are not normally so constructed as to permit expan-

sion. It is desirable that these homes be permitted in single and two family residential zones, and similar residential agricultural zones and that they conform to all front and side yard setbacks and parking requirements of the respective zones, and that the number of guests be limited to the number of persons permitted to occupy board and room facilities in these zones. When the conditions outlined above are met, no permit or public hearing should be required under the zoning ordinances.

2. Boarding homes or institutions for the well-aged caring for over six guests should be allowed in multiple residential zones. The conditional factors for boarding homes of over six capacity should be approximately the same as those for comparable multiple residential dwellings. In zoning terms, the maximum size of the allowed boarding home would generally conform to the population density permissible in the zone. To illustrate this: a home for fifty with a staff of ten would be allowed on the same property where an apartment house accommodating approximately sixty persons would be permitted. Some advance thinking would be required by the home itself in projecting what its ultimate capacity might be, in order to remain consistent with the general density pattern for the zone.

3. Normally boarding homes or institutions for the well-aged should be permitted as a matter of course in multiple zones without special permit or hearing.

4. A boarding home or institution for the well-aged should have the opportunity to serve its own residents who become non-ambulatory, in its own infirmary or nursing facility. Provision for this should be included in the basic zoning law, so that such nursing facilities can be included initially or added later as needed. The basic use, namely to care for the well-aged should be protected with the pro-viso that not more than twenty-five per cent of the total capacity of the institution should be dedicated to the infirmary or nursing adjunct. The total capacity for the institution, including the nursing unit, is to be within the density allowed for the zone.

5. As a general principle, it is appropriate for nursing facilities for both the physically and senile ill (not including the violent or extremely disturbed patient) to be in multiple residential zones. The authorized capacity of any such facility should be related to the population density for the zone in the same way as for the larger boarding homes for the well-aged.

6. Where the conditions established for multiple residential zones are not readily applicable to institutions serving either the physically or senile ill-aged, it is recommended that such use be permitted upon the issuance of a conditional use permit, which would establish the physical relationship of the institution to the community and adjacent property. The conditional use permit is administrative in character designed to review the conditions of establishment of institutions and not to prohibit such use. Such permits might be granted without public hearing when based on previously established principles and policies.

7. From the point of view of the welfare of the residents or patients, boarding homes or institutions for the well-aged and nursing homes for the physically or senile ill, should not be located in industrial zones or in other areas unsuited by noise, traffic or other factors to reasonable living conditions.

8. The larger facilities serving the aging should be allowed in areas zoned for agriculture, but by special permit. This would make possible the planned use of land on the basis of likely future development, as well as current usage.

9. If from a practical point of view, there is no land or very little land available in multiple residential zones for all types of facilities serving the aging, then municipalities should recognize such facilities as uses necessary to the community, comparable to churches and schools -- and provide for their installation under appropriate limitations in other zones not normally permitting such uses. Review at a public hearing would be required prior to the establishment of these uses.

Edward A. Holden, Chairman
Simon Eisner
Thomas D. Cook
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APPENDIX B

SELECTED ZONING PROVISIONS CONCERNING NURSING HOMES

Baltimore (1963)

Definition:

Nursing Care Home: any place or institution for the aged, infirm, senile, chronic or convalescent established to render domiciliary care, custody, treatment and/or lodging of three (3) or more non-related persons who require or receive special diet, assistance in feeding, dressing, walking, or toileting, or assistance in any other ordinary daily activities of life, or are confined to bed or chair. This term includes boarding and rooming houses for aged people, convalescent homes, rest homes, homes for the aged or infirm, convalescent homes for children, and the like.

R-1 Districts (One Family) -- Special exception by board of appeals

Nursing Care Homes, provided:

1. that the following minimum floor space for sleeping rooms shall be provided:

   Each room for one (1) person - 100 square feet;

   Each room for two (2) or more persons - 80 square feet per person;

2. that any new building designed as a nursing care home and any existing building proposed for conversion for such use shall be a completely

detached structure, no part of which is used for any other purpose. Except, that an existing attached building may be converted to such use provided the said building is unattached and accessible for fire-fighting purposes and evacuation at all levels on three (3) sides and provided said building is separated from the adjacent structure on the fourth side by an approved fire wall extending from ground to thirty (30) inches above the roof.

3. that compact evergreen planting, a masonry wall, fence, and/or planting of shrubbery, trees or vines shall be provided as the Board may determine is reasonable and proper to afford adequate screening;

4. the Board may require written approval from the State Department of Health, the City Health Department, the Fire Department or any other applicable agency, prior to its decision;

5. that before taking final action on an application for such use, the Board shall refer a detailed site plan and all pertinent data concerning the application to the Planning Commission for written report and recommendations. The report shall be forwarded within 21 days to the Board, and said Board shall take no action upon the application for a special exception until receipt and consideration of said report; and

6. that in the opinion of the Board, the proposed use will not interfere unreasonably with the present character of future development of the neighboring residential community.

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Maryland-Washington Regional District, Maryland (1952)

Definition:

Nursing homes permitted in all residence districts as special exceptions by a board of appeals provided that "said use will not constitute a nuisance because of traffic, noise or number of patients or persons being cared for;" and that "said use will not adversely affect the present character or future development of the surrounding residential community." The following standards apply:

Number of Persons Cared For	Total Area	Frontage	Setback
Not more than 5	7,500 sq. ft.	50 feet	Same as in area regulations for the residential zone in which proposed to be located
More than 5 but not more than 10	15,000 sq. ft.	75 feet	Same
Eleven or more	20,000 sq. ft.	150 feet	25 feet from all property lines

Minneapolis (1963)

Definition:

A "convalescent home", a "nursing home", or a "rest home" is a home for aged, chronically ill, or incurable persons in which two (2) or more persons not of the immediate family are received, kept, or provided with food and shelter or care for compensation, but not including hospitals, clinics, or similar institutions devoted primarily to the diagnosis and treatment of disease or injury, maternity cases, or mental illness.

Permitted as Conditional Use R-4 General Residence District:

Minimum lot area: 20,000 sq. ft.

Minimum lot width: 100 ft.
FAR 0.5
Yards:
Interior:
Front: 40 ft.
Side: 15 ft.

Corner:
Side: 15 ft.
Rear: 50 ft.

Parking: One space for each four beds, plus one for each two employees (other than staff doctors), plus one for each doctor assigned to the staff.

R-5 Residence District:

Conditional use. All requirements same except FAR of 0.6.

R-6 Residence District:

Conditional use. All requirements same except FAR of 1.1.

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New Haven (1963)

RM1 Districts: Low-Middle Density (3rd Res. Dist.) -- Permitted as special exception.

Convalescent homes, rest homes, nursing homes, sanitariums, homes for the aged and handicapped, and orphanages. Noise, odors, electrical disturbance, radioactive particles and rays, and all other possible disturbing aspects connected with the operation of such uses shall be enclosed, screened or other wise controlled to the extent that the operation of any such use shall not unduly interfere with the use and enjoyment of properties or streets in the surrounding area. Minimum parking: one parking space for each six beds, plus one parking space for each staff or visiting doctor (based upon the average number of such doctors

at such institution at peak times), plus one parking space for each four employees in the largest shift including nurses, located on the same lot or within 300 feet walking distance.

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Richmond, Calif. (1960)

Definition:

CARE HOME: A Building, or portion thereof, wherein the owner and/or proprietor is responsible for furnishing lodging and varying amounts of custodial care to one or more, but not more than 50, persons by reason of their being elderly, handicapped, impaired or convalescing.

Care homes are divided into three types according to size, as follows:

Type A - Care home caring for a maximum of six persons.
Type B - Care home caring for from 7 to 25 persons.
Type C - Care home caring for from 26 to 50 persons.

R-1 Single-Family District: Type A is permitted use.

R-2 Multiple-Family District: Types B and C are permitted use. Planning Commission may also permit care homes as conditional uses in any district.

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Santa Rosa, Calif. (Proposed, 1961; partially adopted)

Definitions:

"BOARDING HOME FOR THE AGED" - A building, or portion thereof, wherein the owner or proprietor is licensed by the State of California and/or the County of Sonoma, to furnish lodging and varying amounts of custodial care to one (1) or more, but no more than fifty (50), persons by reason of their being elderly or handicapped, but not bedfast or mentally ill.

"NURSING HOME" - A building, or portion thereof, wherein the owner or proprietor is licensed by the State of California to furnish lodging and nursing care to one (1) or more, but not more than fifty (50), persons by reason of their being bedfast, chronically ill, handicapped, impaired or convalescing, but not mentally ill or suffering from a communicable disease.

R-1 Single-Family Residential District: Use permit required for boarding homes for the aged providing accommodations for a maximum of six (6) persons.

R-2 Two-Family Residential District: Use permit required for boarding homes for the aged and nursing homes providing accommodations for a

maximum of fifteen (15) persons.

R-3 Multiple-Family Residential District: Use permit required for boarding homes for the aged and nursing homes providing accommodations for a maximum of fifty (50) persons.

R-4 Residential-Professional Office District: Same as R-3.

R-R Rural Residential District: Same as R-2.

C Districts: Ordinance amended to remove nursing homes and boarding homes as permitted uses.

Proposed Amendment to Administrative Regulations:

Article 4. Boarding Homes for the Aged and Nursing Homes (Use Permit Required in "R" Districts)

Section 1. In "R-1" Districts, boarding homes shall not:

a) Construct exterior alterations not customary in residential buildings.

b) Erect or maintain signs or advertising of any type on the lot.

Section 2. One unlighted attached appurtenant sign, not exceeding three (3) square feet in area, may be located in conjunction with boarding and nursing homes in all districts except the "R-1" District.

Section 3. Landscaping and architectural treatment of boarding and nursing homes shall be in harmony with surrounding residential development. The building and grounds shall be maintained so as to enhance the appearance of the area in which they are located.

Section 4. Off-street parking in conjunction with boarding and nursing homes shall be provided in accordance with the following:

a) Boarding homes shall provide one (1) off-street parking space for each five (5) residents, plus one (1) off-street parking space for the owner and/or manager.

b) Nursing homes shall provide one (1) off-street parking space for each three (3) patients, plus one (1) off-street parking space for the owner and/or manager.

c) Boarding homes and nursing homes providing accommodations for more than six (6) persons shall provide a driveway for service vehicles with access to a side or rear entrance.

Section 5. Use Permits for boarding homes and nursing homes shall be granted for a period of one (1) year, at the expiration of which, they shall be reviewed by the Board of Zoning Adjustments for compliance with these conditions.

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Seattle (1961)

Definitions:

Nursing or Convalescent Home.

An establishment which provides full time convalescent or chronic care or both for three or more individuals who are not related by blood or marriage to the operator and who, by reason of chronic illness or infirmity, are unable to care for themselves, No care for the acutely ill, or surgical or obstetrical services, shall be provided in such a home; a Hospital or Sanitarium shall not be construed to be included in this definition.

Single-Family Zones: Nursing homes permitted as conditional use in single-family, low-density zone (and all R-1 zones) subject to conditions:

(h) Nursing or Convalescent Home, subject to the following conditions:

(1) Such homes shall be operated by public or non-profit charitable organizations and established and operated under standards established in accordance with State laws governing such homes.

(2) No Lot so used shall be less than forty thousand (40,000) square feet in area.

(3) No Structure so used shall be more than one Story in height.

(4) No more than twenty (20) patients shall be accommodated at one time.

(5) All Principal Buildings shall be located fifty (50) feet or more from any other Lot in an RS or RD Zone.

Duplex Residence Zone: (Separate requirements for facilities under and over twenty patients).

(c) Nursing or Canvalescent Homes, subject to the following conditions:

(1) Such homes shall be established and operated under

standards established in accordance with State laws governing such homes.

(2) No Lot so used shall be less than fifteen thousand (15,000) square feet plus one thousand (1000) square feet additional for each resident person over fifteen (15) in number.

(3) All Principal Buildings shall be located thirty (30) feet or more from any other Lot in an RS or RD Zone.

(4) No Structure so used shall be more than one Story in height.

(5) Not more than twenty **(20)** patients shall be accommodated at one time.

(6) Any other condition which the Board may impose for the protection of adjacent properties and in the public interest.

(e) Homes for the Retired and Nursing or Convalescent Homes accommodating more than twenty (20) persons in residence or patients at one time, subject to the following conditions:

(1) Such homes shall be established and operated under standards established in accordance with State laws governing such homes.

(2) No Lot so used shall be less than forty thousand (40,000) square feet in area.

(3) No Structure so used shall be greater than two Stories in height where the Lot is less than (4) acres in area.

(4) All Principal Buildings shall be located fifty (50) feet or more from any other Lot in an RS or RD Zone.

Multiple Residence Zones:

(1) Such homes shall be established and operated under standards established in accordance with State laws governing such homes.

(2) No Lot so used shall be less than ten thousand (10,000) square feet in area.

(3) All Principal Buildings shall be located fifteen (15) feet or more from any other Lot in an R Zone.

(4) No more than twenty (20) persons shall be in residence at one time.

Parking: One space for each 2 staff doctors, plus one for each 5 employees, plus one for each 6 beds.

Tacoma (1962)

Definition:

NURSING HOME: Any home, place or institution which operates or maintains facilities providing convalescent or chronic care, or both, for a period in excess of twenty-four consecutive hours for three or more patients not related by blood or marriage to the operator, who by reason of illness or infirmity, are unable properly to care for themselves. Convalescent and chronic care may include any or all procedures commonly employed in waiting on the sick, such as administration of medicines, preparation of special diets, giving of bedside nursing care, application of dressings and bandages, and carrying out of treatment prescribed by a duly licensed practioner of the healing arts. It may also include care of mentally incompetent persons if they do not require psychiatric treatment by or under the supervision of a physician who devotes all or a major portion of his time to this specialized field of medicine. Nothing in this definition shall be construed to include general hospitals or other places which provide care and treatment for the acutely ill and maintain and operate facilities for major surgery or obstetrics, or both; provided, that the mere designation by the operator of any place or institution as a hospital, sanitarium, or any other similar name, which does not provide care for the acutely ill and maintain and operate facilities for major surgery or obstetrics, or both, shall not be deemed to constitute such place or institution a hospital or sanitarium under the provisions of this chapter.

TM District (Medical Center Transitional)
(Combined with other districts with special permit procedure)

(d) Nursing homes, properly licensed by the state, county, or city, provided that the following lot area, yard setback and frontage regulations are complied with:

(1) Where not more than five persons are cared for:
Total lot area: 6,000 square feet.
Frontage: 50 feet.
Yard setback: Same as the residential district with which the TM District is combined.

(2) Where more than five but not more than ten persons are cared for:
Total lot area: 15,000 square feet.
Frontage: 75 feet.
Yard setback: Same as the residential district with which the TM District is combined.

(3) Where eleven or more persons are cared for:
Total lot area: 20,000 square feet.
Frontage: 150 feet.
Yard setback: 20 feet from all property lines.

Parking: One space per five beds.

APPENDIX C

PARKING REQUIREMENTS FOR NURSING HOMES IN SELECTED ZONING ORDINANCES

City and Population (and date of zoning ordinance)	Convalescent, Nursing and Other Health Homes and Institutions
Phoenix, Ariz. 439,170 (1961)	
Fresno, Calif. 133,929 (1960)	1/400 sq. ft. of gross floor area plus 1/3 employees
Mountain View, Calif. 30,889 (1962)	1/2 beds plus 1/employee
Santa Clara, Calif. 58,880 (1960)	1/1,000 sq. ft. of gross floor area
New Haven, Conn. 152,048 (1963)	1/6 beds plus 1/staff or visiting doctor plus 1/4 employees
Fort Lauderdale, Fla. 83,648 (1960)	1/2 beds
Cook County, Ill. 5,129,725 (1960)	1/4 beds plus 1/2 employees plus 1/staff doctor
Evanston, Ill. 79,283 (1960)	1/6 beds plus 1/4 employees plus 1/3 staff doctors
Lake County, Ill. 293,656 (1963)	1/4 patient beds plus 2/3 employees plus 1/staff doctor
Cecil County, Md. 48,408 (1962)	1/800 sq. ft. of floor area
Worcester, Mass. 186,587 (1963)	1/2 beds
Minneapolis, Minn. 482,872 (1963)	1/4 beds plus 1/2 employees plus 1/doctor
Ithaca, N. Y. 28,799 (1960)	1/2 beds
Abilene, Tex. 90,368 (1960)	1/3 beds
Seattle, Wash. 557,087 (1963)	1/6 beds plus 1/5 employees plus 1/2 staff doctors

Tacoma, Wash. 147,979 (1962)	1/5 beds
St. Clair County, Mich. (prototype 1962)	1/6 beds and 1/2 employees
Tulsa Area, Okla. (prototype 1963)	1/2 beds
Fox Valley, Wis. (prototype 1961)	1/3 beds and bassinettes plus 1/3 employees plus 1/staff doctor
Lorain County, Ohio (prototype 1960)	1/3 beds plus 1/2 employees and staff members

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