OREGON DEPARTMENT OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 54

RESIDENTIAL CARE AND ASSISTED LIVING FACILITIES

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(Effective 03/10/2025)

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RESIDENTIAL CARE AND ASSISTED LIVING FACILITIES

411-054-0000 Purpose *(Amended 06/28/2016)*

(1) The purpose of these rules is to establish standards for assisted living and residential care facilities that promote the availability of a wide range of individualized services for elderly and persons with disabilities, in a homelike environment. The standards are designed to enhance the dignity, independence, individuality, and decision making ability of the resident in a safe and secure environment while addressing the needs of the resident in a manner that supports and enables the individual to maximize abilities to function at the highest level possible.

(2) Residential care and assisted living facilities are also required to adhere to Home and Community-Based Services, OAR 411-004. For purposes of these rules, all residential care and assisted living facilities are considered home and community-based care settings and therefore shall be referred to as "facility".

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0005 Definitions *(Amended 12/24/2024)*

For the purpose of these rules, the following definitions apply:

(1) "Abuse" means abuse as defined in OAR 411-020-0002 (Adult Protective Services).

(2) "Activities of Daily Living (ADL)" mean those personal functional activities required by an individual for continued well-being, which are

essential for health and safety. Activities include eating, dressing and grooming, bathing and personal hygiene, mobility, elimination, and cognition.

(3) "Acuity-Based Staffing Tool (ABST)" means the tool described in ORS 443.432 or an acuity-based staffing tool adopted by a facility that meets requirements established by the Department in OAR 411-054-0037. An ABST is used by a facility to assess the acuity of each resident and determine the amount of staff time necessary to meet the 24-hour scheduled and unscheduled needs of each resident. Facilities may choose to use the ABST established by the Department, or use another Department-approved ABST.

(4) "ABST Care Elements" means the required individual care elements that must be addressed and documented in a resident's ABST evaluation as outlined in OAR 411-054-0037(3).

(5) "Acute Sexual Assault" means any non-consensual or unwanted sexual contact that warrants medical treatment or forensic collection.

(6) "Administrator" means the person who is designated by the licensee that is responsible for the daily operation and maintenance of the facility as described in OAR 411-054-0065.

(7) "Advance Directive" means a document that contains a health care instruction or a power of attorney for health care.

(8) "Aging and People with Disabilities (APD)" means the program area of Aging and People with Disabilities, within the Department of Human Services.

(9) "Applicant" means the individual, individuals, or entity, required to complete a facility application for license.

> (a) Except as set forth in OAR 411-054-0013(1)(b), applicant includes a sole proprietor, each partner in a partnership, and each member

with a 10 percent or more ownership interest in a limited liability company, corporation, or entity that:

(A) Owns the residential care or assisted living facility business; or

(B) Operates the residential care or assisted living facility on behalf of the facility business owner.

(b) Except as set forth in OAR 411-054-0013(1)(b), for those who serve the Medicaid population, applicant includes a sole proprietor, each partner in a partnership, and each member with a five percent or more ownership interest in a limited liability company, corporation, or entity that:

(A) Owns the residential care or assisted living facility business; or

(B) Operates the residential care or assisted living facility on behalf of the facility business owner.

(10) "Approved Dementia Training" means a dementia training curriculum approved by an entity selected by the Department to be an approving entity pursuant to a Request for Application (RFA) process.

(11) "Area Agency on Aging (AAA)" as defined in ORS 410.040 means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors or individuals with disabilities in a planning and service area. For the purpose of these rules, the term Area Agency on Aging is inclusive of both Type A and B Area Agencies on Aging that contract with the Department to perform specific activities in relation to residential care and assisted living facilities including:

(a) Conducting inspections and investigations regarding protective service, abuse, and neglect.

(b) Monitoring.

(c) Making recommendations to the Department regarding facility license approval, denial, revocation, suspension, non-renewal, and civil penalties.

(12) "Assisted Living Facility (ALF)" means a building, complex, or distinct part thereof, consisting of fully, self-contained, individual living units where six or more seniors and adult individuals with disabilities may reside in homelike surroundings**.** The assisted living facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, and independence.

(13) "Building Codes" are comprised of the set of specialty codes, including the Oregon Structural Specialty Code (OSSC), Oregon Mechanical Specialty Code (OMSC), Oregon Electrical Specialty Code (OESC), Oregon Plumbing Specialty Code (OPSC), and their reference codes and standards.

(14) "Caregiver" means a facility employee who is either direct care staff or a universal worker, who is trained in accordance with OAR 411-054-0070 to provide personal care services to residents.

(15) "Change in Use" means altering the purpose of an existing room, within the facility, that requires structural changes.

(16) "Change of Condition - Short-Term" means a change in the resident's health or functioning, that is expected to resolve or be reversed with minimal intervention, or is an established, predictable, cyclical pattern associated with a previously diagnosed condition.

(17) "Change of Condition - Significant" means a major deviation from the most recent evaluation, that may affect multiple areas of functioning or health, that is not expected to be short-term, and imposes significant risk to

the resident. Examples of significant change of condition include, but are not limited to:

(a) Broken bones.

(b) Stroke, heart attack, or other acute illness or condition onset.

(c) Unmanaged high blood sugar levels.

(d) Uncontrolled pain.

(e) Fast decline in activities of daily living.

(f) Significant unplanned weight loss.

(g) Pattern of refusing to eat.

(h) Level of consciousness change.

(i) Pressure ulcers (stage 2 or greater).

(18) "Choice" means a resident has viable options that enable the resident to exercise greater control over their life. Choice is supported by the provision of sufficient private and common space within the facility that allows residents to select where and how to spend time and receive personal assistance.

(19) "CMS" means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

(20) "Competency" means to possess specific knowledge, technical skill, and the ability to perform tasks related to the role and responsibilities of direct care staff.

(21) "Competency Assessment" means an evaluation of knowledge, technical skill and ability to carry out care pursuant to the requirements in OAR 411-054-0070. Evaluation shall include verification and

documentation of direct care staff competency through observation, written testing or verbal testing.

(22) "Condition" means a provision attached to a new or existing license that limits or restricts the scope of the license or imposes additional requirements on the licensee.

(23) “Consistently” means regularly and typically. This means occurring steadily and with regularity over a period of time.

(24) “Consumer Summary” means a summary of services provided by the facility. This statement also includes a summary of services not provided. This summary is one of the documents that must be provided to potential residents before move-in.

(25) "Conversion Facility (CF)" means a nursing facility that has followed the requirements in these rules to become a residential care facility through the conversion facility process.

(26) "Department" means the Oregon Department of Human Services (ODHS).

(27) "Designated Representative" means:

(a) Any adult, such as a parent, family member, guardian, advocate, or other person, who is:

(A) Chosen by the individual or, as applicable, the legal representative;

(B) Not a paid provider for the individual; and

(C) Authorized by the individual, or as applicable the legal representative, to serve as the representative of the individual, or as applicable the legal representative, in connection with the provision of funded supports.

(D) The power to act as a designated representative is valid until the individual modifies the authorization or notifies the agency that the designated representative is no longer authorized to act on his or her behalf.

(b) An individual or the legal representative of the individual is not required to appoint a designated representative.

(28) "Dignity" means providing support in such a way as to validate the self-worth of the individual. Dignity is supported by creating an environment that allows personal assistance to be provided in privacy and by delivering services in a manner that shows courtesy and respect.

(29) "Direct Care Staff" means a facility employee whose primary responsibility is to provide personal care services to residents.

(a) These personal care services may include:

(A) Medication administration.

(B) Individualized resident-focused activities, as outlined in a resident’s person-centered service plan.

(C) Assistance with activities of daily living.

(D) Supervision and support of residents.

(E) Serving meals, but not meal preparation.

(b) Employees such as activity staff, activity coordinators, and activity directors whose primary or sole responsibility is to provide social activities are not considered direct care staff.

(30) "Directly Supervised" means a qualified staff member maintains visual contact with the supervised staff.

(31) "Director" means the Director of the Department or that individual's designee.

(32) "Disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or man-made, that renders the licensee unable to operate the facility or makes the facility uninhabitable.

(33) "Disclosure Statement" means the written information the facility is required to provide to consumers to enhance the understanding of facility costs, services, and operations.

(34) "Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation of a state.

(35) "Exception" means a written variance granted by the Department from a regulation or provision of these rules.

(36) "Facility" means the residential care or assisted living facility licensee and the operations, policies, procedures, and employees of the residential care or assisted living facility. For purposes of HCBS, "facility" can also mean "provider".

(37) “Gender expression” means an individual’s gender-related appearance and behavior, whether or not these are stereotypically associated with the sex the individual was assigned at birth.

(38) “Gender identity” means an individual’s internal, deeply held knowledge or sense of the individual’s gender, regardless of physical appearance, surgical history, genitalia, legal sex, sex assigned at birth or name and sex as it appears in medical records or as it is described by any other individual, including a family member, conservator or legal representative of the individual. An individual’s gender identity is the last gender identity expressed by an individual who lacks the present ability to communicate.

(39) “Gender nonconforming” means having a gender expression that does not conform to stereotypical expectations of one’s gender.

(40) “Gender transition” means a process by which an individual begins to live according to that individual’s gender identity rather than the sex the person was assigned at birth. The process may or may not include changing the individual’s clothing, appearance, name or identification documents or undergoing medical treatments.

(41) “Harass” or “harassment” means to act in a manner that is unwanted, unwelcomed or uninvited, or that demeans, threatens or offends a resident.

(a) This includes bullying, denigrating or threatening a resident based on a resident’s actual or perceived status as a member of one of the protected classes in Oregon, as provided:

(A) Race.

(B) Color.

(C) National origin.

(D) Religion.

(E) Disability.

(F) Sex (includes pregnancy).

(G) Sexual orientation.

(H) Gender identity.

(I) Age.

(J) Marital status.

(b) An example of “harassment” includes, but is not limited to, requiring a resident to show identity documents in order to gain

entrance to a restroom or other area of a facility that is available to other individuals of the same gender identity as the resident.

(42) "FPS" means the Facilities, Planning, and Safety Program within the Public Health Division of the Oregon Health Authority (OHA).

(43) "HCB" means "Home and Community-Based."

(44) "HCBS" means "Home and Community-Based Services." HCBS are services provided in the home or community of an individual. ODHS, Safety, Oversight and Quality and OHA provide oversight and license, certify, and endorse programs, settings, or settings designated as HCB.

(45) “Health Care Facility” means a facility, as defined in ORS 442.015(12)(a), that provides acute care or a higher level of care to a resident according to OAR 411-054-0080.

(46) "Homelike Environment" means a living environment that creates an atmosphere supportive of the resident's preferred lifestyle. Homelike environment is also supported by the use of residential building materials and furnishings.

(47) "Hospice Program" means a coordinated program of home and inpatient care, available 24 hours a day, that utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient-family unit experiencing a life-threatening disease with a limited medical prognosis. A hospice program is an institution for purposes of ORS 146.100.

(48) "Immediate Jeopardy" means a situation where the failure of a residential care facility to comply with a Department rule has caused, or is likely to cause, a resident:

(a) Serious injury;

(b) Serious harm;

(c) Serious impairment; or

(d) Death.

(49) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interests.

(50) "Independence" means supporting resident capabilities and facilitating the use of those abilities. Creating barrier free structures and careful use of assistive devices supports independence.

(51) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.

(52) "Individual" means a person enrolled in or utilizing HCBS.

(53) "Individually-Based Limitation" means any limitation to the qualities outlined in OAR 411-004-0020 (1)(d) and (2)(d) to (2)(j), due to health and safety risks. An individually-based limitation is based on specific assessed need and only implemented with the informed consent of the individual, or as applicable, the legal representative, as described in OAR 411-004-0040.

(54) "Informed Consent" means options, risks, and benefits have been explained to an individual, and, as applicable, the legal representative of the individual, in a manner that the individual, and, as applicable, the legal representative, comprehends.

(55) "Individuality" means recognizing variability in residents' needs and preferences and having flexibility to organize services in response to different needs and preferences.

(56) "Intensive Intervention Community (IIC)" means an RCF endorsed to house fewer than six socially dependent individuals or individuals with physical disabilities. The purpose of the IIC is to serve individuals with co-occurring mental, emotional, or behavioral disturbances who are more appropriately served in smaller settings.

(57) “Involuntary Move-Out” means a move out of a resident to which the resident or the resident’s legal representative does not agree.

(58) “Language Access” means the facility must take reasonable steps to provide meaningful language access to a resident with limited English proficiency or a resident with a disability that makes it difficult to communicate using standard English.

(59) “LGBTQIA2S+” means lesbian, gay, bisexual, transgender, queer, intersex, asexual, Two Spirit, nonbinary or other minority gender identity or sexual orientation. These terms are defined below:

(a) “Lesbian” means the sexual orientation of a person who is female, feminine or nonbinary and who is physically, romantically or emotionally attracted to other women. Some lesbians may prefer to identify as gay, a gay woman, queer or in other ways.

(b) “Gay” means the sexual orientation of a person attracted to people of the same gender. Although often used as an umbrella term, it is used more specifically to describe men attracted to men.

(c) “Bisexual” means a person who has the potential to be physically, romantically and/or emotionally attracted to people of more than one gender, not necessarily at the same time, in the same way or to the same degree.

(d) “Transgender” means having a gender identity or gender expression that differs from the sex one was assigned at birth, regardless of whether one has undergone or is in the process of undergoing gender-affirming care. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

(e) “Queer” means individuals who do not identify as exclusively straight or individual who have non-binary or gender-expansive identities and is often used as a catch-all to refer to the LGBTQIA2S+ population as a whole. This term was previously used as a slur, but has been reclaimed by many parts of the LGBTQIA2S+ movement. It can also include transgender people who identify as male or female.

The term should only be used to refer to a specific person if that person self-identifies as queer.

(f) “Intersex” means someone born with a variety of differences in their sex traits and reproductive anatomy. Intersex traits greatly vary, including differences in, but limited to, hormone production and reproductive anatomy.

(g) “Asexual” or “Ace” means a complete or partial lack of sexual attraction or lack of interest in sexual activity with others. Asexuality exists on a spectrum, and asexual people may experience no, little or conditional sexual attraction. Many people who are asexual still identify with a specific romantic orientation.

(h) “2S” or “Two-Spirit” means a term used within some Indigenous communities, encompassing cultural, spiritual, sexual and gender identity. The term reflects complex indigenous understandings of gender roles, spirituality, and the long history of sexual and gender diversity in Indigenous cultures. The definition and common use of the term two-spirit may vary among Tribes and Tribal communities.

(i) The “+” means all other identities and expressions of gender, romantic and sexual orientation, including minority gender identities.

(j) “Nonbinary” means a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. Non-binary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.

(60) "Licensed Nurse" means an Oregon licensed practical or registered nurse.

(61) "Licensee" means the entity that owns the residential care or assisted living facility business, and to whom an assisted living or residential care facility license has been issued.

(62) “Licensing Complaint Unit (LCU)” means the Safety, Oversight and Quality staff who investigate allegations of licensing violations.

(63) "Legal Representative" means a person who has the legal authority to act for an individual.

(a) The legal representative only has authority to act within the scope and limits of his or her authority as designated by the court or other agreement. Legal representatives acting outside of his or her authority or scope must meet the definition of designated representative.

(b) For an individual 18 years of age and older, a guardian appointed by a court order or an agent legally designated as the health care representative, where the court order or the written designation provide authority for the appointed or designated person to make the decisions indicated where the term "legal representative" is used in this rule.

(64) "Major Alteration":

(a) Means:

(A) Any structural change to the foundation, floor, roof, exterior, or load bearing wall of a building;

(B) The addition of floor area to an existing building; or

(C) The modification of an existing building that results in a change in use where such modification affects resident services or safety.

(b) Does not include cosmetic upgrades to the interior or exterior of an existing building (for example: changes to wall finishes, floorings, or casework).

(65) "Management" or "Operator" means possessing the right to exercise operational or management control over, or directly or indirectly conduct, the day-to-day operation of a facility.

(66) "Modified Special Diet" means a diet ordered by a physician or other licensed health care professional that may be required to treat a medical condition (for example: heart disease or diabetes).

(a) Modified special diets include, but are not limited to:

(A) Small frequent meals;

(B) No added salt;

(C) Reduced or no added sugar; and

(D) Simple textural modifications.

(b) Medically complex diets are not included.

(67) "New Construction" means:

(a) A new building.

(b) An existing building or part of a building that is not currently licensed.

(c) A major alteration to an existing building.

(d) Additions, conversions, renovations, or remodeling of existing buildings.

(68) "Nursing Care" means the practice of nursing as governed by ORS chapter 678 and OAR chapter 851.

(69) "OHA" means the Oregon Health Authority.

(70) "Owner" means an individual with an ownership interest.

(71) "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of an entity.

(72) "Person-Centered Service Plan" means the details of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety, as described in OAR 411-004-0030.

(a) FOR INDIVIDUALS RECEIVING MEDICAID. The person-centered service plan coordinator completes the person-centered service plan.

(b) FOR NON-MEDICAID INDIVIDUALS. The person-centered service plan may be completed by the resident, and as applicable, the representative of the individual, and others as chosen by the individual. The licensee may assist non-Medicaid individuals in developing person-centered service plans when no alternative resources are available. The elements of the individual's person-centered service plan may be incorporated into the resident's care plan.

(73) "Person-Centered Service Plan Coordinator" means a:

(a) Resident's AAA or APD case manager assigned to provide case management services or person-centered service planning for and with individuals; or

(b) Person of the individual's choice for individuals who pay privately.

(74) "Personal Incidental Funds (PIF)" means the monthly amount allowed each Medicaid resident for personal incidental needs. For purposes of this definition, personal incidental funds include monthly payments, as allowed, and previously accumulated resident savings.

(75) “Preferred Language” means the chosen language of ~~for~~ the resident. Preferred language must be legally recognized language.

(76) "Pre-Service Training" means training that must be completed before direct care staff provide care to residents.

(77) "Primary Care Provider" means the health care provider primarily responsible for the on-going diagnosis and treatment of the resident where they currently reside.

(78) "Privacy" means a specific area or time over which the resident maintains a large degree of control. Privacy is supported with services that are delivered with respect for the resident's civil rights.

(79) "Provider" means any person or entity providing HCBS.

(80) "P.R.N." means those medications and treatments that have been ordered by a qualified practitioner to be administered as needed.

(81) "Psychotropic Medications" means any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(a) Anti-psychotic.

(b) Anti-depressant.

(c) Anti-anxiety.

(d) Hypnotic.

(82) “Qualified facility staff,” for purposes of OAR 411-054-0080, means the facility nurse, administrator, or administrator’s designee.

(83) "Quality Measurement Program" means the quality metrics program, as described in OAR 411-054-0320.

(84) "Quality Measurement Council" means a group of individuals appointed by the Governor to develop and oversee the Quality Metric Reporting Program as described in OAR 411-054-0320.

(85) "Remodel" means a renovation or conversion of a building that requires a building permit and meets the criteria for review by the Facilities Planning and Safety Program as described in OAR 333-675-0000.

(86) "Renovate" means to restore to good condition or to repair.

(87) "Residency Agreement" means the written, legally enforceable agreement between a facility and an individual, or legal representative receiving services in a residential setting. This agreement is one of the documents that must be provided to potential residents before move-in.

(88) "Resident" means any individual who is receiving room, board, care, and services on a 24-hour basis in a residential care or assisted living facility for compensation.

(89) "Resident Evaluation" means an evaluation that uses the information obtained when addressing the elements required in OAR 411-054-0034(5).

(90) "Residential Care Facility (RCF)" means a building, complex, or distinct part thereof, consisting of shared or individual living units in a homelike surrounding, where six or more seniors and adult individuals with disabilities may reside. The residential care facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, individuality, and independence.

(91) "Residential Care Facility Administrator (RCFA)" means an administrator of a residential care or assisted living facility, as defined in ORS 678.710 and licensed by the Oregon Health Licensing Office, according to OAR chapter 853. All individuals serving as administrators in residential care or assisted living facilities will be required to hold this license as of January 1, 2022.

(92) "Restraint" means:

(a) Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached to or adjacent to the individual's body that the individual cannot remove easily, which restricts freedom of movement or normal access of the individual to the individual's body. Any manual method includes physically restraining someone by manually holding someone in place.

(b) Chemical restraints are any substance or drug used for the purpose of discipline or convenience that has the effect of restricting the individual's freedom of movement or behavior and is not used to treat the individual's medical or psychiatric condition.

(93) "Retaliation" means to threaten, intimidate, or take an action that is detrimental to an individual (for example, harassment, abuse, or coercion).

(94) "Risk Agreement" means a process where a resident's high-risk behavior or choices are reviewed with the resident. Alternatives to and consequences of the behavior or choices are explained to the resident and the resident's decision to modify behavior or accept the consequences is documented.

(95) "Service Plan" means a written, individualized plan for services, developed by a service planning team and the resident or the resident's legal representative, that reflects the resident's capabilities, choices, and if applicable, measurable goals, and managed risk issues. The service plan defines the division of responsibility in the implementation of the services.

(96) "Service Planning Team" means two or more individuals, as set forth in OAR 411-054-0036, that assist the resident in determining what services and care are needed, preferred, and may be provided to the resident. For IICs, the term "interdisciplinary team" is synonymous with "service planning team."

(97) "Services" mean supervision or assistance provided in support of a resident's needs, preferences, and comfort, including health care and activities of daily living, that help develop, increase, maintain, or maximize the resident's level of independent, psychosocial, and physical functioning.

(98) “Sexual orientation” means romantic or sexual attraction, or a lack of romantic or sexual attraction, to other people.

(99) “Staffing Assessment” means a review conducted by the Department to determine if a facility is using an acuity-based staffing tool according to administrative rule.

(100) “Staffing Levels” means the number of staff required to provide the levels, intensity and qualifications of staff necessary to meet the scheduled and unscheduled needs of each resident 24 hours a day, seven days a week. Staffing levels are established by using an acuity-based staffing tool to determine the amount of time and expertise necessary to provide services to assist with activities of daily living and related tasks.

(101) “Staffing Plan” means a plan outlining the staffing levels required to meet the scheduled and unscheduled needs of all residents within a facility. Staffing plans should incorporate and be consistent with the facility’s acuity-based staffing tool data.

(102) "Subject Individual" means any individual 16 years of age or older on whom the Department may conduct a background check as defined in OAR 407-007-0210 and from whom the Department may require fingerprints for the purpose of conducting a national background check.

(a) For the purpose of these rules, subject individual includes:

(A) All applicants, licensees, and operators of a residential care or assisted living facility.

(B) All individuals employed or receiving training in an assisted living or residential care facility.

(C) Volunteers, if allowed unsupervised access to residents.

(b) For the purpose of these rules, subject individual does not apply to:

(A) Residents and visitors of residents.

(B) Individuals that provide services to residents who are employed by a private business not regulated by the Department.

(103) "Substantial Compliance" means a level of compliance with state law and rules of the Department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents of a facility.

(104) "Supportive Device" means a device that may have restraining qualities that supports and improves a resident's physical functioning.

(105) "These Rules" mean the rules in OAR chapter 411, division 054.

(106) “Transgender” means having a gender identity or gender expression that differs from the sex one was assigned at birth, regardless of whether one has undergone or is in the process of undergoing gender-affirming care. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

(107) "Underserved" means services are significantly unavailable within the service area in a comparable setting for:

(a) The general public.

(b) A specific population, for example, residents with dementia or traumatic brain injury.

(108) "Unit" means the personal and sleeping space of an individual receiving services in an RCF or ALF setting, as agreed to in the Residency Agreement.

(109) "Universal Worker" means a facility employee whose assignments include other tasks (for example, housekeeping, laundry, or food service) in

addition to providing direct resident services. Universal worker does not include administrators, clerical or administrative staff, building maintenance staff, or licensed nurses who provide services as specified in OAR 411-054-0034.

(110) "Voluntary Move-Out" means the facility and the resident, or resident's legal representative, have mutually agreed the facility can no longer meet the resident's health, behavior or care needs.

Stat. Auth.: ORS 410.070, 441.122, 443.450, 443.738
Stats. Implemented: ORS 441.111, 443.400 - 443.455, 443.738, 443.991, 678.710

411-054-0008 Licensing Moratorium *(Repealed 1/1/2009)*

411-054-0010 Licensing Standard *(Amended 9/1/2012)*

(1) No individual, entity, or governmental unit acting individually or jointly with any other individual, entity, or governmental unit may establish, maintain, conduct, or operate a residential care or assisted living facility, use the term residential care or assisted living facility, or hold itself out as being a residential care or assisted living facility or as providing residential care or assisted living services, without being duly licensed as such.

(2) Each license to operate a residential care or assisted living facility shall expire two years following the date of issuance unless revoked, suspended, terminated earlier, or issued for a shorter specified period.

(3) Each residential care and assisted living facility must be licensed, maintained, and operated as a separate and distinct facility.

(4) A license may not be required for a building, complex, or distinct part thereof, where six or more individuals reside where activities of daily living assistance and health services are not offered or provided by the facility.

(a) Facility representatives and written materials may not purport that such care and services are offered or provided by the facility.

(b) Prospective and actual tenants must have no expectations that such care and services are offered or shall be provided by the facility.

(c) The Department's Director shall determine whether a residential care or assisted living facility license is required in cases where the definition of a facility's operations is in dispute.

(5) NOT TRANSFERABLE. No residential care or assisted living facility license is transferable or applicable to any location, facility, management agent, or ownership other than that indicated on the application and license.

(6) SEPARATE BUILDINGS. Separate licenses are not required for separate buildings of the same license type located contiguously and operated as an integrated unit by the same licensee. Distinct staffing plans are required for each building.

(7) IDENTIFICATION. Every facility must have distinct identification or name and must notify the Department of any intention to change such identification.

(8) DESCRIPTIVE TITLE. A residential care or assisted living facility licensed by the Department may neither assume a descriptive title nor be held under any descriptive title other than what is permitted within the scope of its license.

(9) RESIDENT DISPLACEMENT DUE TO REMODELING. The licensee must notify the Department 90 days prior to a remodel or renovation of part of a facility if there shall be a disruption to residents in the facility (for example: residents must be temporarily moved to another room overnight). During a non-emergent remodel, if any residents need to be moved from their rooms, the residents must continue to be housed in another area of the facility and may not be moved to another care setting.

(a) NON-EMERGENT REMODEL.

(A) For a non-emergent remodel, the licensee must submit a written proposal for remodeling or renovation to the Department. The proposal must include:

(i) A specific plan as to where residents shall be housed within the existing facility. For those providers who have several buildings on the same campus, a move to a different building of the same license type within the campus setting is allowed, as long as the resident agrees to the move;

(ii) A specific plan outlining the extended details of the renovation or remodeling; and

(iii) A timeline for completion of the project. If the project is expected to take longer than three months, the licensee must provide a monthly update to the Department. The maximum time allowed for a renovation or remodel is one year from the date of the Department's approval. The Department may approve renovations that exceed one year.

(B) The licensee must give the residents written notice 60 days prior to beginning any non-emergent remodel that shall displace the residents. The notice must include:

(i) Where the residents shall be moved;

(ii) The approximate length of time of the remodel; and

(iii) Assurance that the residents shall be able to return to their own rooms when the remodel is completed, if the residents choose to do so.

(C) The licensee must submit an outline of the work to be completed, construction documents, and any necessary drawings if required by the scope of work, to the Facilities Planning and Safety Program (FPS). FPS has 15 business days for review.

(D) The licensee must comply with the rules in OAR chapter 333, division 675 (Project Plans and Construction Review) and all other structural requirements when remodeling.

(E) Nothing in this rule is intended to preclude the Department from taking other regulatory action on a violation of the licensing requirements in these rules during the time of remodeling or renovation.

(b) EMERGENT REMODEL OR CLOSURE.

(A) When an emergency or disaster requires all residents of a facility or part of a facility to be immediately evacuated while remodeling occurs, the licensee must:

(i) Provide the Department written details regarding the transfer of residents within two working days of the emergency or disaster;

(ii) Submit a plan regarding the details for remodel or if necessary, a plan for permanent closure, to the Department within two weeks;

(iii) Contact FPS to determine if drawings need to be submitted based on the scope of the remodel; and

(iv) Assure that any residents who were transferred out of the facility shall be moved back to the facility when compliance with all building requirements of these rules is met.

(B) All residents who have been transferred out of the facility must be notified in writing, at the last address known to the facility, as to when the residents shall be able to return to the facility.

(C) The facility must ensure the safe transfer of residents from and back to the facility and bear all costs of the moves.

(D) A refusal by a facility to allow a resident to return after the resident has been transferred out of the facility due to an emergent closure shall be regarded as an involuntary move out:

(i) For an involuntary move out, the facility must comply with the requirements of OAR 411-054-0080; and

(ii) The resident shall have all rights provided in OAR 411-054-0080.

(E) In the event of an emergent closure, the Department may renew the existing license for a period not to exceed two years from the renewal date.

(10) PERMANENT FACILITY CLOSURE. A facility is considered closed if the licensee is no longer providing services and the residents have moved out or must be moved from the facility.

(a) The licensee must submit a written proposal for approval to the Department 60 days prior to permanent closure. The proposal must specify the plan for safe transfer of all residents.

(b) The licensee must notify the residents at least 60 days prior to facility closure.

(c) If the facility is closed and no residents are in the facility, the facility is considered unlicensed.

(11) NOTICE OF BANKRUPTCY OR FORECLOSURE. The licensee must notify the Department in writing within 10 days after receipt of any notice of foreclosure or trustee notification of sale with respect to a real estate contract, trust deed, mortgage, or other security interest affecting the property of the licensee, as defined in OAR 411-054-0005. The written notice to the Department must include a copy of the notice provided to the licensee.

(a) The licensee must update the Department in writing not less often than every 90 days thereafter until the matter is resolved and the default has been resolved and no additional defaults have been declared or actions threatened. The update must include:

(A) The latest status on what action has been or is about to be taken by the licensee with respect to the notice received;

(B) What action is being demanded or threatened by the holder of the security interest; and

(C) Any other information reasonably requested by the Department related to maintaining resident health and safety.

(b) The licensee must update the Department upon final resolution of the matters leading up to or encompassed by the notice of foreclosure or trustee notification of sale.

(c) The licensee must notify the Department and all residents of the facility in writing immediately upon:

(A) The filing of any litigation regarding such security interest, including the filing of a bankruptcy petition by or against the licensee or an entity owning any property occupied or used by the licensee;

(B) The entry of any judgment with respect to such litigation; or

(C) The outcome of the judgment or settlement.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0012 Requirements for New Construction or Initial Licensure
(Amended 06/24/2020)

(1) An applicant requesting approval of a potential license for new construction or licensing of an existing building that is not operating as a licensed facility, must communicate with the Department before submitting a letter of intent as described in section (3) of this rule.

(2) Before beginning new construction of a building, or purchase of an existing building with intent to request a license, the applicant must provide the following information for consideration by the Department for a potential license:

(a) Demonstrate a past history, if any, of substantial compliance with all applicable state and local laws, rules, codes, ordinances, and

permit requirements in Oregon, and the ability to deliver quality services to citizens of Oregon; and

(b) Provide a letter of intent as set forth in section (3) of this rule.

(3) LETTER OF INTENT. Before applying for a building permit, a prospective applicant, with intent to build or operate a facility, must submit to the Department a letter of intent that includes the following:

(a) Identification of the potential applicant.

(b) Identification of the city and street address of the intended facility.

(c) Intended facility type (for example, RCF, ALF, IIC, or memory care), the intended number of units, and maximum resident capacity.

(d) Statement of whether the applicant is able to provide care and services for an underserved population and a description of any underserved population the applicant is able to serve.

(e) Indication of whether the applicant is able to provide services through the state medical assistance program.

(f) Identification of operations within Oregon or within other states that provide a history of the applicant's ability to serve the intended population.

(g) An independent market analysis completed by a third-party professional that meets the requirements of section (4) of this rule.

(4) Conversion Facility Letter of Intent. If a nursing facility licensee has elected to convert the license to a residential care facility through the conversion facility process, the licensee must submit a conversion facility "Letter of Intent" to the Department at least 90 days prior to the planned closure of the nursing facility. This letter must outline the:

(a) Effective date of the proposed conversion; and

(b) Licensee’s intent to follow OAR 411-085-0025(2) regarding nursing facility closure requirements.

(5) MARKET ANALYSIS. The applicant must submit a current market analysis to the Department before applying for a building permit. A market analysis is not required for CFs or change of owner applicants of existing licensed buildings. The market analysis must include:

(a) A description of the intended population to be served, including underserved populations and those eligible to receive services through the state medical assistance program, as applicable.

(b) A current demographic overview of the area to be served.

(c) A description of the area and regional economy and the effect on the market for the project.

(d) Identification of the number of individuals in the area to be served who are potential residents.

(e) A description of available amenities (for example, transportation, hospital, shopping center, or traffic conditions).

(f) A description of the extent, types, and availability of existing and proposed facilities, as described in ORS 443.400 to 443.455, located in the area to be served.

(g) The rate of occupancy, including waiting lists, for existing and recently completed developments competing for the same market segment.

(6) The Department shall issue a written decision of a potential license within 60 days of receiving all required information from the applicant.

(a) If the applicant is dissatisfied with the decision of the Department, the applicant may request a contested case hearing in writing within 14 calendar days from the date of the decision.

(b) The contested case hearing shall be in accordance with ORS chapter 183.

(7) Before issuing a license, the Department shall consider the applicant's stated intentions and compliance with the requirements of this rule and all structural and other licensing requirements as stated in these rules.

(8) BUILDING DRAWINGS. After the letter of intent has been submitted to the Department, one set of building drawings and specifications must be submitted to FPS and must comply with OAR chapter 333, division 675.

(a) Building drawings must be submitted to FPS:

(A) Before beginning construction of any new building;

(B) Before beginning construction of any addition to an existing building;

(C) Before beginning any remodeling, modification, or conversion of an existing building that requires a building permit; or

(D) After application for an initial license of a facility not previously licensed under this rule.

(b) Drawings must comply with the building codes and the Oregon Fire Code (OFC) as required for the occupancy classification and construction type.

(c) Drawings submitted for a licensed assisted living or residential facility must be prepared by and bear the stamp of an Oregon licensed architect or engineer.

(9) 60 DAYS BEFORE LICENSURE OR OPENING A CONVERSION FACILITY. At least 60 days before anticipated licensure, the applicant must submit to the Department:

(a) A completed application form with the required fee.

(b) A copy of the facility's written rental agreements.

(c) Disclosure information.

(d) Facility policies and procedures to ensure the facility's administrative staff, personnel, and resident care operations are conducted in compliance with these rules.

(10) 30 DAYS BEFORE LICENSURE. 30 days before anticipated licensure the applicant must submit:

(a) To the Department, one of the following pieces of documentation concerning the individual designated as facility administrator:

(A) Verification of a valid Residential Care Facility Administrator (RCFA) license issued by the Oregon Health Licensing Office, pursuant to OAR chapter 853.

(B) Verification of a provisional Residential Care Facility Administrator license issued by the Oregon Health Licensing Office and valid until December 31, 2021. As of January 1, 2022, the individual must have successfully obtained the RCFA license defined in paragraph (A).

(C) A completed and signed Administrator Reference Sheet that reflects the qualifications and training of the individual designated as facility administrator and a background check request. This documentation will be valid until December 31, 2021. As of January 1, 2022, the individual must have successfully obtained the RCFA license defined in paragraph (A).

(b) To FPS, a completed and signed Project Substantial Completion Notice that attests substantial completion of the building project and requests the scheduling of an onsite licensing inspection.

(11) TWO-DAYS BEFORE LICENSURE. At least two working days before the scheduled onsite licensing inspection of the facility, the applicant must submit, to the Department and FPS, a completed and signed Project Completion/Inspection Checklist that confirms the building project is complete and fully in compliance with these rules.

(a) The scheduled, onsite licensing inspection may not be conducted until the Project Completion/Inspection Checklist has been received by both FPS and the Department.

(b) The onsite licensing inspection may be rescheduled at the Department's convenience if the scheduled, onsite licensing inspection reveals the building is not in compliance with these rules as attested to on the Project Completion/Inspection Checklist.

(12) CERTIFICATE OF OCCUPANCY. The applicant must submit to the Department and FPS, a copy of the Certificate of Occupancy issued by the building codes agency having jurisdiction that indicates the intended occupancy classification and construction type.

(13) CONFIRMATION OF LICENSURE. The applicant, before admitting any resident into the facility, must receive a written confirmation of licensure issued by the Department.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0013 Application for Initial Licensure and License Renewal
(Amended 12/24/2024)

(1) APPLICATION. Applicants for initial licensure and license renewal must complete the Department’s application form. A licensing fee, as described in ORS 443.415, must be submitted to the Department.

(a) The application form must be signed by the applicant's legally authorized representative, dated, and contain all information requested by the Department.

(b) A licensing fee must be submitted to the Department. The initial licensing fee for a new building or recently purchased building is paid according to number of beds, as required by ORS 443.415:

(A) For 1 to 15 beds: application fee shall be $2,000 and the biennial renewal fee shall be $1,000.

(B) For 16 to 49 beds: application fee shall be $3,000 and the biennial renewal fee shall be $1,500.

(C) For 50 to 99 beds: application fee shall be $4,000 and the biennial renewal fee shall be $2,000.

(D) For 100 to 150 beds: application fee shall be $5,000 and the biennial renewal fee shall be $2,500.

(E) For 151 or more beds: application fee shall be $6,000 and the biennial renewal fee shall be $3,000.

(c) Applicants must provide all information and documentation as required by the Department including but not limited to identification of financial interest of any individual, including stockholders who have an incident of ownership in the applicant representing an interest of 10 percent or more. For purposes of rule, an individual with a 10 percent or more incident of ownership is presumed to have an effect on the operation of the facility with respect to factors affecting the care or training provided, unless the individual establishes the individual has no involvement in the operation of the facility. For those who serve the Medicaid population, the applicant must identify any individual with a 5 percent or more incident of ownership, regardless of the individual's effect on the operation of the facility.

(d) If the owner of the facility is a different entity from the operator or management company of the facility, both the operator and the owner must complete an application for licensure. Only one license fee is required.

(e) The application shall require the identification of any individual with a 10 percent or more incident of ownership that has ever been convicted of a crime associated with the operation of a long-term, community-based, or health care facility or agency under federal law or the laws of any state. For those who serve the Medicaid population, any individual with a 5 percent or more incident of ownership must be identified, regardless of the individual's effect on the operation of the facility.

(f) The application shall require the identification of all states where the applicant, or individual having a 10 percent or more incident of ownership in the applicant, currently or previously has been licensed as owner or operator of a long-term, community-based, or health care facility or agency under the laws of any state including any facility, currently or previously owned or operated, that had its license denied or revoked or received notice of the same under the laws of any state. For those who serve the Medicaid population, all states where the applicant or any individual having a 5 percent or more incident of ownership must be identified, regardless of the individual's effect on the operation of the facility.

(g) The Department may deny, revoke, or refuse to renew the license if the applicant fails to provide complete and accurate information on the application and the Department concludes that the missing or corrected information is needed to determine if a license shall be granted.

(h) Each application for a new license must include a completed background check request form for the applicant and for each individual with 10 percent or more incident of ownership in the applicant. For those who serve the Medicaid population, a background check request form is required for the applicant and for each individual with a 5 percent or more incident of ownership, regardless of the individual's effect on the operation of the facility.

(i) The Department may require financial information as stated in OAR 411-054-0016 (New Applicant Qualifications), when considering an applicant's request for renewal of a license.

(j) Applicants must identify the Department-approved acuity-based staffing tool the facility will implement and use as outlined in OAR 411-054-0037.

(k) Applicants must provide other information and documentation as the Department may reasonably require for the proper administration of these rules, including but not limited to information about incident of ownership and involvement in the operation of the facility or other business enterprises, as relevant.

(l) For facilities that serve the Medicaid population and are managed by a Board of Directors, the Centers for Medicare and Medicaid Services (CMS) require a social security number and date of birth for each board member.

(2) LICENSE RENEWAL. Application for a license renewal must be made at least 45 days prior to the expiration date of the existing license. Filing of an application for renewal and submission of the required non-refundable fee before the date of expiration extends the effective date of expiration until the Department acts upon such application.

(a) The Department shall refuse to renew a license if the facility is not substantially in compliance with all applicable laws and rules or if the State Fire Marshal or authorized representative has given notice of noncompliance.

(b) An applicant for license renewal must provide the Department with a completed background check request form for the applicant and for each individual with incident of ownership of 10 percent or more in the applicant when required by the Department. For those who serve the Medicaid population, a background check request form is required for the applicant and each individual with a 5 percent or more incident of ownership, regardless of the individual's effect on the operation of the facility.

(c) A building inspection may be requested at the Department's discretion. The Department may require physical improvements if the health or safety of residents is negatively impacted.

(3) DEMONSTRATED CAPABILITY.

(a) Prior to issuance of a license or a license renewal, the applicant must demonstrate to the satisfaction of the Department that the applicant can provide services in a manner consistent with the requirements of these rules.

(b) The Department may consider the background and qualifications of any individual with a 10 percent or more incident of ownership in the applicant when determining whether an applicant may be licensed. For those who serve the Medicaid population, the

background and qualifications of any individual with a 5 percent or more incident of ownership, regardless of the individual's effect on the operation of the facility, may be considered.

(c) The Department may consider the applicant's history of compliance with Department rules and orders including the history of compliance of any individual with a 10 percent or more incident of ownership in the applicant. For those who serve the Medicaid population, the history of compliance of the applicant and any individual with a 5 percent or more incident of ownership, regardless of the individual's effect on the operation of the facility, may be considered.

(4) KITCHEN INSPECTION. The Department shall annually conduct an in-person inspection of each facility’s kitchen and other places where food is prepared.

(a) During a year in which the facility is surveyed, the kitchen inspection shall be completed as part of the standard survey.

(b) During a year in which a facility is not surveyed, the kitchen inspection shall require a separate visit and inspection by the Department. The fee for this separate kitchen inspection is $200.

(c) This section (4) will not go into effect until July 1, 2022.

Stat. Auth.: ORS 410.070, 443.417, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0016 New Applicant Qualifications *(Amended 6/29/2018)*

For the purpose of this rule, "applicant" means each entity, as defined in OAR 411-054-0005, who holds 10 percent or more incident of ownership in the applicant as described in OAR 411-054-0013(1)(b). For those who serve the Medicaid population, "applicant" means each entity, as defined in OAR 411-054-0005, who holds 5 percent or more incident of ownership regardless of the individual's effect on the operation of the facility. Applicants for licensure (excluding license renewal, but including all conversion facilities, changes of ownership, management, or operator) must meet the following criteria:

(1) BACKGROUND CHECK. Each applicant may not have convictions of any of the crimes listed in OAR 407-007-0275 and must complete a background check conducted by the Department in accordance with OAR 407-007-0200 to 407-007-0370.

(2) PERFORMANCE HISTORY. The Department shall consider an applicant's performance history, including repeat sanctions or rule violations, before issuing a license.

(a) Each applicant must be free of incident of ownership history in any facility in Oregon that provides or provided (at the time of ownership) care to children, elderly, ill, or individuals with disabilities that had its license or certification involuntarily suspended or voluntarily terminated during any state or federal sanction process during the past five years.

(b) Applicants must be free of incident of ownership history in any facility in any state that had its license or certification involuntarily suspended or voluntarily terminated during any state or federal sanction process during the past five years.

(c) Failure to provide accurate information or demonstrate required performance history may result in the Department's denial of a license.

(3) FINANCIAL HISTORY. Each applicant must:

(a) Be free of incident of ownership history in any facility or business that failed to reimburse any state for Medicaid overpayments or civil penalties during the past five years.

(b) Be free of incident of ownership history in any facility or business that failed to compensate employees or pay worker's compensation, food supplies, utilities, or other costs necessary for facility operation during the past five years.

(c) Submit proof of fiscal responsibility, including an auditor's certified financial statement, and other verifiable documentary evidence of fiscal solvency documenting that the prospective licensee has

sufficient resources to operate the facility for 60 days. Proof of fiscal responsibility must include liquid assets sufficient to operate the facility for 45 days. Anticipated Medicaid income is not considered "liquid assets," but may be considered "financial resources." Liquid assets may be demonstrated by:

(A) An unencumbered line of credit;

(B) A performance bond; or

(C) Any other method satisfactory to the Department.

(d) Provide a pro forma (revenues, expenditures, and resident days) by month for the first 12 months of operation of the facility and demonstrate the ability to cover any cash flow problems identified by the pro forma.

(4) EXPERIENCE. If an applicant does not have experience in the management of assisted living or residential care facilities in Oregon, the applicant must employ the services of a consultant or management company with experience in the provision of assisted living or residential care for a period of at least six months of operation. The consultant, and the terms and length of employment, are subject to the approval of the Department.

(a) Conversion Facilities: Unless the applicant has a history of managing an ALF or RCF, a contracted consultant with experience providing residential care must be retained by a CF for six months of operation.

(b) Intensive Intervention Communities: IIC applicants must have history of an unencumbered license from the Department or have operated a specialized living contract with the Department.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0019 Change of Ownership or Management *(Amended 12/24/2024)*

(1) The licensee and the prospective licensee must each notify the Department in writing of a contemplated change in ownership or management entity. The written notification must be received at least 60 days prior to the proposed date of change.

(a) The prospective licensee or management entity must submit at least 60 days in advance of the proposed date change:

(A) A completed application form;

(B) A copy of policies, procedures, rental agreements, service plans, required disclosure information, including the Consumer Summary Statement, and identification of the Department-approved Acuity-Based Staffing Tool the facility will implement and use as outlined in OAR 411-054-0037; and

(C) A licensing fee, as described in ORS 443.415, submitted according to Department policy.

(b) The prospective licensee must notify the residents in writing 30 days in advance of a change in ownership or management entity. The notice to residents must include any changes to rates or policies.

(c) The prospective licensee or operator may not assume possession or control of the facility until the Department has notified the prospective licensee or operator that the license application has been approved.

(d) The licensee is responsible for the operation of the facility and resident services until a new license is issued to the new owner.

(2) A building inspection may be requested at the Department's discretion. The Department may require physical improvements if the health or safety of residents is negatively impacted.

(3) Resident records maintained by the licensee must be turned over to the new owner when the license application is approved, and the new licensee assumes possession or control of the facility.

(4) The new owner or licensee shall send a revised copy of the Consumer Summary Statement to the Department prior to a change of ownership or management. The revised copy must include new ownership or management information and any other amendments to the document. All Consumer Summary Statements are posted to the Department's licensing webpage.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0025 Facility Administration *(Amended 12/24/2024)*

(1) FACILITY OPERATION.

(a) The licensee is responsible for the operation of the facility and the quality of services rendered in the facility.

(b) The licensee is responsible for the supervision, training, and overall conduct of staff when staff are acting within the scope of his or her employment duties.

(c) The licensee is responsible for ensuring that the facility complies with the tuberculosis screening recommendations in OAR 333-019-0041.

(d) The licensee is responsible for obtaining background checks on all subject individuals.

(2) BACKGROUND CHECK REQUIREMENTS.

(a) Background checks must be submitted to the Department for a criminal fitness determination on all subject individuals in accordance with OAR chapter 407-007-0200 to 407-007-0370, and 407-007-0600 to 0640, including before a subject individual's change in position.

(A) On or after July 28, 2009, no individual may be a licensee, or employed in any capacity in a facility, who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(B) Subject individuals who are employees and hired before July 28, 2009 are exempt from subsection (a) of this section provided that the employee remains in the same position working for the same employer after July 28, 2009. This exemption is not applicable to licensees.

(C) Background checks are to be completed every two years on all subject individuals.

(b) PORTABILITY OF BACKGROUND CHECK APPROVAL. A subject individual may be approved to work in multiple facilities under the same operational entity. The Department's Background Check Request must be completed by the subject individual to show intent to work at various facilities.

(3) EMPLOYMENT APPLICATION. An application for employment in any capacity at a facility must include a question asking whether the applicant has been found to have committed abuse. The licensee must check all potential employees against the Oregon State Board of Nursing (Board) and inquire whether the individual is licensed or certified by the Board and whether there has been any disciplinary action by the Board against the individual or any substantiated abuse findings against a nursing assistant.

(4) Reasonable precautions must be exercised against any condition that may threaten the health, safety, or welfare of residents.

(5) REQUIRED POSTINGS. Required postings must be posted in a routinely accessible and conspicuous location to residents and visitors and must be available for inspection at all times. The licensee is responsible for posting the following:

(a) Facility license.

(b) The name of the administrator or designee in charge. The designee in charge must be posted by shift or whenever the administrator is out of the facility.

(c) The current facility staffing plan, with date(s).

(d) A copy of the most recent re-licensure survey, including all revisits and plans of correction as applicable.

(e) The Ombudsman Notification Poster.

(f) Resident Rights and Protections, as described in OAR 411-054-0027, including the LGBTQIA2S+ Rights and Protections.

(g) The LGBTQIA2S+ Nondiscrimination Notice, as described in paragraph (7)(i) of this section, must be posted in all places and on all materials where that notice or those written materials are posted.

(h) Other notices relevant to residents or visitors required by state or federal law.

(6) NOTIFICATION. The facility must notify the Department's Central Office immediately by telephone, fax, or email, (if telephone communication is used the facility must follow-up within 72 hours by written or electronic confirmation) of the following:

(a) Any change of the administrator of record through the submission of the Administrator Reference Summary (SDS 0566).

(b) Severe interruption of physical plant services where the health or safety of residents is endangered, such as the provision of heat, light, power, water, or food.

(c) Occurrence of epidemic disease in the facility. The facility must also notify the Local Public Health Authority as applicable.

(d) Facility fire or any catastrophic event that requires residents to be evacuated from the facility.

(e) Unusual resident death or suicide.

(f) A resident who has eloped from the facility and has not been found within 24 hours.

(7) POLICIES AND PROCEDURES. The facility must develop and implement written policies and procedures that promote high quality

services, health and safety for residents, and incorporate the community-based care principles of individuality, independence, dignity, privacy, choice, and a homelike environment. The facility must develop and implement:

(a) A policy on the possession of firearms and ammunition within the facility. The policy must be disclosed in writing and by one other means of communication commonly used by the resident or potential resident in his or her daily living.

(b) A written policy that prohibits sexual relations between any facility employee and a resident who did not have a pre-existing relationship.

(c) Effective methods of responding to and resolving resident complaints.

(d) All additional requirements for written policies and procedures as established in OAR 411-054-0012 (Requirements for New Construction or Initial Licensure), OAR 411-054-0040 (Change of Condition and Monitoring), OAR 411-054-0045 (Resident Health Services), and OAR 411-054-0085 (Refunds and Financial Management).

(e) A policy on smoking.

(A) The smoking policy must be in accordance with:

(i) The Oregon Indoor Clean Air Act, ORS 433.835 to 433.875;

(ii) The rules in OAR chapter 333, division 015; and

(iii) Any other applicable state and local laws.

(B) The facility may designate itself as non-smoking.

(f) A policy for the referral of residents who may be victims of acute sexual assault to the nearest trained sexual assault examiner. The policy must include information regarding the collection of medical

and forensic evidence that must be obtained within 86 hours of the incident.

(g) A policy on facility employees not receiving gifts or money from residents.

(h) Protocols for preventing and controlling infection, as described in [OAR 411-054-0050](OAR 411-054-0050).

(i) LGBTQIA2S+ Nondiscrimination Notice:

> "(Name of care facility) does not discriminate and does not permit discrimination, including but not limited to bullying, abuse or harassment, based on an individual's actual or perceived sexual orientation, gender identity, gender expression or human immunodeficiency virus status, or based on an individual's association with another individual on account of the other individual's actual or perceived sexual orientation, gender identity, gender expression or human immunodeficiency virus status. If you believe you have experienced this kind of discrimination, you may file a complaint with the Oregon Department of Human Services at (provide current contact information)."

(j) ABST Policy for accurate and consistent implementation of the ABST. The policy must explain how a facility evaluates and accounts for both scheduled and unscheduled resident needs.

(8) RECORDS. The facility must ensure the preparation, completeness, accuracy, and preservation of resident records.

(a) The facility must develop and implement a written policy that prohibits the falsification of records.

(b) Unless required or allowed by state or federal law, a facility shall not disclose any personally identifiable information regarding:

(A) A resident's sexual orientation;

(B) Whether a resident is LGBTQIA2S+;

(C) A resident's gender transition status; or

(D) A resident's human immunodeficiency virus status.

(c) The facility shall take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of information described in subsection (b) of this section to other residents, visitors or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Facilities must notify residents or resident representatives if the facility inadvertently or accidentally discloses such information to unauthorized persons.

(d) Resident records must be kept for a minimum of three years after the resident is no longer in the facility.

(e) Upon closure of a facility, the licensee must provide the Department with written notification of the location of all records.

(9) QUALITY IMPROVEMENT PROGRAM. The facility must develop and conduct an ongoing quality improvement program that evaluates services, resident outcomes, and resident satisfaction.

Stat. Auth.: ORS 181.534, 410.070, 441.122, 443.004, 443.012, 443.450
Stats. Implemented: ORS 181.534, 441.112, 441.114, 443.004, 443.400 - 443.455, 443.991

411-054-0026 Disclosure and Notification to Potential Residents
(Amended 09/25/2024)

The facility must provide the following documents to potential residents before move-in:

(1) UNIFORM DISCLOSURE STATEMENT. This is a Department-designated form (form APD 9098A) to provide to each individual who requests information about the facility.

(2) RESIDENCY AGREEMENT. This is an agreement prepared by the facility. The residency agreement must be reviewed by the Department before distribution and must include the following:

(a) Terms of occupancy, including policy on the possession of firearms and ammunition.

(b) Payment provisions including the basic rental rate and what it includes, cost of additional services, billing method, payment system and due dates, deposits, and non-refundable fees, if applicable.

(c) The method for evaluating a resident's service needs and assessing the costs for the services provided.

(d) Policy for increases, additions, or changes to the rate structure. The disclosure must address the minimum requirement of 30 days prior written notice of any facility-wide increases or changes and the requirement for immediate written notice for individual resident rate changes that occur as a result of changes in the service plan.

(e) Refund and proration conditions.

(f) A description of the scope of resident services available according to OAR 411-054-0030.

(g) A description of the service planning process.

(h) Additional available services.

(i) The philosophy of how health care and ADL services are provided to the resident.

(j) Resident rights and responsibilities.

(k) The facility's system for packaging medications including the option for residents to choose a pharmacy that meets the requirements of ORS 443.437.

(l) Criteria, actions, circumstances, or conditions that may result in a move-out notification or intra-facility move consistent with OAR 411-054-0080.

(m) Resident rights pertaining to notification of involuntary move-out.

(n) Notice that the Department has the authority to examine resident records as part of the evaluation of the facility.

(o) The facility's staffing plan.

(p) Additional elements as listed in 411-054-0027(2).

(3) CONSUMER SUMMARY STATEMENT. The facility must develop a Consumer Summary Statement specific to the facility. This form is separate from the residency agreement. For a model consumer summary that may be used as an example, please see the Department form (form APD 9098CS).

(a) Similar to the residency agreement, this summary statement must be provided to a potential resident before move-in. The consumer summary must include the following:

(A) A summary of the services provided by the facility.

(B) A summary of the services and types of care the facility does not provide.

(C) A statement that, if the facility is not capable of meeting the resident's needs for care and services, the facility may require the resident to move to another facility or care setting, in accordance with OAR 411-054-0080.

(D) A statement explaining that, if a resident leaves the facility to receive acute medical, psychiatric, nursing or other specialized care, the facility will evaluate the facility's ability to meet the resident's care needs before the resident is permitted to return to the facility, in accordance with OAR 411-054-0080(6).

(E) An explanation of the resident's right to appeal should the facility either require the resident to leave the facility, or not permit the resident to return following treatment as described in

paragraph (D). Appeal rights are explained in OAR 411-054-0080(7).

(F) A statement as to whether the facility will arrange or coordinate hospice care for a resident upon request.

(b) The information in the summary statement outlined in subsection (a) above must:

(A) Be in writing.

(B) Be written in plain English.

(C) Be explained to the individual or the person acting on behalf of the individual in a manner the individual or representative understands.

(D) Be provided separately from all other disclosure documents, such as the Uniform Disclosure Statement (APD form 9098A), and the facility's Residency Agreement.

(E) Be signed by the individual or the person acting on behalf of the individual, acknowledging that the individual or representative understands the content and implications of the information.

(c) The facility must submit an updated Consumer Summary Statement to the Department any time the facility has a management or ownership change. The Consumer Summary Statement must be submitted to the Department 60 days prior to the change of ownership or management. All Consumer Summary Statements will be posted on the Department's licensing webpage.

(4) LGBTQIA2S+ PROTECTIONS. A facility shall provide a copy of the LGBTQIA2S+ Protections as described in OAR 411-054-0027(2), and the facility's LGBTQIA2S+ Nondiscrimination Notice, as described in OAR 411-054-0025(7)(i).

(5) All disclosure information and residency agreements must be written in compliance with these rules.

(a) The facility may not include any provision in the residency agreement, summary statement or disclosure information that is in conflict with these rules and may not ask or require a resident to waive any of the resident's rights or the facility's liability for negligence.

(b) The facility must retain a copy of the original and any subsequent signed and dated residency agreements and must provide copies to the resident or to the resident's designated representative.

(c) The facility must give residents 30 days prior written notice of any additions or changes to the residency agreement. Changes to the residency agreement must be faxed, emailed, or mailed to the Department before distribution.

Stat. Auth.: ORS 410.070, 441.122
Stat. Implemented: ORS 441.112, 441.114, 443.443

411-054-0027 Resident Rights and Protections *(Amended 09/25/2024)*

(1) GENERAL RIGHTS. The facility must implement a residents' Bill of Rights. Each resident and the resident's designated representative, if appropriate, must be given a copy of the resident's rights and responsibilities before moving into the facility. The Bill of Rights must state that residents have the right:

(a) To be treated with dignity and respect.

(b) To be given informed choice and opportunity to select or refuse service and to accept responsibility for the consequences.

(c) To be given informed consent before any nontherapeutic examination, observation or treatment is provided.

(d) To participate in the development of their initial service plan and any revisions or updates at the time those changes are made.

(e) To receive information about the method for evaluating their service needs and assessing costs for the services provided.

(f) To exercise individual rights that do not infringe upon the rights or safety of others.

(g) To be free from neglect, financial exploitation, verbal, mental, physical, or sexual abuse.

(h) To receive services in a manner that protects privacy and dignity.

(i) To have prompt access to review all of their records and to purchase photocopies. Photocopied records must be promptly provided, but in no case require more than two business days (excluding Saturday, Sunday, and holidays).

(j) To have medical and other records kept confidential except as otherwise provided by law.

(k) To associate and communicate privately with any individual of choice, to send and receive personal mail unopened, and to have reasonable access to the private use of a telephone.

(l) To be free from physical restraints and inappropriate use of psychoactive medications.

(m) To manage personal financial affairs unless legally restricted.

(n) To have access to, and participate in, social activities.

(o) To be encouraged and assisted to exercise rights as a citizen.

(p) To be free of any written contract or agreement language with the facility that purports to waive their rights or the facility's liability for negligence.

(q) To voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of retaliation.

(r) To be free of retaliation after they have exercised their rights provided by law or rule.

(s) To have a safe and homelike environment.

(t) To be free of discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.

(u) To receive proper notification if requested to move-out of the facility, and to be required to move-out only for reasons stated in OAR 411-054-0080 (Involuntary Move-out Criteria) and have the opportunity for an administrative hearing, if applicable.

(2) LGBTQIA2S+ PROTECTIONS. A facility and the staff of the facility may not take any of the following actions based in whole or in part on a resident's actual or perceived sexual orientation, gender identity, gender expression or human immunodeficiency virus status:

(a) Deny admission to a facility, transfer or refuse to transfer a resident within a facility or to another facility or discharge or evict a resident from a facility;

(b) Deny a request by a resident to choose the resident's roommate, when a resident is sharing a room;

(c) Refuse to assign a room to a transgender or other LGBTQIA2S+ resident other than in accordance with the resident's gender identity, unless at the request of the resident or if required by federal law;

(d) Prohibit a resident from using, or harass a resident who seeks to use or does use, a restroom that is available to other individuals of the same gender identity as the resident, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery or presents as gender nonconforming. Harassment includes, but is not limited to, requiring a resident to show documentation of gender identity in order to gain entrance to a restroom or other area of a care facility that is available to other individuals of the same gender identity as the resident;

(e) Repeatedly and willfully refuse to use a resident's name or pronouns after being reasonably informed of the resident's name or pronouns;

(f) Deny a resident the right to wear or be dressed in clothing, accessories or cosmetics, or to engage in grooming practices, that are permitted to any other resident;

(g) Restrict a resident's right to associate with other residents or with visitors, including the resident's right to consensual sexual relations or to display physical affection, unless the restriction is uniformly applied to all residents in a nondiscriminatory manner;

(h) Deny or restrict medical or nonmedical care that is appropriate to a resident's organs and bodily needs, or provide medical or nonmedical care that, to a similarly situated, reasonable person, unduly demeans the resident's dignity or causes avoidable discomfort;

(i) Fail to accept a resident's verbal or written attestation of the resident's gender identity or require a resident to provide proof of the resident's gender identity using any form of identification;

(j) Fail to take reasonable actions, within the care facility's control, to prevent discrimination or harassment when the facility knows or should have known about the discrimination or harassment;

(k) Refuse or willfully fail to provide any service, care or reasonable accommodation to a resident; or

(l) Refuse or willfully fail to provide any service, care or reasonable accommodation to a potential resident applying for services or care.

(3) HCBS RIGHTS.

(a) Effective January 1, 2016 for providers initially licensed after January 1, 2016, and effective no later than June 30, 2019 for providers initially licensed before January 1, 2016 the following rights

must include the freedoms authorized by 42 CFR 441.301(c)(4) & 42 CFR 441.530(a)(1):

(A) Live under a legally enforceable residency agreement.

(B) The freedom and support to access food at any time.

(C) To have visitors of the resident's choosing at any time.

(D) Choose a roommate when sharing a bedroom.

(E) Furnish and decorate the resident's bedroom according to the Residency Agreement.

(F) The freedom and support to control the resident's schedule and activities.

(b) The rights described in (B) through (F) of this section must meet the requirements set forth in OAR 411-054-0038 and shall not be limited without the informed, written consent of the resident or the resident's representative, and approved by the person-centered service plan coordinator.

(4) Licensees and facility personnel may not act as a resident's guardian, conservator, trustee, or attorney-in-fact unless related by birth, marriage, or adoption to the resident, as follows, parent, child, brother, sister, grandparent, grandchild, aunt or uncle, or niece or nephew. An owner, administrator, or employee may act as a representative payee for the resident or serve in other roles as provided by law.

(5) Licensees and facility personnel may not spend resident funds without the resident's consent.

(a) If the resident is not capable of consenting, the resident's representative must give consent.

(b) If the resident has no representative and is not capable of consenting, licensees and facility personnel must follow the requirements described in OAR 411-054-0085 and may not spend

resident funds for items or services that are not for the exclusive benefit of the resident.

Stat. Auth.: ORS 410.070, 441.122, 443.450
Stats. Implemented: ORS 441.112, 441.114, 443.400 - 443.455, 443.991

411-054-0028 Reporting and Investigating Abuse and Other Actions Affecting Resident Welfare *(Amended 12/15/2021)*

(1) The facility must have policies and procedures in place to assure the prevention and appropriate response to any incident. In the case of incidents of abuse, suspected abuse, or injury of unknown cause, policies and procedures must follow the requirements outlined below. In the case of incidents that are not abuse or injuries of unknown cause where abuse has been ruled out, the facility must have policies and procedures in place to respond appropriately, which may include such things as re-assessment, monitoring, or medication review.

(2) ABUSE REPORTING. Abuse is prohibited. The facility employees, agents and licensee must not permit, aid, or engage in abuse of residents who are under their care.

(a) STAFF REPORTING. All facility employees are required to immediately report abuse and suspected abuse to the local Department office, or the local AAA, the facility administrator, or to the facility administrator's designee.

(b) FACILITY REPORTING. The facility administrator, or designee, must immediately notify the local Department office, or the local AAA, of any incident of abuse or suspected abuse, including events overheard or witnessed by observation.

(c) LAW ENFORCEMENT AGENCY. The local law enforcement agency must be called first when the suspected abuse is believed to be a crime (e.g., rape, murder, assault, burglary, kidnapping, theft of controlled substances, etc.).

(d) INJURY OF UNKNOWN CAUSE. Physical injury of unknown cause must be reported to the local Department office, or the local AAA, as suspected abuse, unless an immediate facility investigation

reasonably concludes and documents that the physical injury is not the result of abuse.

(3) FACILITY INVESTIGATION OF ABUSE OR SUSPECTED ABUSE. In addition to immediately reporting abuse or suspected abuse to the Department, AAA, or the law enforcement agency, the facility must promptly investigate all reports of abuse and suspected abuse and take measures necessary to protect residents and prevent the reoccurrence of abuse. Investigation of suspected abuse must document:

(a) Time, date, place and individuals present;

(b) Description of the event as reported;

(c) Response of staff at the time of the event;

(d) Follow-up action; and

(e) Administrator's review.

(4) IMMUNITY AND PROHIBITION OF RETALIATION.

(a) The facility shall not interfere with a good faith disclosure of information by an employee or volunteer concerning abuse or other action affecting a resident’s safety or welfare. The information that is shared may include the reporting of violations of licensing or certification requirements, criminal activity at the facility, violations of state or federal laws or any practice that threatens the health and safety of a resident of the facility to:

(A) The Long-Term Care Ombudsman, the Oregon Department of Human Services, a law enforcement agency or other entity with legal or regulatory authority over the facility; or

(B) A family member, guardian, friend or other person who is acting on behalf of the resident.

(b) Unless performed with the intent to comply with state or federal law, including but not limited to protecting residents’ rights or carrying out a facility’s policies and procedures that are consistent with state

and federal law, it is interference with the disclosure of information as described in subsection (a) if a facility:

(A) Asks or requires an employee or volunteer to sign a nondisclosure or similar agreement prohibiting the employee or volunteer from disclosing the information;

(B) Trains an employee or volunteer not to disclose the information; or

(C) Takes actions or communicates to the employee or volunteer that the employee or volunteer may not disclose the information.

(c) The facility licensee, employees and agents must not retaliate in any way against anyone who participates in the making of an abuse complaint, including but not limited to restricting otherwise lawful access to the facility or to any resident, or if an employee, dismissal or harassment.

(d) Anyone who, in good faith, reports abuse or suspected abuse shall have immunity from any liability that might otherwise be incurred or imposed with respect to the making or content of an abuse complaint.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0030 Resident Services *(Amended 06/24/2020)*

(1) The residential care or assisted living facility must provide a minimum scope of services as follows:

(a) Three daily nutritious, palatable meals with snacks available seven days a week, in accordance with the recommended dietary allowances found in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables;

(A) Modified special diets that are appropriate to residents' needs and choices. The facility must encourage residents' involvement in developing menus.

(B) Menus must be prepared at least one week in advance, and must be made available to all residents. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes.

(C) Food must be prepared and served in accordance with OAR 333-150-0000 (Food Sanitation Rules).

(b) Personal and other laundry services;

(c) A daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and creates opportunities for active participation in the community at large;

(d) Equipment, supplies and space to meet individual and group activity needs;

(e) Services to assist the resident in performing all activities of daily living, on a 24-hour basis, including:

(A) Assistance with mobility, including one-person transfers;

(B) Assistance with bathing and washing hair;

(C) Assistance with personal hygiene (e.g., shaving and caring for the mouth);

(D) Assistance with dressing and undressing;

(E) Assistance with grooming (e.g., nail care and brushing/combing hair);

(F) Assistance with eating (e.g., supervision of eating, cueing, or the use of special utensils);

(G) Assistance with toileting and bowel and bladder management;

(H) Intermittent cuing, redirecting and environmental cues for cognitively impaired residents; and

(I) Intermittent intervention, supervision and staff support for residents who exhibit behavioral symptoms.

(f) Medication administration; and

(g) Household services essential for the health and comfort of the resident that are based upon the resident's needs and preferences (e.g., floor cleaning, dusting, bed making, etc.)

(2) The facility must provide or arrange for the following:

(a) Transportation for medical and social purposes; and

(b) Ancillary services for medically related care (e.g., physician, pharmacist, therapy, podiatry, barber or beauty services, social or recreational opportunities, hospice, and home health) and other services necessary to support the resident.

(3) Upon admission of a resident, the facility shall provide the resident or the resident’s representative with information developed by the Long-Term Care Ombudsman describing the availability and services of the ombudsman. The facility shall document that the facility provided this information as required.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0034 Resident Move-In and Evaluation *(Amended 12/24/2024)*

(1) INITIAL SCREENING AND MOVE-IN.

(a) The facility must determine whether a potential resident meets the facility's admission requirements.

(b) Before the resident moving in, the facility must conduct an initial screening to determine the prospective resident's service needs and preferences. The screening must determine the ability of the facility to meet the potential resident's needs and preferences, including evaluating staff time required to meet estimated acuity needs for the resident, while considering the needs of the other residents and the facility's overall service capability.

(c) Each resident record must, before move-in and when updated, include the following information:

(A) Legal name for billing purposes.

(B) To promote person-centered care, any variance from legal records, as indicated by the resident, regarding:

(i) Name.

(ii) Pronouns.

(iii) Gender identity.

(C) Prior living arrangements;

(D) Emergency contacts;

(E) Service plan involvement - resident, family, and social supports;

(F) Financial and other legal relationships, if applicable, including, but not limited to:

(i) Advance directives;

(ii) Guardianship;

(iii) Conservatorship; and

(iv) Power of attorney.

(G) Primary language;

(H) Community connections; and

(I) Health and social service providers.

(2) RESIDENT EVALUATION - GENERAL. The resident evaluation identifies the resident's preferences, strengths, and relationships, as well as activities that are meaningful to the individual. The evaluation describes the resident's physical health status, mental status, and the environmental factors that help the individual function at their optimal level. The evaluation is the foundation that a facility uses to develop the resident's service plan. The evaluation information may be collected using tools and protocols established by the facility, but must contain the elements stated in this rule.

(a) Resident evaluations must be:

(A) Performed before the resident moves into the facility, with updates and changes as appropriate within the first 30 days; and

(B) Performed at least quarterly, to correspond with the quarterly service plan updates.

(C) Reviewed and any updates must be documented each time a resident has a significant change in condition.

(D) Done in person and the facility must gather data that is relevant to the needs and current condition of the resident.

(E) Documented, dated, and indicate who was involved in the evaluation process.

(b) 24 months of past evaluations must be kept in the resident's files in an accessible, on-site location.

(c) The facility administrator is responsible for assuring only trained and experienced staff perform resident evaluations.

(3) EVALUATION REQUIREMENTS AT MOVE-IN.

(a) The resident evaluation must be completed before the resident moves into the facility. This evaluation provides baseline information of the resident's physical and mental condition at move-in.

(b) If there is an urgent need and the evaluation is not completed before move-in, the facility must document the reasons and complete the evaluation within eight hours of move-in.

(c) The initial evaluation must contain the elements specified in section (5) of this rule and address sufficient information to develop an initial service plan to meet the resident's needs.

(d) The initial evaluation must be updated and modified as needed during the 30 days following the resident's move into the facility.

(e) After the initial 30 day move-in period, the initial evaluation must be retained in the resident's file for 24 months. Future evaluations must be separate and distinct from the initial evaluation.

(4) QUARTERLY EVALUATION REQUIREMENTS.

(a) Resident evaluations must be performed quarterly after the resident moves into the facility.

(b) The quarterly evaluation is the basis of the resident's quarterly service plan.

(c) The most recent quarterly evaluation, with documented change of condition updates, must be in the resident's current record and available to staff.

(d) If the evaluation is revised and updated at the quarterly review, changes must be dated and initialed and prior historical information must be maintained.

(5) The resident evaluation must address the following elements:

(a) For service planning purposes, if indicated by the resident,

(A) Name.

(B) Pronouns.

(C) Gender identity.

(b) Resident routines and preferences including:

(A) Customary routines, such as those related to sleeping, eating, and bathing;

(B) Interests, hobbies, and social and leisure activities;

(C) Spiritual and cultural preferences and traditions; and

(D) Additional elements as listed in OAR 411-054-0027(2).

(c) Physical health status including:

(A) List of current diagnoses;

(B) List of medications and PRN use;

(C) Visits to health practitioners, emergency room, hospital, or nursing facility in the past year; and

(D) Vital signs if indicated by diagnoses, health problems, or medications.

(d) Mental health issues including:

(A) Presence of depression, thought disorders, or behavioral or mood problems;

(B) History of treatment; and

(C) Effective non-drug interventions.

(e) Cognition, including:

(A) Memory;

(B) Orientation;

(C) Confusion; and

(D) Decision-making abilities.

(f) Personality, including how the person copes with change or challenging situations.

(g) Communication and sensory abilities including:

(A) Hearing;

(B) Vision;

(C) Speech;

(D) Use of assistive devices; and

(E) Ability to understand and be understood.

(h) Activities of daily living including:

(A) Toileting, bowel, and bladder management;

(B) Dressing, grooming, bathing, and personal hygiene;

(C) Mobility - ambulation, transfers, and assistive devices; and

(D) Eating, dental status, and assistive devices.

(i) Independent activities of daily living including:

(A) Ability to manage medications;

(B) Ability to use call system;

(C) Housework and laundry; and

(D) Transportation.

(j) Pain - pharmaceutical and non-pharmaceutical interventions, including how a person expresses pain or discomfort.

(k) Skin condition.

(l) Nutrition habits, fluid preferences, and weight if indicated.

(m) List of treatments - type, frequency, and level of assistance needed.

(n) Indicators of nursing needs, including potential for delegated nursing tasks.

(o) Review of risk indicators including:

(A) Fall risk or history;

(B) Emergency evacuation ability;

(C) Complex medication regimen;

(D) History of dehydration or unexplained weight loss or gain;

(E) Recent losses;

(F) Unsuccessful prior placements;

(G) Elopement risk or history;

(H) Smoking. The resident's ability to smoke without causing burns or injury to themselves or others or damage to property must be evaluated and addressed in the resident's service plan; and

(I) Alcohol and drug use. The resident's use of alcohol or the use of drugs not prescribed by a physician must be evaluated and addressed in the resident's service plan.

(p) Environmental factors that impact the resident's behavior including, but not limited to:

(A) Noise.

(B) Lighting.

(C) Room temperature.

(6) If the information has not changed from the previous evaluation period, the information does not need to be repeated. A dated and initialed notation of no changes is sufficient. The prior evaluation must then be kept in the current resident record for reference.

Stat. Auth.: ORS 410.070, 441.122, 443.450
Stats. Implemented: ORS 441.111, 441.114, 443.400-443.455, 443.991

411-054-0036 Service Plan – General *(Amended 12/24/2024)*

(1) If the resident has a Person-Centered Service Plan pursuant to OAR 411-004-0030, the facility must incorporate all elements identified in the person-centered service plan into the resident's service plan.

(2) SERVICE PLAN. The service plan must reflect the resident's needs as identified in the evaluation and include resident preferences that support the principles of dignity, privacy, choice, individuality, and independence.

(a) The service plan must be completed:

(A) Before resident move-in, with updates and changes as appropriate within the first 30-days; and

(B) Following quarterly evaluations.

(b) The service plan must be readily available to staff and provide clear direction regarding the delivery of services.

(c) The service plan must include a written description of who shall provide the services and what, when, how, and how often the services shall be provided.

(d) Changes and entries made to the service plan must be dated and initialed.

(e) When the resident experiences a significant change of condition the service plan must be reviewed and updated as needed.

(f) A copy of the service plan, including each update, must be offered to the resident or to the resident's legal representative.

(g) The facility administrator is responsible for ensuring the implementation of services.

(h) Review and update the resident’s ABST evaluation based on changes to the resident’s service plan, quarterly updates or a significant change of condition.

(3) SERVICE PLAN REQUIREMENTS BEFORE MOVE-IN.

(a) Based on the resident evaluation performed before move-in, an initial service plan must be developed before move-in that reflects the identified needs and preferences of the resident.

(b) The initial service plan must be reviewed within 30-days of move-in to ensure that any changes made to the plan during the initial 30-days, accurately reflect the resident's needs and preferences.

(c) Staff must document and date adjustments or changes as applicable.

(4) QUARTERLY SERVICE PLAN REQUIREMENTS.

(a) Service plans must be completed quarterly after the resident moves into the facility.

(b) The quarterly evaluation is the basis of the resident's quarterly service plan.

(c) If the resident's service plan is revised and updated at the quarterly review, changes must be dated and initialed, and prior historical information must be maintained.

(5) SERVICE PLANNING TEAM. The service plan must be developed by a Service Planning Team that consists of the resident, the resident's legal representative, if applicable, any person of the resident's choice, the facility administrator or designee and at least one other staff person who is familiar with, or who is going to provide services to the resident. Involved family members and case managers must be notified in advance of the service-planning meeting.

(a) As applicable, the Service Planning Team must also include:

(A) Local APD or AAA case managers and family invited by the resident, as available.

(B) A licensed nurse if the resident shall need, or is receiving nursing services or experiences a significant change of condition as required in OAR 411-054-0045(1)(f)(D) (Resident Health Services).

(C) The resident's physician or other health practitioner.

(b) Each resident must actively participate in the development of the service plan to the extent of the resident's ability and willingness to do so. If resident participation is not possible, documentation must reflect the facility's attempts to determine the resident's preferences.

(6) RISK AGREEMENT. When a resident's actions or choices pose a potential risk to that resident's health or well-being, the facility may utilize a risk agreement to explore alternatives and potential consequences with the resident.

(a) The facility must identify the need for and develop a written risk agreement following the facility's established guidelines and procedures. A risk agreement must include:

(A) An explanation of the cause of concern;

(B) The possible negative consequences to the resident or others;

(C) A description of the resident's preference;

(D) Possible alternatives or interventions to minimize the potential risks associated with the resident's current preferences and actions;

(E) A description of the services the facility shall provide to accommodate the residents' choice or minimize the potential risk; and

(F) The final agreement, if any, reached by all involved parties, must be included in the service plan.

(b) The licensing policy analyst must be consulted, and alternatives reviewed before the resident signs the agreement.

(c) The facility must involve the resident, the resident's designated representative, and others as indicated, to develop, implement, and review the risk agreement. The resident's preferences shall take precedence over those of a family member.

(d) A risk agreement shall not be entered into or continued with, or on behalf of, a resident who is unable to recognize the consequences of their behavior or choices.

(e) The risk agreement must be reviewed at least quarterly.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0037 Acuity-Based Staffing Tool *(Amended 12/24/2024)*

(1) DEVELOP AND MAINTAIN ACUITY-BASED STAFFING. Facilities must select and implement a Department-approved Acuity-Based Staffing Tool (ABST) for determining appropriate staffing levels. Individual resident needs and care elements must be the primary consideration when developing and maintaining an ABST. Regardless of the ABST adopted, all requirements set forth in this rule and OAR 411-054-0034 (Resident Move-in Evaluation) must be met. Facilities shall:

(a) Select and implement the Department's developed ABST or submit a proprietary ABST to the Department for approval as outlined in paragraph (2) of this rule.

(b) Accurately capture care time and care elements that staff are providing to each resident as outlined in each individual service plan. Established care time for each care element must be resident specific, rather than a predetermined average.

(c) Develop a staffing plan for each shift, that meets the scheduled and unscheduled needs of all residents.

(d) Develop ABST reports and posted staffing plans that reflect distinct and segregated areas as outlined in OAR 411-054-0070(1).

(e) If applicable, determine ABST time for residents on a Specific Needs Settings Contract and residents not on a Specific Needs Setting Contract to build posted staffing plan as outlined in this rule.

(f) Develop written policies and procedures to accurately and consistently implement the ABST. The policy must explain how a facility evaluates and accounts for both scheduled and unscheduled resident needs.

(g) Provide the relevant ABST information for a specific resident if requested by the Department, that specific resident, that specific resident's legal representative, or the Long-Term Care Ombudsman.

(2) PROPRIETARY ABST. A facility that chooses to use a proprietary ABST must implement a Department-approved ABST that meets this rule.

(a) REQUIRED ELEMENTS. The proprietary ABST the facility adopts must meet the following requirements:

(A) Facilities can group or combine ABST care elements in their ABST reports, however each resident's ABST evaluation must individually address and document all ABST care elements outlined in paragraph (3) of this rule.

(B) When calculating total time, the ABST must include the care elements for each resident and staff time needed to complete each individual care element.

(C) Ensure the ABST can produce a report that identifies all residents currently residing in the facility, the care elements for each of the residents, and the staff time required to complete the care elements for each resident.

(D) ABST total time must present in minutes per shift, per day. If the proprietary ABST does not have this functionality, at a minimum the ABST total time must present in daily minutes. If a Proprietary ABST presents total time in daily minutes the facility's ABST policy must describe how staffing per shift is determined.

(E) Identify the date the resident's ABST evaluation was last completed.

(F) If applicable, determine ABST time for both residents on a Specific Needs Contract and residents not on a Specific Needs Contract to build posted staffing plans as outlined in this rule.

(b) PROPRIETARY ABST REVIEW REQUEST. If a facility proposes to use a proprietary ABST, the facility must submit the Proprietary ABST ODHS Review Request form (se528132), including but not limited to the following:

(A) Facilities who want to implement or switch to a proprietary ABST must submit Proprietary ABST ODHS Review Request form (se528132) prior to implementation.

(B) Sample ABST report displaying the ABST care elements, and the staff time needed to complete the displayed care elements, with a total time in minutes shown per shift, per day. If the proprietary ABST only provides total time in daily minutes, the facility's ABST policy must describe how staffing per shift is determined.

(C) The facility's ABST policy required under OAR 411-054-0025(7)(i).

(c) ABST SUMMARY STATEMENT. If the proprietary review request is approved, a facility must develop and maintain an ABST Summary Statement that meets the requirements, as outlined in the Proprietary ABST ODHS Review Request form (se528132). This includes providing a general guide explaining how the ABST functions. The summary statement must be available upon request by the Department.

(d) DEPARTMENT REVIEW OF PROPOSED PROPRIETARY ABST REQUEST. The Department will review and either approve or deny the facility's proprietary ABST. The Department may request additional documentation, potentially including a virtual demonstration, to make the determination. If the ABST is deemed to

not meet this rule, the Department may deny or rescind approval at any time. The Department shall provide the facility with a written explanation of the reasons for the denial or decision to rescind approval. If a facility appeals a decision to rescind, the facility may continue to use the facility's existing proprietary ABST until a final order has been issued.

(e) APPEALS PROCESS. The Department will determine whether to approve or deny the request. If the proprietary ABST is denied or rescinded, the facility is entitled to a contested case hearing pursuant to ORS chapter 183. Prior to a contested case hearing, the facility may request an informal conference.

(f) ANNUAL STATEMENT. Once approved, the facility must provide the Department an annual statement attesting no substantive changes have occurred to the design of the facility's proprietary ABST that impacts its functionality. The facility must submit statements to the Department every year, between January 1 and March 31.

(g) If the facility makes substantive changes to the proprietary ABST design, and if those changes impact ABST functionality making the prior submitted information inaccurate or invalid, then the facility must re-submit to the Department the Proprietary ABST ODHS Review Request Form (se528132) as described in this rule for review prior to implementing the new or revised ABST.

(3) ABST CARE ELEMENTS. The required ABST care elements include activities of daily living and other tasks related to resident care and services, as outlined in OAR 411-054-0030, 411-054-0034, and 411-057-0160. If any individual care element requires more than one staff, additional time must be accounted for as described in OAR 411-054-0070(1). The ABST must individually address and document the care time required to complete each of the following individual ABST care elements:

(a) Personal hygiene.

(b) Grooming.

(c) Dressing and undressing.

(d) Toileting, bowel, and bladder management.

(e) Bathing.

(f) Transfers.

(g) Repositioning.

(h) Ambulation.

(i) Supervising, cueing, or supporting while eating.

(j) Medication administration.

(k) Providing non-drug interventions for pain management.

(l) Providing treatments.

(m) Cueing or redirecting due to cognitive impairment or dementia.

(n) Ensuring non-drug interventions for behaviors.

(o) Assisting with leisure activities, assist with social and recreational activities.

(p) Monitoring physical conditions or symptoms.

(q) Monitoring behavioral conditions or symptoms.

(r) Assisting with communication, assistive devices for hearing, vision, and speech.

(s) Responding to call lights.

(t) Safety checks, fall prevention

(u) Completing resident specific housekeeping or laundry services performed by care staff.

(v) Providing additional care services. If additional services are not provided, this element can be omitted.

(4) FREQUENCY OF UPDATES. Facilities must complete, update, review, and document the ABST evaluation for each resident according to the following schedule.

(a) Before a resident moves in.

(b) Whenever there is a significant change of condition as defined in [OAR 411-054-0040(1)(b)].

(c) No less than quarterly and corresponding with resident service plan updates, updating as required by [OAR 411-054-0034].

(5) DEVELOP AND MAINTAIN UPDATED POSTED STAFFING PLAN. Each facility should use the results of an ABST to develop and update the facility's posted staffing plan. The staffing plan must outline the staffing numbers required to meet the scheduled and unscheduled needs of all residents in the facility, for each shift. The ABST and staffing plan must be reviewed at the frequency required in paragraph (4) of this rule.

(a) The posted staffing plan must incorporate:

(A) The total ABST care time in minutes per shift, per day. If a proprietary ABST does not have this functionality, at a minimum the ABST total time must be shown in daily minutes as referenced in paragraph (2) of this rule.

(B) The unscheduled care needs of residents.

(C) The staffing requirements outlined in [OAR 411-054-0070(1)].

(D) Any other applicable factors to be considered. (e.g., disruptions to normal facility operations.)

(E) The time for paid or unpaid staff meal breaks must be accounted for and should not be included in the total scheduled staff time per shift.

(F) The facility's distinct and segregated areas as outlined in OAR 411-054-0070(1) to meet the scheduled and unscheduled needs of residents who reside in each segregated area. Each distinct and segregated area must have a posted staffing plan.

(G) The staffing needs required under the Specific Needs Contracts, if applicable.

(b) The facility must maintain staffing documentation to show consistent staffing to meet or exceed the posted staffing plan 24 hours a day, seven days a week.

(c) The facility must maintain historical posted staffing plans. The posted staffing plan must contain the date(s) it was effective. Records must be kept for a minimum of three years.

(6) CONSISTENTLY MEETING NEEDS. The facility must consistently meet the scheduled and unscheduled needs of all residents, 24 hours a day, seven days a week.

(7) ABST REPORTING OF SPECIFIC NEEDS CONTRACTS AND EXCEPTIONAL PAYMENTS. Staffing required by a Specific Needs Contract (Contract), as described in OAR chapter 411, division 027, must be included in a facility's ABST.

(a) If all residents within the facility are receiving service through a Contract:

(A) The facility's staffing plan must include the number of staff required by the Contract and additional staff time, if required to meet the scheduled and unscheduled needs of the residents.

(B) If the ABST staffing analysis indicates numbers higher than the Contract, the facility must staff to the numbers indicated by the ABST.

(b) If certain residents within the facility are served under a Contract, and other residents are not served by a Contract:

(A) The facility must maintain a posted staffing plan that includes the staffing required for residents served by the Contract as well as the staffing required for residents not served by the Contract.

(B) The facility must prepare two distinct ABST reports: one for residents served by the Contract and the other for residents not served by the Contract.

(C) If the ABST indicates higher staffing numbers than the Contract for residents who are served by the Contract, the facility must staff to numbers indicated by the ABST.

(c) If the facility has any residents funded by an exceptional payment, as provided in OAR 411-027-0050, that must be included in the ABST and the facility must staff to the greater of the numbers as indicated in the exception or the ABST.

(8) ABST DOCUMENTATION: Each facility must be able to provide the Department with the following documentation, including but not limited to:

(a) Current ABST report.

(b) ABST total staff time in minutes necessary to meet the scheduled needs of residents daily, per shift, per day. If a proprietary ABST does not have this functionality, at a minimum the ABST total time must be shown in daily minutes as referenced in paragraph (2) of this rule.

(c) The date the last ABST evaluation for each individual resident was completed.

(d) The facility's proprietary ABST Summary Statement, if applicable.

(e) The Department's ABST Proprietary Review Request form documenting the Department's approval, upon request of the Department.

(f) The staffing needs required under the Specific Needs Contracts or Exceptional Payments, if applicable.

(9) REVIEW BY DEPARTMENT.

(a) The Department is required to assess facility staffing levels each time the Department conducts a survey or an investigation into a complaint regarding:

(A) Resident abuse;

(B) Resident injury;

(C) Resident safety; or

(D) Staffing levels.

(b) The Department must confirm the facility is using a Department approved ABST that meets the requirements established in this rule. This includes verifying whether the facility is:

(A) Consistently meeting the scheduled and unscheduled needs of all residents 24 hours a day, seven days a week.

(B) Consistently updating staffing levels at the frequency required by paragraph (4) of this rule.

(C) Consistently staffing to the posted staffing plan as required by paragraph (5) of this rule.

(10) REQUIRED REGULATORY ACTION.

(a) The Department is required to take the following actions if it determines the facility:

(A) Has not selected and implemented an ABST, the Department will require the facility to adopt and implement the ODHS ABST until the facility selects and implements either the Department's ABST or a Department-approved proprietary ABST.

(B) Is not meeting the scheduled and unscheduled needs of all residents 24 hours a day, seven days a week, the Department shall place a license condition in accordance with OAR 411-054-0110(3)(a), (b), (c) or (f). The facility will be monitored for continued compliance or until the licensed condition is withdrawn.

(b) The Department may issue corrective action in accordance with OAR 411-054-0106 to compel compliance if the facility is not:

(A) Consistently staffing to the levels, intensity and qualifications indicated by the ABST.

(B) Updating the posted staffing plan to meet the scheduled and unscheduled needs of all residents.

(C) Updating the ABST for all residents at required frequencies, as outlined in paragraph (4) of this rule.

(D) Accurately capturing the care element time in the ABST based on the typical time taken to complete the task for each individual resident.

(E) Accurately capturing the care being provided by staff or outlined in the resident's personal service plan.

(F) Using a Department-approved ABST.

Stat. Auth.: ORS 410.070, 443.450, 443.738
Stats. Implemented: ORS 443.400 - 443.455, 443.738, 443.991, 678.710

411-054-0038 Individually-Based Limitations *(Amended 12/15/2017)*

This rule will begin being implemented January 1, 2017. The requirements in this rule must be in place no later than June 30, 2019.

(1) When the condition under OAR 411-004-0020(1)(d) may not be met due to a threat to the health and safety of an individual or others, an individually-based limitation process, as described in this rule, must apply in any residential or non-residential setting.

(2) When a condition under OAR 411-004-0020(2)(d) to (2)(j) may not be met due to a threat to the health and safety of an individual or others, in a provider owned, controlled, or operated residential setting, an individually-based limitation process, as described in this rule, must apply.

(3) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate individually-based limitation. The form identifies and documents, at a minimum, all of the following requirements:

(a) The specific and individualized assessed need justifying the individually-based limitation.

(b) The positive interventions and supports used prior to any individually-based limitation.

(c) Less intrusive methods that have been tried but did not work.

(d) A clear description of the limitation that is directly proportionate to the specific assessed need.

(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation.

(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually.

(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative.

(h) An assurance that the interventions and support do not cause harm to the individual.

(i) If using a restraint, a facility must meet the requirements of OAR 411-054-0060.

(4) Providers are responsible for:

(a) Maintaining a copy of the completed and signed form documenting the consent to the appropriate limitation. The form must be signed by the individual, or, if applicable, the legal representative of the individual prior to the implementation being implemented.

(b) Regular collection and review of data to measure the ongoing effectiveness of and the continued need for the individually-based limitation.

(c) Requesting a review of the individually-based limitation when a new individually-based limitation is indicated, or change or removal of an individually-based limitation is needed.

Stat. Auth.: ORS 409.050, 413.042, 413.085, 443.738

Stats. Implemented: [ORS 409.050], [413.042, 413.085], [443.738]

411-054-0040 Change of Condition and Monitoring *(Amended 12/24/2024)*

(1) CHANGE OF CONDITION. These rules define a resident's change of condition as either short term or significant with the following meanings:

(a) Short term change of condition means a change in the resident's health or functioning that is expected to resolve or be reversed with minimal intervention or is an established, predictable, cyclical pattern associated with a previously diagnosed condition.

(b) Significant change of condition means a major deviation from the most recent evaluation that may affect multiple areas of functioning or health that is not expected to be short term and imposes significant risk to the resident.

(c) If a resident experiences a significant change of condition that is a major deviation in the resident's health or functional abilities, the facility must evaluate the resident, refer to the facility nurse, document the change, and update the service plan and the ABST. The staffing plan should also be updated, as needed.

(d) If a resident experiences a short-term change of condition that is expected to resolve or reverse with minimal intervention, the facility must determine and document what action or intervention is needed for the resident.

(A) The determined action or intervention must be communicated to staff on each shift.

(B) The documentation of staff instructions or interventions must be resident specific and made part of the resident record with weekly progress noted until the condition resolves.

(2) MONITORING. The facility must have written policies to ensure a resident monitoring and reporting system is implemented 24-hours a day. The policies must specify staff responsibilities and identify criteria for

notifying the administrator, registered nurse, or healthcare provider. The facility must:

(a) Monitor each resident consistent with his or her evaluated needs and service plan;

(b) Train staff to identify changes in the resident's physical, emotional and mental functioning and document and report on the resident's changes of condition;

(c) Have a reporting protocol with access to a designated staff person, 24-hours a day, seven days a week, who can determine if a change in the resident's condition requires further action; and

(d) Provide written communication of a resident's change of condition, and any required interventions, for direct care staff on each shift.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0045 Resident Health Services *(Amended 6/29/2018)*

(1) RESIDENT HEALTH SERVICES. The facility must provide health services and have systems in place to respond to the 24-hour care needs of residents. The system must:

(a) Include written policies and procedures on medical emergency response for all shifts.

(b) Include an Oregon licensed nurse who is regularly scheduled for onsite duties at the facility and who is available for phone consultation.

(c) Assure an adequate number of nursing hours relevant to the census and acuity of the resident population. IICs must meet contract requirements concerning nursing hours.

(d) Ensure that the facility RN is notified of nursing needs as identified in OAR 411-054-0034 (Resident Move-In and Evaluation) or OAR 411-054-0036 (Service Plan – General).

(e) Define the duties, responsibilities and limitations of the facility nurse in policy and procedures, admission, and disclosure material.

(f) Licensed nurses must deliver the following nursing services:

(A) Registered nurse (RN) assessment in accordance with facility policy and resident condition. At minimum, the RN must assess all residents with a significant change of condition. The assessment may be a full or problem focused assessment as determined by the RN. A chart review or phone consultation may be performed as part of this assessment. The RN must document findings, resident status, and interventions made as a result of this assessment. The assessment must be timely, but is not required prior to emergency response in acute situations.

(B) Delegation and Teaching. Delegation and teaching must be provided and documented by a RN in accordance with the Oregon Administrative Rules adopted by the Oregon State Board of Nursing in chapter 851, division 047.

(C) Monitoring of Resident Condition. The facility must specify the role of the licensed nurse in the facility's monitoring and reporting system.

(D) Participation on Service Planning Team. If the resident experiences a significant change of condition and the service plan is updated, the licensed nurse must participate on the Service Planning Team, or must review the service plan with date and signature within 48 hours.

(E) Health Care Teaching and Counseling. A licensed nurse must provide individual and group education activities as required by individual service plans and facility policies.

(F) Intermittent Direct Nursing Services. If a resident requires nursing services that are not available through hospice, home health, a third-party referral, or the task cannot be delegated to facility staff, the facility must arrange to have such services

provided on an intermittent or temporary basis. Such services may be of a temporary nature as defined in facility policy, admission agreements and disclosure information.

(2) ON-SITE AND OFF-SITE HEALTH SERVICES. The facility must assist residents in accessing health care services and benefits to which they are entitled from outside providers. When benefits are no longer available, or if the resident is not eligible for benefits, the facility must provide or coordinate the required services, as defined in facility disclosure information, for residents whose health status is stable and predictable.

(a) On-site Health Services. The facility must coordinate on-site health services with outside service providers such as hospice, home health, or other privately paid supplemental health care providers.

(A) The facility management or licensed nurse must be notified of the services provided by the outside provider to ensure that staff are informed of new interventions, and that the service plan is adjusted if necessary, and reporting protocols are in place.

(B) The facility nurse must review the resident's health related service plan changes made as a result of the provision of on-site health services noted in section (2)(a)(A) of this rule.

(C) The facility must have policies to ensure that outside service providers leave written information in the facility that addresses the on-site services being provided to the resident and any clinical information necessary for facility staff to provide supplemental care.

(b) Off-site Health Services. The facility must coordinate off-site health services for residents who cannot or choose not to self-manage their health services.

(A) The facility must assist the resident by coordinating appointments, with outside providers, that are necessary to support the resident's health needs.

(B) Transportation for medical purposes must be arranged or provided for by the facility.

(C) Following a resident's visit to an outside medical provider, if information is obtained from said provider, it must be included in the resident's record. Adjustments to the resident's services and service plan must be made as applicable.

(D) The facility must provide relevant information to the off-site provider and must have a protocol to facilitate the receipt of information from the provider.

(c) The facility is exempt from the coordination of outside health services for residents who are capable and choose to independently arrange and manage their health care needs.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0050 Infection Prevention and Control *(Amended 03/18/2022)*

(1) Facilities must establish and maintain infection prevention and control protocols to provide a safe, sanitary and comfortable environment. This includes protocols to prevent the development and transmission of communicable diseases.

(2) Each facility must designate an individual to be the facility's "Infection Control Specialist" responsible for carrying out the infection prevention and control protocols and serving as the primary point of contact for the Department regarding disease outbreaks. The Infection Control Specialist must:

(a) Be qualified by education, training and experience or certification; and

(b) Complete specialized training in infection prevention and control protocols within three months of being designated under this paragraph, unless the designee has received the specialized training within the 24-month period prior to the time of the designation. The

Department will describe trainings that will be acceptable to meet the specialized training requirement in rule, by January 1, 2022.

(3) Each facility must establish infection prevention and control protocols and have an Infection Control Specialist, trained as required in this rule, by July 1, 2022.

(4) Facilities must comply with masking requirements as prescribed in OAR 333-019-1011 or, if applicable, OAR 437-001-0744, to control the spread of COVID-19.

(5) Facilities must comply with vaccination requirements for COVID-19 as prescribed in OAR 333-019-1010. Facilities must maintain proof of vaccination or documentation of a medical or religious exemption as required in OAR 333-019-1010(4).

Stat. Auth.: ORS 410.070, 443.004, 443.012, 443.450
Stats. Implemented: ORS 443.004, 443.400-443.455, 443.991

411-054-0055 Medications and Treatments *(Amended 09/01/19)*

(1) MEDICATION AND TREATMENT ADMINISTRATION SYSTEMS. The facility must have safe medication and treatment administration systems in place that are approved by a pharmacist consultant, registered nurse, or physician.

(a) The administrator is responsible for ensuring adequate professional oversight of the medication and treatment administration system.

(b) Medications administered by the facility must be set-up or poured and documented by the same person who administers the medications.

(c) The staff person who administers the medication must visually observe the resident take (e.g., ingest, inhale, apply) the medication unless the prescriber's order for that specific medication states otherwise.

(d) Medications must be kept secure between set-up and administration of medications.

(e) The facility must have a system approved by a pharmacist consultant or registered nurse for tracking controlled substances and for disposal of all unused, outdated or discontinued medications administered by the facility.

(f) Medication and treatment orders must be carried out as prescribed.

(g) Written, signed physician or other legally recognized practitioner orders must be documented in the resident's facility record for all medications and treatments that the facility is responsible to administer.

(h) Only a physician or other legally recognized prescribing practitioner is authorized to make changes in a medication or treatment order.

(i) A registered pharmacist or registered nurse must review all medications and treatments administered by the facility to a resident at least every 90 days. The facility must provide documentation related to the recommendations made by the reviewer.

(j) The resident or the person legally authorized to make health care decisions for the resident has the right to consent to, or refuse, medications and treatments.

(k) The physician or other practitioner must be notified if a resident refuses consent to an order. Subsequent refusals to consent to an order will be reported as requested by the prescriber.

(2) MEDICATION ADMINISTRATION. An accurate Medication Administration Record (MAR) must be kept of all medications, including over-the-counter medications that are ordered by a legally recognized prescriber and are administered by the facility.

(a) Documentation of the MAR must be completed using one of the following processes. An alternative process may be used only with a written exception from the Department.

(A) The MAR may be signed as the medications are set-up or poured. Medications must not be set-up in advance for more than one administration time. If a medicine cup or other individual container is used to set-up the medications, it must be placed in a closed compartment labeled with the resident's name. Changes to the MAR that occur after the medication is delivered, must be documented by the same staff person who administered the medication.

(B) The facility may choose to sign the MAR after the medication is administered to a specific resident and prior to the next resident-specific medication or treatment.

(b) MEDICATION RECORD. At minimum, the medication record for each resident that the facility administers medications to, must include:

(A) Current month, day and year.

(B) Name of medications, reason for use, dosage, route and date and time given.

(C) Any medication specific instructions, if applicable (e.g., significant side effects, time sensitive dosage, when to call the prescriber or nurse).

(D) Resident allergies and sensitivities, if any.

(E) Resident specific parameters and instructions for p.r.n. medications.

(F) Initials of the person administering the medication.

(3) TREATMENT ADMINISTRATION.

(a) An accurate treatment record for each resident must be kept of all treatments ordered by a legally recognized practitioner and administered by the facility to that resident.

(b) The treatment record must include:

(A) Current month, day and year.

(B) Type of treatment (e.g., dressing change, ointment application), treatment instructions and if applicable, significant side effects or when to call the prescriber or nurse.

(C) Date and time administered.

(D) Resident allergies and sensitivities, applicable to treatments.

(E) Instructions for p.r.n. treatments, including resident specific parameters.

(F) Initials of person administering the treatments.

(G) Any deviation from instructions or refusal of treatment must be documented.

(4) MEDICATION AND TREATMENT – GENERAL. The facility must maintain legible signatures of staff that administer medication*s* and treatments, either on the MAR or on a separate signature page, filed with the MAR.

(a) If the facility administers or assists a resident with medication, all medication obtained through a pharmacy must be clearly labeled with the pharmacist's label, in the original container, in accordance with the facility's established medication delivery system.

(b) The facility shall ensure that prescription drugs dispensed to residents are packaged in a manner that reduces errors in the tracking and administration of the drugs, including, but not limited to, the use of unit dose systems or blister packs.

(A) The facility shall have as its primary goal dispensing prescription drugs in unit dose systems, blister packs or similar packaging.

(B) When unit dose packaging cannot be reasonably achieved, the facility shall have a written policy describing how prescription drugs that are not prepared as unit dose or blister packs shall be dispensed. Written policies shall be in effect not later than October 1, 2018.

(C) Subsection (b) of this rule does not apply to residents receiving pharmacy benefits through the United States Department of Veterans Affairs, if the pharmacy benefits do not reimburse cost of such packaging.

(c) Over-the-counter medication or samples of medications must have the original manufacturer's labels if the facility administers or assists a resident with medication.

(d) All medications administered by the facility must be stored in locked containers in a secured environment such as a medication room or medication cart.

(e) Medications that have to be refrigerated must be stored at the appropriate temperature in a locked, secure location.

(f) Order changes obtained by telephone must be documented in the resident's record and the MAR must be updated prior to administering the new medication stated on the order. Telephone orders must be followed-up with written, signed orders.

(g) The facility must not require residents to purchase prescriptions from a pharmacy that contracts with the facility.

(5) SELF ADMINISTRATION OF MEDICATION.

(a) Residents who choose to self-administer their medications must be evaluated upon move-in and at least quarterly thereafter, to assure ability to safely self-administer medications.

(b) Residents must have a physician's or other legally recognized practitioner's written order of approval for self-administration of prescription medications.

(c) Residents able to administer their own medication regimen may keep prescription medications in their unit.

(d) If more than one resident resides in the unit, an evaluation must be made of each person and the resident's ability to safely have medications in the unit. If safety is a factor, the medications must be kept in a locked container in the unit.

(e) Unless contraindicated by a physician or resident evaluation, residents may keep and use over-the-counter medications in their unit without a written order.

(6) PSYCHOTROPIC MEDICATION. Psychotropic medications may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use.

(a) Facility administered psychotropic medications may be used only when required to treat a resident's medical symptoms or to maximize a resident's functioning.

(b) The facility must not request psychotropic medication to treat a resident's behavioral symptoms without a consultation from a physician, nurse practitioner, registered nurse, or mental health professional. This does not apply when a resident is enrolled in a hospice program as defined in OAR 333-035-0050.

(c) Prior to requesting a psychotropic medication, the facility must demonstrate through the evaluation and service planning process that non-pharmacological interventions have been attempted.

(d) Prior to administering any psychotropic medications to treat a resident's behavior, all direct care staff administering medications for the resident must know:

(A) The specific reasons for the use of the psychotropic medication for that resident.

(B) The common side effects of the medications.

(C) When to contact a health professional regarding side effects.

(e) When a psychotropic medication is ordered by a health care practitioner other than the resident's primary care provider, the facility is responsible for notifying the resident's primary care provider of that medication order within 72 hours of when the facility was notified of the order. This includes weekends and holidays. Notification may be either by telephone or electronic submission and should be documented by the facility.

(f) Medications that are administered p.r.n. that are given to treat a resident's behavior must have written, resident-specific parameters.

(A) These p.r.n. medications may be used only after documented; non-pharmacological interventions have been tried with ineffective results.

(B) All direct care staff must have knowledge of non-pharmacological interventions.

(g) Psychotropic medications must not be given to discipline a resident, or for the convenience of the facility.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0060 Restraints and Supportive Devices *(Amended 06/29/2018)*

Residential care and assisted living facilities are intended to be restraint free environments.

(1) Restraints are not permitted except when a resident's actions present an imminent danger to self or others and only until immediate action is taken by medical, emergency, or police personnel.

(2) Supportive devices with restraining qualities are permitted under the following documented circumstances, the:

(a) Resident specifically requests or approves of the device and the facility has informed the individual of the risks and benefits associated with the device;

(b) Facility registered nurse, a physical therapist or occupational therapist has conducted a thorough assessment;

(c) Facility has documented other less restrictive alternatives evaluated prior to the use of the device; and

(d) Facility has instructed direct care staff on the correct use and precautions related to use of the device.

(3) Supportive devices with restraining qualities may be utilized for residents who are unable to evaluate the risks and benefits of the device when sections (2)(b), (2)(c) and (2)(d) have been met. As of July 1, 2018, the process as identified in 411-054-0038 for Individually-Based Limitations must be followed for anything that meets the definition of restraint, including, but not limited to, supportive devices with restraining qualities.

(4) Documentation of the use of supportive devices with restraining qualities must be included in the resident service plan and evaluated on a quarterly basis.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0065 Administrator Qualifications and Requirements
(*Amended 06/24/2020)*

(1) FULL-TIME ADMINISTRATOR. Each licensed residential care and assisted living facility must employ a full-time administrator. The administrator must be scheduled to be on-site in the facility at least 40 hours per week. Each individual serving as an administrator of a residential care or assisted living facility must soon obtain an administrator’s license. This new licensing program will be phased in over a two-year period; by January 1, 2022, in order to work as an administrator, individuals must

obtain a full "Residential Care Facility Administrator" license from the Health Licensing Office, Oregon Health Authority, as required by OAR chapter 853. Until January 1, 2022, there are three different options available to administrators. These three options are outlined in sections (2), (3) and (4) below:

(2) FULL ADMINISTRATOR LICENSE.

(a) Individuals who applied to the Health Licensing Office by July 1, 2019 and met all requirements of OAR chapter 853, were issued a full residential care administrator license.

(b) At any time, individuals who apply to the Health Licensing Office and complete all requirements in OAR chapter 853, including passing the Oregon laws and rules examination, will be issued a full administrator license.

(c) By January 1, 2022, all individuals working as an administrator of a residential care or assisted living facility must have obtained this full license.

(d) All individuals holding a full administrator license must comply with the annual training requirements and the standards of practice and professional conduct established by the Long Term Care Administrators Board, as outlined in OAR chapter 853, in order to maintain this license,

(3) PROVISIONAL ADMINISTRATOR LICENSE.

(a) Individuals who applied to the Health Licensing Office by July 1, 2019 but did not meet all requirements in OAR chapter 853, were issued a provisional administrator license. This provisional license expires on December 31st, 2020. Individuals holding a provisional license are required to pass the Oregon laws and rules examination before January 1, 2022 as outlined in OAR chapter 853, in order to continue to work as an administrator.

(b) All individuals holding a provisional administrator license must comply with the annual training requirements and the standards of

practice and professional conduct established by the Long Term Care Administrators Board, as outlined in OAR chapter 853,

(4) DHS-APPROVED ADMINISTRATOR REQUIREMENTS.

(a) Individuals may continue to serve as administrators under the original Department-approved program until January 1, 2022. This Department-approved program requires potential administrators meet the following:

(A) Be at least 21 years of age:

(B) Possess a high school diploma or equivalent; and

(i) Have at least two years professional or management experience that has occurred within the last five years, in a health or social service related field or program, or have a combination of experience and education; or

(ii) Possess an accredited Bachelor's Degree in a health or social service related field.

(b) Facility administrators must meet the following training requirements before employment:

(A) Complete a Department approved classroom administrator training program of at least 40 hours;

(B) Complete a Department approved administrator training program that includes both a classroom training of less than 40 hours and a Department approved 40-hour internship program with a Department approved administrator; or

(C) Complete another Department approved administrator training program.

(c) Administrators must have 20 hours of documented Department-approved continuing education credits each year. The approved administrator training program fulfills the 20-hour continuing education requirement for the first year.

(d) Persons who have met Department approved training program requirements, but have been absent from an administrator position for five years or less, do not have to re-take the administrator training, but must provide evidence of 20 hours of annual continuing education until January 1, 2022, by which date all administrators must have obtained a residential care administrator license.

(e) Before employment as a facility administrator, persons must complete the criminal records check requirements in OAR 407-007-0200 to 407-007-0370 and comply with the tuberculosis screening recommendations in OAR 333-019-0041. An administrator of a facility may not have convictions of any of the crimes described in OAR 407-007-0275.

(f) Newly hired administrators are responsible for the completion of form SDS 0566, Administrator Reference Summary, and are required to email or fax the completed form to the Department upon hire. The Department may reject a form that has been falsified or is incomplete.

(5) DESIGNEE WHEN ADMINISTRATOR TEMPORARILY ABSENT. The administrator must appoint a staff member as designee to oversee the operation of the facility in the temporary absence of the administrator. Whomever is in charge, whether the administrator or the temporary designee, must at all times:

(a) Be in charge on-site.

(b) Ensure there are sufficient, qualified staff.

(c) Ensure the care, health, and safety needs of the residents are met.

(d) If the absence of the administrator is to exceed 30 days, the facility must notify the Department and obtain approval for arrangements prior to the absence.

(6) INTERIM ADMINISTRATOR. During times of transition, when the facility does not have a licensed or approved administrator, the facility is

responsible for providing administrator functions. In such a situation, the facility must contact the Department immediately and provide the following:

(a) Documentation of the background and qualifications of the proposed interim administrator.

(b) A completed background check request.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0070 Staffing Requirements and Training *(Amended 12/24/2024)*

(1) STAFFING REQUIREMENTS. Facilities must consistently have qualified awake direct care staff, sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident. Direct care staff provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervision, and support.

(a) If a facility employs universal workers whose duties include other tasks (e.g., housekeeping, laundry, food service), in addition to direct resident care, staffing must be increased to maintain adequate resident care and services.

(b) Prior to providing care and services to residents, direct care staff must be trained as required in sections (2) - (4) of this rule.

(c) The following facility employees are ancillary to the caregiver requirements in this section:

(A) Individuals whose duties are exclusively housekeeping, building maintenance, clerical, administrative, or food preparation.

(B) Licensed nurses who provide services as specified in OAR 411-054-0045 (Resident Health Services).

(C) Administrators.

(d) The Department retains the right to require minimum staffing standards based on acuity, complaint investigation or survey inspection.

(e) Based on resident acuity and facility structural design there must be adequate direct care staff present at all times, to meet the fire safety evacuation standards as required by the fire authority or the Department.

(f) The licensee is responsible for assuring that staffing is increased to compensate for the evaluated care and service needs of residents at move-in and for the changing physical or mental needs of the residents.

(g) A minimum of two direct care staff must be scheduled and available at all times whenever a resident requires the assistance of two direct care staff for scheduled and unscheduled needs.

(h) In facilities where residents are housed in two or more detached buildings, or if a building has distinct and segregated areas, a designated caregiver must be awake and available in each building and each segregated area at all times.

(i) Facilities must have a written, defined system to determine appropriate numbers of direct care staff and general staffing based on resident acuity and service needs. Such systems may be either manual or electronic.

(A) Guidelines for systems must also consider physical elements of a building, use of technology if applicable and staff experience.

(B) Facilities must be able to demonstrate how their staffing system works.

(j) All staff will have a written position description that specifies their specific duties and responsibilities.

(2) REQUIREMENTS APPLICABLE TO ALL TRAINING. The facility shall:

(a) Have a training program that includes methods to determine competency of direct care staff through evaluation, observation, or written testing. Facility shall also maintain documentation regarding each direct care staff's demonstrated competency.

(b) Maintain written documentation of all trainings completed by each employee.

(3) PRE-SERVICE ORIENTATION FOR ALL EMPLOYEES. Prior to beginning their job responsibilities, all employees must complete orientation training regarding:

(a) A review of their written position description with their job responsibilities.

(b) RESIDENTS' RIGHTS. Residents' rights and the values of community-based care, including the Department-approved LGBTQIA2S+ trainings.

(A) Effective December 31, 2024, all staff must have completed the required training. All new staff, hired on and after January 1, 2025, must complete the required training prior to beginning job responsibilities.

(B) The Department-approved LGBTQIA2S+ trainings shall address the elements described in paragraph (6)(b) of this rule.

(c) Abuse and reporting requirements.

(d) Fire safety and emergency procedures.

(e) INFECTIOUS DISEASE PREVENTION. Prior to beginning their job responsibilities, unless the employee received the training described below within the 24-month period prior to the time of hiring, all employees must complete training addressing the prevention, recognition, control and reporting of the spread of infectious disease.

(A) The Department, in consultation with the Oregon Health Authority, has determined this training must address the following curricula:

(i) Transmission of communicable disease and infections, including development of a policy with criteria directing staff to stay home when ill with a communicable disease, so as not to transmit disease.

(ii) Policy addressing respiratory hygiene and coughing etiquette.

(iii) Standard precautions.

(iv) Hand hygiene.

(v) Use of personal protective equipment.

(vi) Cleaning of physical environment, including, but not limited to disinfecting high-touch surfaces and equipment, and handling, storing, processing and transporting linens to prevent the spread of infection.

(vii) Isolating and cohorting of residents during a disease outbreak.

(viii) Employees must also receive training on the rights and responsibilities of employees to report disease outbreaks under ORS 433.004 and safeguards for employees who report disease outbreaks.

(B) INFECTIOUS DISEASE TRAINING CURRICULUM. Pre-service infectious disease training curriculum must be approved by the Department before facilities may offer training to staff.

(i) The pre-service training may be provided in person, in writing, by webinar or by other electronic means.

(ii) Facilities or other entities that want to provide training curriculum to facilities must first present that curriculum to the Department for review and approval.

(f) HOME AND COMMUNITY-BASED SERVICES (HCBS) TRAINING. All staff are required to complete the Department-approved HCBS training, as provided below:

(A) Effective March 31, 2024, all staff must have completed the required training.

(B) All new staff, hired on or after April 1, 2024, must complete the required training prior to beginning job responsibilities.

(g) FOOD HANDLING. If the staff member's duties include preparing food, they must have a food handler's certificate.

(4) PRE-SERVICE TRAINING FOR ALL DIRECT CARE STAFF.

(a) DEMENTIA. Prior to providing care to residents, all direct care staff must complete an approved pre-service dementia training.

(A) Documentation of dementia training:

(i) A certificate of completion shall be issued to direct care staff who satisfactorily complete approved dementia training. Facilities shall also maintain records of all direct care staff who have successfully completed pre-service dementia training.

(ii) Each facility shall maintain written documentation of continuing education completed, including required pre-service dementia training, for all direct care staff.

(B) Portability of pre-service dementia training: After completing the pre-service training, if a direct care staff person is hired within 24 months by a different facility, the hiring facility may choose to accept the previous training or require the direct care staff to complete the hiring facility's pre-service dementia training.

(C) A certificate of completion must be made available to the Department upon request.

(D) Pre-service dementia care training must include the following subject areas:

(i) Education on the dementia disease process, including the progression of the disease, memory loss, and psychiatric and behavioral symptoms.

(ii) Techniques for understanding, communicating, and responding to distressful behavioral symptoms, including, but not limited to, reducing the use of antipsychotic medications for non-standard uses.

(iii) Strategies for addressing social needs of persons with dementia and engaging them with meaningful activities.

(iv) Information concerning specific aspects of dementia care and ensuring the safety of residents with dementia, including, but not limited to, how to:

(I) Identify and address pain.

(II) Provide food and fluids.

(III) Prevent wandering and elopement.

(IV) Use a person-centered approach.

(b) ORIENTATION TO RESIDENT. Pre-service orientation to resident:

(A) Prior to providing personal care services for a resident, direct care staff must receive an orientation to the resident, including the resident's service plan.

(B) Direct care staff members must be directly supervised by a qualified person until they have successfully demonstrated

satisfactory performance in any task assigned and the provision of individualized resident services, as applicable.

(5) TRAINING WITHIN 30 DAYS OF HIRE FOR DIRECT CARE STAFF.

(a) The facility is responsible to verify that direct care staff have demonstrated satisfactory performance in any duty they are assigned.

(b) Knowledge and performance must be demonstrated in all areas within the first 30 days of hire, including, but not limited to:

(A) The role of service plans in providing individualized resident care.

(B) Providing assistance with the activities of daily living.

(C) Changes associated with normal aging.

(D) Identification of changes in the resident's physical, emotional and mental functioning and documentation and reporting on the resident's changes of condition.

(E) Conditions that require assessment, treatment, observation and reporting.

(F) General food safety, serving and sanitation.

(G) If the direct care staff person’s duties include the administration of medication or treatments, appropriate facility staff, in accordance with OAR 411-054-0055 (Medications and Treatments) must document that they have observed and evaluated the individual's ability to perform safe medication and treatment administration unsupervised.

(6) ANNUAL AND BIENNIAL INSERVICE FOR ALL STAFF.

(a) Annual infectious disease training requires the following:

(A) Administrators and employees will be required to complete annual training on infectious disease outbreak and infection control. Such training will be included within the current number of required annual training hours and will not necessitate additional hours of training.

(B) Annual in-service training must be documented in the employee record.

(b) Biennial LGBTQIA2S+ training requires the following:

(A) Administrators and employees shall be required to complete biennial training addressing LGBTQIA2S+ protections, as described in this section. The facility is responsible for the cost of providing this training to all facility staff.

(i) Each facility shall designate two employees, one who represents management and one who represents direct care staff by July 1, 2024. It is acceptable for the designated employee representing management to generally be housed offsite, but the direct care representative must be onsite.

(ii) The designated employees shall serve as points of contact for the facility regarding compliance with the preservice and biennial training requirements. These individuals shall develop a general training plan for the facility.

(B) Facilities must select the LGBTQIA2S+ training to be used by the facility by either:

(i) Choosing to use the standard Department-approved biennial LGBTQIA2S+ training, or

(ii) Applying to the Department to request approval of a biennial LGBTQIA2S+ training to be provided by the facility.

(C) ORS 441.116 requires all LGBTQIA2S+ trainings address:

(i) Caring for LGBTQIA2S+ residents and residents living with human immunodeficiency virus.

(ii) Preventing discrimination based on a resident's sexual orientation, gender identity, gender expression or human immunodeficiency virus status.

(iii) The defined terms commonly associated with LGBTQIA2S+ individuals and human immunodeficiency virus status.

(iv) Best practices for communicating with or about LGBTQIA2S+ residents and residents living with human immunodeficiency virus, including the use of an individual's chosen name and pronouns.

(v) A description of the health and social challenges historically experienced by LGBTQIA2S+ residents and residents living with human immunodeficiency virus, including discrimination when seeking or receiving care at care facilities and the demonstrated physical and mental health effects within the LGBTQIA2S+ community associated with such discrimination.

(vi) Strategies to create a safe and affirming environment for LGBTQIA2S+ residents and residents living with human immunodeficiency virus, including suggested changes to care facility policies and procedures, forms, signage, communication between residents and their families, activities, in-house services and staff training.

(vii) The facility, individual or entity providing the training must demonstrate a commitment to advancing quality care for LGBTQIA2S+ residents and residents living with human immunodeficiency virus in this state.

(D) The proposal for training submitted by a facility, entity, or individual shall include:

(i) The regulatory criteria described in paragraph (C) of this section as part of the proposal.

(ii) The following elements must be included in the proposal:

(I) A statement of the qualifications and training experience of the facility, individual or entity providing the training;

(II) The proposed methodology for providing the training either online or in person.

(III) An outline of the training.

(IV) Copies of the materials to be used in the training.

(iii) The Department will review the materials and determine whether to approve or deny the training. No later than 90 days after the request is received, the Department will inform the facility in writing of the Department's decision.

(c) Annual Home and Community-Based Services (HCBS) training requires the following:

(A) All staff will be required to complete annual training concerning the Home and Community-Based Services regulations.

(B) Annual in-service training must be documented in the employee record.

(C) These annual trainings will be required as of April 1, 2025.

(7) ANNUAL IN-SERVICE TRAINING FOR DIRECT CARE STAFF.

(a) All direct care staff must complete and document a minimum of 12 hours of in-service training annually on topics related to the provision

of care for persons in a community-based care setting, including training on chronic diseases in the facility population, LGBTQIA2S+ and dementia training. Annual in-service training hours are based on the anniversary date of hire.

(b) Requirements for annual in-service dementia training:

(A) Except as provided in paragraph (B) of this section, each direct care staff must complete 6 hours of annual in-service training on dementia care.

(B) Exception: Staff hired prior to January 1, 2019 must complete 6 hours of dementia care in-service training by the anniversary of their hire date in 2020 and annually thereafter.

(C) Dementia care training may be included in the required minimum 12 hours of annual in-service training described in subsection (a) above.

(D) Dementia care training must reflect current standards for dementia care and be informed by the best evidence in the care and treatment of dementia.

(E) The facility shall determine the competency of direct care staff in dementia care in the following ways:

(i) Utilize approved dementia care training for its direct care staff, coupled with methods to perform a competency assessment as defined in OAR 411-054-0005(19).

(ii) Ensure direct care staff have demonstrated competency in any duty they are assigned. Facility staff in a supervisory role shall perform assessment of each direct care staff.

(iii) Maintain written documentation of all dementia care training completed by each direct care staff and shall maintain documentation regarding each employee's assessed competency.

(8) APPROVAL OF DEMENTIA TRAINING CURRICULUM. All dementia care training provided to direct care staff must be approved by a private or non-profit organization that is approved by the Department through a "Request for Application" (RFA) process.

(9) ADDITIONAL REQUIREMENTS. Staff:

(a) Under 18 years of age may not perform medication administration or delegated nursing tasks. Staff under the age of 18 must be directly supervised when providing bathing, toileting, incontinence care or transferring services.

(b) Must be trained in the use of the abdominal thrust and First Aid. Cardiopulmonary resuscitation (CPR) training is recommended, but not required.

(c) Must have sufficient communication and language skills to enable them to perform their duties and communicate with residents, other staff, family members, and health care professionals, as needed.

(10) Contractors who provide services or supports directly to residents must complete the required LGBTQIA2S+ trainings outlined in paragraph (6)(b)(C) of this rule.

(a) Contractors who must be trained include, but are not limited to, RN and administrative consultants, housekeeping services, dietary services, beauticians, barbers, or other contractors who provide services or supports directly to residents.

(b) Exempt from this training requirement are contractors who contract directly with the resident or the resident's representative, and contractors who do not generally provide services or supports directly to residents, including, but not limited to, contractors for landscaping, pest control, deliveries and building repairs.

(c) By December 31, 2024, facilities shall ensure that all contracts entered into with entities described in paragraph (a) of this section shall include language requiring contractors provide Department-approved LGBTQIA2S+ training to their employees within 12 months

of entering into the contract with the facility and every two years thereafter.

(d) For existing contracts in effect January 1, 2025, facilities shall require the contractor provide Department-approved LGBTQIA2s+ training to employees by December 31, 2025, and every two years thereafter.

(e) For new contracts created after January 1, 2025, facilities shall require contractors provide the Department-approved LGBTQIA2S+ training to employees within 12 months of entering into the contract with the facility, and every two years thereafter.

(f) Facilities must inform contractors that the cost of all LGBTQIA2S+ trainings for contracted employees shall be paid by the contractor.

Stat. Auth.: ORS 410.070, 441.112, 443.450
Stats. Implemented: ORS 441.116, 443.400 - 443.455, 443.991

411-054-0080 Involuntary Move-out Criteria *(Statutory Minor Correction 03/10/2025)*

The Department of Human Services, Aging and People with Disabilities Office encourages facilities to support a resident's choice to remain in his or her living environment while recognizing that some residents may no longer be appropriate for the community-based care setting due to safety and medical limitations.

(1) Information must be specified in the facility's disclosure information OAR 411-054-0026 (Notice to Potential Residents) that describes the types of health, nursing, behavior, and care services the facility is able and unable to provide. In addition, facilities endorsed under OAR chapter 411, division 057 (Endorsed Memory Care Communities) must provide services to support residents with the progressive symptoms of dementia. Facilities will not be required to permanently provide staffing beyond the staffing services stated in the residency agreement; however, facilities may need to provide additional services to residents on a short-term basis to ensure safety of residents and to facilitate transfer to a more appropriate setting. The minimum required services identified in the following sections and

outlined in disclosure documents must be provided before a resident may be asked to move out:

(a) OAR 411-054-0070(1) (Staffing).

(b) OAR 411-054-0030 (Resident Services).

(c) OAR 411-054-0045(1)(f)(F) (Intermittent Direct Nursing Services). Such services may be of a temporary nature as defined in the facility policy, admission agreements and disclosure information. This means the facility is not required to provide services beyond the scope of the facility license or in a manner that does not support the health and safety of the resident or others in the facility.

(2) REASONS FOR INVOLUNTARY 30-DAY MOVE-OUT NOTICE. A resident may be asked to move from a facility if one or more of the following circumstances exists:

(a) The resident's needs exceed the level of ADL services the facility provides as specified in the facility's disclosure information;

(b) The resident engages in behavior or actions that repeatedly and substantially interferes with the rights, health, or safety of residents or others;

(c) The resident has a medical or nursing condition that is complex, unstable or unpredictable, and exceeds the level of health services the facility provides as specified in the facility's disclosure information;

(d) The facility is unable to accomplish resident evacuation in accordance with OAR 411-054-0090 (Fire and Life Safety);

(e) The resident exhibits behavior that poses a danger to self or others;

(f) The resident engages in illegal drug use, or commits a criminal act that causes potential harm to the resident or others; or

(g) Non-payment of charges.

(3) Prior to issuing a move-out notice, the facility shall communicate with the resident or resident's legal representative regarding the reasons for the move-out and attempt to resolve the reason for move out. The facility must document efforts to resolve the move out.

(4) PROCESS FOR ISSUING AN INVOLUNTARY 30-DAY MOVE-OUT NOTICE. Except as otherwise provided in these rules, the following apply to a 30-day move out:

(a) A facility may not require a resident to engage in an involuntary move out from the facility without first providing 30-day notice to the resident, resident's legal representative, the Office of the Long-Term Care Ombudsman, and the resident's case manager, if the resident has a case manager.

(b) Before the facility issues a 30-day notice to the resident, the resident's legal representative, the Office of the Long-Term Care Ombudsman, or the resident's case manager, the facility must first submit the written notice to the Department for review and receive a written response from the Department stating the notice and other documentation submitted by the facility complies with these rules.

(5) As part of the facility submission of the 30-day notice to the Department as described in (4), the facility must demonstrate that the facility has made all relevant, appropriate efforts to resolve the reason(s) for the requested move-out. At a minimum, the facility must provide to the Department the following written information concerning the proposed move-out:

(a) A copy of the proposed 30-Day Move-out and Administrative Hearing Request (form APD 0567 and form MSC 0443), which includes a written explanation of the reason(s) for the requested move out.

(b) The two (2) most recent service plans, showing modifications made in attempt to resolve the reason for the requested move out. The only exception to this specific requirement involves any proposed move-out due to resident non-payment issues.

(c) All relevant documentation that supports the facility's reason(s) for the proposed 30-Day Move-out Notice.

(6) After receiving the facility's documentation under (5) of this rule, the Department may request additional documentation from the facility concerning the proposed move-out. Such requested documentation may include, but is not limited to:

(a) Documentation of the facility's attempts to resolve the reason for the proposed move-out such as related progress notes, relevant Medication Administration Record(s), evaluations, clinical assessments, physician notes, and other documentation demonstrating the facility has attempted to staff resident's temporary or intermittent needs.

(b) Documentation that demonstrates the proposed move-out is consistent with the facility's:

(A) Uniform Disclosure Statement, as required by OAR 411-054-0026(1).

(B) Residency Agreement, as required by OAR 411-054-0026(2).

(C) Consumer Summary Statement, as required by OAR 411-054-0026(3).

(c) Names and contact information of additional parties or witnesses, as appropriate, to allow the Department to obtain additional facts regarding the reason for the move.

(7) After receiving all information required under (5) and requested under (6) of this rule, the Department will have two business days to review the 30-day involuntary move out notice and any related documentation and provide the facility with written notice indicating whether or not the Department has determined the facility has provided satisfactory documentation in compliance with these rules. If the Department determines sufficient documentation has not been provided, the Department will deny the move-out notice. A denial does not prohibit a facility from submitting or resubmitting a move-out notice that satisfies the criteria contained in (5) of this rule.

(8) The Department will provide written notice to the facility with a determination regarding the proposed move-out. However, if the Department determines regulatory criteria established in rule were not met, the facility may not issue the move-out notice.

(9) The facility may issue the notice if the Department has determined regulatory criteria were met; the facility must email a copy of the final version of form APD 0567 to the Department, the resident, the resident's legal representative, the resident's case manager, and the Office of the Long-Term Care Ombudsman.

(a) The 30-Day Move-Out and Hearing Notification form (form APD 0567) must include notice of both the move-out and the right to request a hearing (form MSC 0443).

(b) If the correct form, containing both notices, is not delivered to all necessary parties, the 30-Day Move-Out and Hearing Notice form is insufficient, and the timeline does not start until both notices are jointly supplied.

(10) Informal conferences and administrative hearings requested under (9) will be conducted according to (19) of this rule.

(11) LESS THAN 30-DAY MOVE-OUT NOTICE. The resident must be given 30 days advance written notice before being asked to move out or not return to the facility, except in the following unusual circumstances:

(a) A resident has been admitted or treated at a health care facility for a significant medical or psychiatric event. At the time the resident is to return to the facility, qualified facility staff have evaluated the resident's health, medical, behavioral or care needs and have determined the facility is unable to meet the resident's needs pursuant to section (1) of this rule due to the resident's significant and ongoing change of condition related to a medical or psychiatric event, whether that event was the reason for leaving the facility for treatment, or arose while the resident was being treated at the health care facility.

(A) A "significant medical or psychiatric event" is defined as a serious illness, injury, impairment, or physical or mental

condition that results in a change of condition such that the facility cannot meet the needs of the resident, and the resident requires inpatient care in a health care facility on a continuing and permanent basis.

(B) For the duration of the resident’s time in the health care facility, a facility must stay informed of the status of the resident’s health by communicating with the health care facility on a consistent, ongoing basis.

(C) When a resident has been admitted or treated at a health care facility for a significant medical or psychiatric event, once the health care facility has given notice to the facility that the resident is ready to be discharged to return to the facility, qualified facility staff shall evaluate the resident's health, medical, behavioral or care needs within a reasonable time, but no later than 24 hours after the resident has been deemed ready for discharge.

(b) The resident’s behavior places the health or safety of the resident or others in jeopardy and undue delay in moving the resident increases the risk of harm.

(12) PROCESS FOR ISSUING AN INVOLUNTARY LESS THAN 30-DAY MOVE-OUT NOTICE. A facility may not issue a move-out notice before first submitting written documentation described in (13) of this rule to the Department and then receiving written response from the Department stating the written documentation submitted by the facility is in compliance with these rules.

(13) Prior to providing notice to the resident or the resident’s legal representative, the facility must provide to the Department the following written information concerning the proposed less than 30-day move-out:

(a) A copy of the proposed Less Than 30-Day Move-out and Hearing Notice form (form APD 0568 and form MSC 0443), which includes a written explanation of the reason(s) for the requested move out.

(b) The two (2) most recent service plans, showing service plan modification, if possible.

(c) Appropriate documentation that demonstrates the efforts taken to address all service needs of the resident, including providing intermittent direct nursing services or obtaining home health, hospice, or a third-party referral, as required by rule.

(d) Documentation demonstrating compliance with 411-054-0070(1) and 411-054-0030(2)(b).

(e) Explanation of whether the facility has the ability to respond to 24-hour care needs and also assist residents to access health care services from outside vendors, as defined by 411-054-0045(1) and (2).

(f) Any and all additional documentation that supports the facility's reasons for proposing a Less Than 30-day Move-out notice.

(14) After receiving the facility's documentation under (13) of this rule, the Department may request additional documentation from the facility concerning the proposed less than 30-day move-out, as deemed necessary by the Department. Such requested documentation may include, but is not limited to:

(a) Documentation of attempts to resolve the reason for the requested move-out such as related progress notes, relevant Medication Administration Record(s), evaluations, clinical assessments, physician notes, and other documentation demonstrating the facility has attempted to staff resident's temporary or intermittent needs, as required by OAR 411-054-0045(1)(f)(F).

(b) Documentation that demonstrates the proposed move-out is consistent with the facility's:

(A) Uniform Disclosure Statement, as required by OAR 411-054-0026(1).

(B) Residency Agreement, as required by OAR 411-054-0026(2).

(C) Consumer Summary Statement, as required by OAR 411-054-0026(3).

(c) Names and contact information concerning additional parties or witnesses, as appropriate, to allow the Department to obtain additional statements or evidence regarding the reason for the move.

(15) After receiving all information required under (13) and requested under (14) of this rule, the Department will have two business days to review the involuntary move-out notice and any related documentation and provide the facility with written notice indicating whether or not the Department has determined the facility has provided documentation in compliance with these rules. If the Department determines sufficient documentation has not been provided, the Department will deny the move-out notice. A denial does not prohibit a facility from submitting or resubmitting a move-out notice that satisfies the criteria contained in (13) of this rule.

(16) The Department will provide written notice to the facility with a determination regarding the proposed move-out. If the Department determines regulatory criteria were not met, the facility may not issue the move-out notice.

(17) The facility may issue the notice if the Department has determined regulatory criteria has been met; the facility must submit the final version of form APD 0568 and form MSC 0443 to the Department, the resident, the resident's legal representative, the resident's case manager, and the Office of the Long-Term Care Ombudsman.

(a) The Less Than 30-Day Move-Out and Hearing Notice (form APD 0568) must include notice of both the move-out and the rights to request a hearing (form MSC 0443). The completed form must contain both notices and be delivered to all required parties.

(b) The facility must provide as much notice to the resident as possible but must always provide at least 24 hours.

(c) The facility must email a copy of the Less Than 30-Day Move-Out and Hearing Notice form to the Department and to the Office of the Long-Term Care Ombudsman on the same day the notice is delivered to the resident or the resident's legal representative.

(d) The facility is responsible for providing a request for hearing from the resident or the resident's legal representative, to the Department, within 24 hours of receiving it.

(18) Administrative hearings requested under (17) will be conducted according to (19) of this rule.

(19) INFORMAL CONFERENCE AND ADMINISTRATIVE HEARING. Except when a facility has had its license revoked, not renewed, voluntarily surrendered, or terminates its Medicaid contract, a resident who receives an involuntary move-out notice is entitled to an administrative hearing, provided the resident or resident's designee requests an administrative hearing in a timely manner.

(a) A resident who receives a Move-Out and Hearing Notice can request a formal administrative hearing:

(A) Residents have the following deadlines for requesting an administrative hearing after receipt of the notice:

(i) Within ten (10) business days, for a 30-day notice.

(ii) Within five (5) business days, for a less than 30-day notice.

(B) If a resident wants to preserve the right to an administrative hearing, the resident, the resident's legal representative, or the Long Term Care Ombudsman may check the appropriate box on the Move-Out and Hearing Notice (form APD 0567 and form MSC 0443), and return the notice to the facility. Residents may also exercise their administrative hearing rights by informing the facility, verbally or in writing, of the request for an administrative hearing.

(C) If the resident or resident's legal representative informs the facility of the request for a hearing, the facility must immediately notify the Department.

(D) In cases involving a less than 30-day notice or where the resident is incapacitated and does not have a legal representative, the Office of the Long-Term Care Ombudsman is allowed to provide notice to the Department on behalf of the resident, requesting an administrative hearing.

(E) The resident, resident's legal representative, the Long Term Care Ombudsman, or the facility may request the Department facilitate an informal conference before the administrative hearing, to discuss the move-out.

(F) The Department may extend the time allowed requesting an informal conference or administrative hearing if the Department determines that good cause exists for failure to make a timely request.

(G) The Department shall immediately notify the Office of Administrative Hearings of the request for a formal administrative hearing and, for a less than 30-day move-out, shall request an expedited hearing be held within 5 business days.

(H) The Department may decide to hold an informal conference to resolve the matter without a formal administrative hearing. The Department shall notify all appropriate parties of the informal conference and shall facilitate the conference.

(I) If the Department decides to hold an informal conference, the conference shall be scheduled to be held:

> (i) Within ten (10) business days of the Department receiving the request for hearing, for a 30 day move-out.
>
> (ii) Within four (4) business days of the Department receiving the request for hearing, for a less than 30-day move-out.

(J) No formal administrative hearing shall be held if the resident is satisfied with the outcome of the informal conference.

(b) The resident who has received a Less Than 30-Day Move-Out Notice will be allowed to continue to reside in the facility until the hearing process is completed unless substantial evidence is provided by the facility to the Department documenting that the change of behavior or medical condition of the resident creates a serious and immediate threat to the resident, other residents, or staff and all reasonable alternatives to move-out (consistent with the orders of the attending physician or primary care provider) have been attempted and documented in the resident's medical record.

(A) When a hearing has been requested, the Department shall request the Office of Administrative Hearings hold an expedited administrative hearing within five (5) business days.

(B) When a hearing has been requested, but the resident has been moved out of the facility, the facility must hold the resident's room, without charge for room and board or services, pending resolution of the administrative hearing. The facility may not rent the resident's unit pending resolution of the administrative hearing.

(20) A resident who was admitted January 1, 2006 or later may be moved without advance notice if all of the following are met:

(a) The facility was not notified before admission that the resident is on probation, parole, or post-prison supervision after being convicted of a sex crime.

(b) The facility learns the resident is on probation, parole, or post-prison supervision after being convicted of a sex crime.

(c) The resident presents a current risk of harm to another resident, staff, or visitor in the facility, as evidenced by:

(A) Current or recent sexual inappropriateness, aggressive behavior of a sexual nature, or verbal threats of a sexual nature; or

(B) Current communication from the State Board of Parole and Post-Prison Supervision, Department of Corrections, or

community corrections agency parole or probation officer that the individual's Static 99 score or other assessment indicates a probable sexual re-offense risk to others in the facility.

(d) Before the move, the facility must contact the Department's central office in Salem by telephone and review the criteria in sections (11), (12) and (13) of this rule. The Department shall respond within one working day of contact by the facility. The Department of Corrections parole or probation officer must be included in the review, if available. The Department shall advise the facility if rule criteria for immediate move-out are not met. DHS shall assist in locating placement options.

(e) A written move-out notice must be completed on form SDS 0568A. The form must be filled out in its entirety and a copy of the notice delivered in person, to the resident, or the resident's legal representative, if applicable. Where a person lacks capacity and there is no legal representative, a copy of the notice to move-out shall be immediately faxed or emailed to the State Long Term Care Ombudsman.

(f) Before the move, the facility shall orally review the notice and right to object with the resident or legal representative and determine if a hearing is requested. A request for hearing does not delay the involuntary move-out. The facility shall immediately telephone the Department's central office in Salem when a hearing is requested. The hearing shall be held within five business days of the resident's move. No informal conference shall be held before the hearing.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0085 Refunds and Financial Management *(Amended 9/1/2012)*

(1) RESIDENT DEATH. If a resident dies, the licensee may not require payment for more than 15 days, or the time specified in the admission agreement, whichever is less, after the date of the resident’s death.

(2) RESIDENT UNABLE TO RETURN. If a resident must leave the facility for medical reasons and the resident or the resident's representative

indicates the intent not to return, the facility may not charge the resident for more than 15 days after the date notification is received from the resident or the resident's representative, or the time specified in the admission agreement, whichever is less.

(a) If the resident’s personal belongings are not removed from the facility within the 15-day timeframe, the facility may charge the resident as specified in the admission agreement. However, the facility may not charge for more than 30 days after receiving notification that the resident is unable to return.

(b) A reasonable storage fee may be charged for storage of the resident’s belongings beyond 30 days if the admission agreement includes fees for storage.

(3) SUBSTANTIATED ABUSE. If a resident dies or leaves a facility due to substantiated neglect, substantiated abuse, or due to conditions of imminent danger of life, health, or safety, as substantiated by the Department, the facility may not charge the resident beyond the resident's last day in the facility.

(4) INVOLUNTARY MOVE-OUT. If the facility gives written notice for the resident to leave, the facility waives the right to charge for services or room and board beyond the date of the resident’s departure. If applicable, the facility may pursue past due charges that the resident incurred prior to move-out.

(5) REFUNDS. The provider must refund any advance payments within 30 days after the resident leaves the facility.

(6) RATE INCREASES. The facility must provide 30 days written notice prior to any facility-wide increases, additions, or changes.

(7) SERVICE RATE INCREASES. The facility must provide immediate written notice to the resident at the time the facility determines the resident’s service rates shall increase due to increased service provision, as negotiated in the resident's service plan.

(8) MEDICAID PERSONAL INCIDENTAL FUNDS. The facility must have written policies, procedures, and accounting records for handling residents’

personal incidental funds that are managed in the resident's own best interest.

(a) The resident may manage their personal financial resources, or may authorize another individual or the facility to manage their personal incidental funds.

(b) The facility must hold, manage, and account for the personal incidental funds of the resident when requested in writing by the resident.

(c) Records must include the Resident Account Record (SDS 713) or other comparable expenditure form if the facility manages or handles a resident's personal incidental funds.

(A) The resident account record must show in detail, with supporting documentation, all monies received on behalf of the resident and the disposition of all funds received.

(B) Individuals shopping for residents must provide a list showing description and price of items purchased, along with payment receipts for these items.

(C) The facility must provide a copy of the individual Resident Account Record to the resident on a quarterly basis.

(d) Resident personal incidental fund accounts may not be co-mingled with facility funds.

(e) Residents must have reasonable access to their personal incidental funds. At minimum, requests to access personal incidental funds must be acted upon by the facility within one day of the request, excluding weekends and holidays.

(f) Upon the death of a Medicaid resident with no known surviving spouse, personal incidental funds held by the facility for the resident must be forwarded within 10 business days of the death of the resident to the Department of Human Services, Estate Administration Unit, P.O. Box 14021, Salem OR 97309.

(g) The facility must maintain documentation of the action taken and the amount of personal incidental funds conveyed.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0090 Fire and Life Safety *(Amended 1/15/2015)*

(1) FIRE DRILLS. All fire drills shall be conducted according to the Oregon Fire Code (OFC).

(a) Unannounced fire drills must be conducted and recorded every other month at different times of the day, evening, and night shifts.

(b) Fire and life safety instruction to staff must be provided on alternate months.

(c) The Fire Authority may develop an alternative fire drill plan for the facility. Any such plan must be submitted to the Department.

(d) A written fire drill record must be kept to document fire drills that include:

(A) Date and time of day;

(B) Location of simulated fire origin;

(C) The escape route used;

(D) Problems encountered and comments relating to residents who resisted or failed to participate in the drills;

(E) Evacuation time period needed;

(F) Staff members on duty and participating; and

(G) Number of occupants evacuated.

(e) Alternate exit routes must be used during fire drills to react to varying potential fire origin points.

(f) The evacuation capability of the residents and staff is a function of both the ability of the residents to evacuate and the assistance provided by the staff.

(g) Staff must provide fire evacuation assistance to residents from the building to a designated point of safety as determined by the Fire Authority having jurisdiction. Points of safety may include, outside the building, through a horizontal exit, or other areas as determined by the Fire Authority having jurisdiction.

(h) The fire alarm system shall be activated during each fire drill, unless otherwise directed by the Fire Authority having jurisdiction.

(2) If the facility is unable to meet the applicable evacuation level, the facility must make an immediate effort to make changes to ensure the evacuation standard is met. Changes must include, but not be limited to:

(a) Increasing staff levels,

(b) Changing staff assignments,

(c) Requesting change in resident rooms, and

(d) Arranging for special equipment.

After making necessary changes, if the facility fails to meet the applicable evacuation level, the facility must issue an involuntary move-out notice to the residents in accordance with OAR 411-054-0080.

(3) Fire detection and protection equipment, including visual signals with alarms for hearing-impaired residents, must be maintained in accordance with the OFC and the manufacturer's instructions.

(a) The facility must provide and maintain one or more 2A:10B:C fire extinguishers on each floor in accordance with the OFC.

(b) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original containers in accordance with the fire authority having jurisdiction.

(4) SAFETY PROGRAM. A safety program must be developed and implemented to avoid hazards to residents, such as dangerous substances, sharp objects, unprotected electrical outlets, slippery floors or stairs, exposed heating devices, broken glass, water temperatures, and fire prevention.

(5) TRAINING FOR RESIDENTS. Residents must be instructed about the facility's fire and life safety procedures per OFC.

(a) Each resident must be instructed within 24 hours of admission and re-instructed, at least annually, in general safety procedures, evacuation methods, responsibilities during fire drills, and designated meeting places outside the building or within the fire safe area in the event of an actual fire. This requirement does not apply to residents whose mental capability does not allow for following such instruction.

(b) A written record of fire safety training, including content of the training sessions and the residents attending, must be kept.

(6) UNOBSTRUCTED EGRESS. Stairways, halls, doorways, passageways, and exits from rooms and the building must be unobstructed.

(7) FIRST-AID SUPPLIES. First-aid supplies must be provided, properly labeled, and readily accessible.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0093 Emergency and Disaster Planning *(Amended 1/15/2015)*

An emergency preparedness plan is a written procedure that identifies a facility's response to an emergency or disaster for the purpose of minimizing loss of life, mitigating trauma, and to the extent possible, maintaining services for residents, and preventing or reducing property loss.

(1) The facility must prepare and maintain a written emergency preparedness plan in accordance with the OFC.

(2) The emergency preparedness plan must:

(a) Include analysis and response to potential emergency hazards, including, but not limited to:

(A) Evacuation of a facility;

(B) Fire, smoke, bomb threat, and explosion;

(C) Prolonged power failure, water, and sewer loss;

(D) Structural damage;

(E) Hurricane, tornado, tsunami, volcanic eruption, flood, and earthquake;

(F) Chemical spill or leak; and

(G) Pandemic.

(b) Address the medical needs of the residents, including:

(A) Access to medical records necessary to provide services and treatment; and

(B) Access to pharmaceuticals, medical supplies, and equipment during and after an evacuation.

(c) Include provisions and supplies sufficient to shelter in place for a minimum of three days without electricity, running water, or replacement staff.

(3) The facility must notify the Department, the local AAA office, or designee, of the facility's status in the event of an emergency that requires evacuation and during any emergent situation when requested.

(4) The facility must conduct a drill of the emergency preparedness plan at least twice a year in accordance with the OFC and other applicable state and local codes as required. One of the practice drills may consist of a

walk-through of the duties or a discussion exercise with a hypothetical event, commonly known as a tabletop exercise. These simulated drills may not take the place of the required fire drills.

(5) The facility must annually review or update the emergency preparedness plan as required by the OFC and the emergency preparedness plan must be available on-site for review upon request.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991, OL 2007 chapter 205

411-054-0100 Exceptions and Waivers *(Adopted 11/1/2007)*

(1) SPD may grant exceptions to these rules as provided herein. Exceptions will not be granted that are determined, in the discretion of SPD, to be detrimental to the residents. The facility seeking an exception must submit to SPD, in writing, reasons for the exception request.

(2) No exception will be granted from a regulation or provision of these rules pertaining to the monitoring of the facility, resident rights, and inspection of the public files.

(3) Exceptions granted by SPD must be in writing and be reviewed periodically. Exceptions and waivers may be rescinded at any time if SPD determines that continuance of the waiver has a potential adverse impact on resident well-being, privacy, or dignity. SPD will send written notice to the provider with reason(s) why a waiver is denied or rescinded.

(4) If applicable, exceptions will not be granted by SPD without prior consultation with other agencies involved.

(5) For assisted living facilities: an individual exception is required for each resident who chooses to share a unit with someone other than his/her spouse or partner.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0105 Inspections and Investigations *(Amended 12/15/2021)*

(1) The facility must cooperate with Department personnel in inspections, complaint investigations, planning for resident care, application procedures, and other necessary activities.

(a) Records must be made available to the Department upon request. Department personnel must have access to all resident and facility records and may conduct private interviews with residents. Failure to comply with this requirement shall result in regulatory action.

(b) The State Long Term Care Ombudsman must have access to all resident and facility records that relate to an investigation. Certified Ombudsman volunteers may have access to facility records that relate to an investigation and access to resident records with written permission from the resident or guardian.

(c) The State Fire Marshal or authorized representative must be permitted access to the facility and records pertinent to resident evacuation and fire safety.

(d) The Oregon Health Authority and appropriate Local Public Health Authority must be permitted access to the facility and records pertinent to investigation of illness or outbreak, as authorized by law.

(2) The facility shall not interfere with a good faith disclosure of information by an employee or volunteer concerning abuse or other action affecting a resident's safety or welfare, as described in OAR 411-054-0028(4).

(3) Staff of the Department shall visit and inspect every facility at least but not limited to once every two years for a full in-person survey to determine whether the facility is maintained and operated in accordance with these rules.

(a) For each year during which a facility does not have a full survey, the Department shall conduct an in-person inspection of the kitchen and other areas where food is prepared for residents.

(b) Subsection (a) will not go into effect until July 1, 2022.

(c) Facilities not in compliance with these rules must submit, within ten days of receipt of the inspection report, a plan of correction that satisfies the Department.

(d) The Department may impose sanctions for failure to comply with these rules.

(4) Department staff may consult with and advise the facility administrator concerning methods of care, records, housing, equipment, and other areas of operation.

(5) A copy of the most current inspection report and any conditions placed upon the license must be posted with the facility's license in public view near the main entrance to the facility.

(6) ABUSE OR RULE VIOLATION. Upon completion of substantiation of abuse or rule violation, the Division shall immediately provide written notification to the facility.

(a) WRITTEN NOTICE. The written notice shall:

(A) Explain the nature of each allegation;

(B) Include the date and time of each occurrence;

(C) For each allegation, include a determination of whether the allegation is substantiated, unsubstantiated, or inconclusive;

(D) For each substantiated allegation, state whether the violation was abuse or another rule violation;

(E) Include a copy of the complaint investigation report;

(F) State that the complainant, any person reported to have committed wrongdoing, and the facility have 15 days to provide additional or different information; and

(G) For each allegation, explain the applicable appeal rights available.

(b) APPORTIONMENT. If the Department determines there is substantiated abuse, the Department may determine that the facility, an individual, or both the facility and an individual are responsible for the abuse. In determining responsibility, the Department shall consider intent, knowledge and ability to control, and adherence to professional standards as applicable.

(A) FACILITY. Examples of when the Department shall determine the facility is responsible for the abuse include but are not limited to:

(i) Failure to provide minimum staffing in accordance with these rules without reasonable effort to correct;

(ii) Failure to check for or act upon relevant information available from a licensing board;

(iii) Failure to act upon information from any source regarding a possible history of abuse by any staff or prospective staff;

(iv) Failure to adequately provide oversight, training, or orientation of staff;

(v) Failure to allow sufficient time to accomplish assigned tasks;

(vi) Failure to provide adequate services;

(vii) Failure to provide adequate equipment or supplies; or

(viii) Failure to follow orders for treatment or medication.

(B) INDIVIDUAL. Examples of when the Department shall determine the individual is responsible for the abuse include but are not limited to:

(i) Intentional acts against a resident including assault, rape, kidnapping, murder, sexual abuse, or verbal or mental abuse;

(ii) Acts contradictory to clear instructions from the facility, unless the act is determined by the Department to be caused by the facility as identified in paragraph (A) above;

(iii) Callous disregard for resident rights or safety; or

(iv) Intentional acts against a resident's property (e.g., theft, misuse of funds).

(C) An individual may not be considered responsible for the abuse if the individual demonstrates the abuse was caused by factors beyond the individual's control. "Factors beyond the individual's control" are not intended to include such factors as misuse of alcohol or drugs or lapses in sanity.

(c) DUE PROCESS RIGHTS.

(A) NON-NURSING ASSISTANT. The written notice in cases of substantiated abuse by a person other than a nursing assistant shall explain the person's right to:

(i) File a petition for reconsideration pursuant to OAR 137-004-0080; and

(ii) Petition for judicial review pursuant to ORS 183.484.

(B) NURSING ASSISTANT. The written notice in cases of substantiated abuse by a nursing assistant shall explain:

(i) The Department's intent to enter the finding of abuse into the Nursing Assistant Registry following the procedure set out in OAR 411-089-0140; and

(ii) The nursing assistant's right to provide additional information and request a contested case hearing as provided in OAR 411-089-0140.

(C) FACILITY. The written notice shall advise the facility of the facility's due process rights as appropriate.

(d) DISTRIBUTION.

(A) The written notice shall be mailed to the facility, any person reported to have committed wrongdoing, the complainant (if known), and the Department or Type B AAA office; and

(B) A copy of the written notice shall be placed in the Department's facility complaint file.

(7) Upon receipt of a notice of abuse for victims covered by ORS 430.735, the facility shall provide written notice of the findings to the person found to have committed abuse, the residents of the facility, the residents' case managers, and the residents' guardians.

Stat. Auth.: ORS 410.070, 443.417, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0106 Regulatory Framework *(Amended 12/15/2021)*

(1) PURPOSE. The goal of the regulatory framework is to provide transparency, accuracy, and equity related to regulatory actions taken by the Department in response to facilities' lack of substantial compliance with Oregon Administrative Rules. The framework should include application of preventative, positive, and progressively more restrictive measures taken by the Department in response to facilities' lack of substantial compliance with Oregon Administrative Rules. Whenever possible and appropriate, the framework shall be based on a progressive method of regulation based on scope and severity, which includes positive reinforcement, as well as sanctions and penalties.

(2) FOCUS. The framework will address measures related to the scope and severity of noncompliance, including but not limited to:

(a) Whether the facility has qualified awake direct care staff in consistent numbers to consistently meet the scheduled and unscheduled needs of each resident 24 hours a day; and

(b) The impact of any compliance deficiencies on the rights, health, welfare and safety of the residents.

(3) PROCESS. The framework will provide information on processes related to the Department's:

(a) Accurate and equitable assessment of substantial compliance based on regulatory requirements.

(b) Employment of progressive and positive action to promote and achieve facility substantial compliance.

(c) Accurate and equitable imposition of corrective actions.

(d) Administration of Enhanced Oversight Program to focus compliance activities on facilities that consistently fail to achieve substantial compliance.

(4) TECHNIQUES. Regulatory compliance will be promoted through the use of progressive compliance techniques, as appropriate, including, but not limited to:

(a) Proactive communication.

(b) Technical support to facilities.

(c) Consultation with policy analysts to clarify regulatory requirements.

(d) Corrective action involving civil penalties.

(e) Imposition of sanctions, including, but not limited to conditions on a provider's license.

(f) Suspension, non-renewal or revocation of license.

(5) ENHANCED OVERSIGHT AND SUPERVISION PROGRAM.

(a) Facilities that consistently demonstrate a lack of substantial compliance with the requirements of rules adopted to regulate residential care facilities or assisted living facilities or perform substantially below statewide averages on quality metrics will be

considered for the Enhanced Oversight and Supervision Program. "Consistently" is defined as regularly and typically for purposes of this rule.

(b) The Department shall take one or more of the following actions, the Department deems necessary, to improve the performance of a facility:

(A) Increase the frequency of surveys of the facility.

(B) Conduct surveys that focus on areas of consistent non-compliance as identified by the Department.

(C) Impose one or more conditions on the license of the facility.

(c) The Department shall terminate the enhanced oversight and supervision of a facility as follows, after:

(A) Three years, if the facility has shown substantial compliance according to the Department; or

(B) One year, if the facility submits a written assertion of substantial compliance and the Department determines the facility no longer meets the criteria of the program.

(d) The Department shall publish notice on the Department's licensing website of any facility enrolled in the Enhanced Oversight and Supervision program.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0110 Conditions *(Amended 12/24/2024)*

(1) The Department may impose a condition on the license of a residential care or assisted living facility in response to a substantiated finding of rule violation, including, but not limited to a substantiated finding of abuse. A condition shall be imposed in response to a finding of immediate jeopardy, whether or not the finding of immediate jeopardy is substantiated at the time the license condition is imposed.

(2) The Department shall immediately remove the license condition if the finding of immediate jeopardy is not substantiated within 30 calendar days after the imposition of the license condition.

(3) Conditions that may be imposed on a licensee include, but are not limited to:

(a) Restricting the total number of residents;

(b) Restricting the number and impairment level of residents based upon the capacity of the licensee and staff to meet the health and safety needs of all residents;

(c) Requiring additional staff or staff qualifications;

(d) Requiring additional training for staff;

(e) Requiring additional documentation; or

(f) Restriction on admissions, if the Department makes a finding of immediate jeopardy that is likely to present an immediate jeopardy to future residents upon admission.

(4) IMPENDING IMPOSITION OF LICENSE CONDITION.

(a) Except where the threat to residents is so imminent that the Department determines it is not safe or practical to give the facility advance notice, the Department shall provide the licensee with a Notice of Impending Imposition of License Condition (Notice) at least 48 hours prior to issuing an Order Imposing License Condition (Order). The Notice may be provided in writing, sent by certified or registered mail to the licensee, or provided orally in person or by telephone to the licensee or to the person represented by facility staff to be in charge at the facility. When the Notice is delivered orally, the Department must subsequently provide written notice to the licensee by registered or certified mail. The Notice must:

(A) Describe the acts or omissions of the licensee that support the imposition of the license condition and the circumstances

that led to the substantiated finding of a rule violation, including, but not limited to, a:

(i) Substantiated finding of abuse.

(ii) Finding of immediate jeopardy.

(B) Describe why the acts or omissions and the circumstances create a situation for which the imposition of a condition is warranted.

(C) Provide a brief statement identifying the nature of the impending condition.

(D) Provide a brief statement describing how the license condition is designed to remediate the circumstances that lead to the condition.

(E) Provide a brief statement of the requirements for withdrawal of the condition.

(F) Identify a person at the Department whom the licensee may contact and who is authorized to enter the Order or to make recommendations regarding issuance of the Order.

(G) Specify the date and time an informal conference will be held, if requested by the licensee.

(H) Specify the date and time the Order will take effect.

(b) If the threat to residents of a facility is so imminent the Department determines it is not safe or practical to give the facility advance notice of a license condition, the Department must provide the notice required under section (5)(a) within 48 hours after issuing an order imposing the license condition.

(5) INFORMAL CONFERENCE. If an informal conference is requested, the conference will be held at a location designated by the Department. If determined to be appropriate by the Department, the conference may be held by telephone.

(a) With Notice. If a Notice of Impending License Condition is issued, the licensee must be provided with an opportunity for an informal conference to object to the Department's proposed action before the license condition is scheduled to take effect. The Order Imposing License Condition may be issued at any time after the informal conference.

(b) Without Notice. If an Order Imposing License Condition is issued without a prior Notice of Impending License Condition, the licensee may request an immediate informal conference to object to the Department's action.

(6) ORDER IMPOSING LICENSE CONDITION.

(a) When an Order Imposing License Condition (Order) is issued, the Department must serve the Order to the licensee either personally or by registered or certified mail.

(b) The Order must include the following statements:

(A) The authority under which the condition is being issued.

(B) A reference to the specific sections of the statute and administrative rules involved.

(C) The effective date of the condition.

(D) A short and plain statement of the matters asserted or charged.

(E) The specific terms of the license condition.

(F) A specific description of how the scope and manner of the license condition is designed to remediate the findings that lead to the license condition.

(G) A specific description of the requirements for withdrawal of the license condition.

(H) Statement of the licensee's right to request a hearing.

(I) That the licensee may elect to be represented by counsel and to respond and present evidence and argument on all issues involved. If the licensee is to be represented by counsel, the licensee must notify the Department.

(J) That, if a request for hearing is not received by the Department within 21 calendar days from the date of the Order, the licensee has waived the right to a hearing under ORS chapter 183.

(K) Findings of specific acts or omissions of the licensee that are grounds for the license condition, and the reasons the acts or omissions create a situation for which the imposition of a license condition is warranted.

(L) That the Department may combine the hearing on the Order with any other Department proceeding affecting the licensee. The procedures for the combined proceeding must be those applicable to the other proceedings affecting the license.

(7) A licensee who has been ordered to restrict admissions to a facility must immediately post a "Restriction of Admissions Notice" that is provided by the Department, on both the inside and outside faces of each door of the facility through which any person enters or exits a facility. The notices must not be removed, altered or obscured until the Department has lifted the restriction or the restriction is automatically removed pursuant to subsection (10)(d) of this rule.

(8) HEARING.

(a) Right to Hearing. If the Department imposes an Order, the licensee is entitled to a contested case hearing pursuant to ORS chapter 183.

(b) Hearing Request. The Department must receive the licensee's request for a hearing within 21 calendar days of the date of Order. If a request for hearing is not received by the Department within 21

calendar days of the date of the Order, the licensee will have waived the right to a hearing under ORS chapter 183.

(c) A licensee's request for a hearing does not delay enforcement.

(d) Date of Hearing. When a timely request for hearing is received, the hearing shall be held as soon as practical.

(e) Consolidation. If a request for hearing is received on an Order, and a subsequent Order is issued, the Department may consolidate the Orders into a single contested case hearing.

(9) REQUEST FOR REINSPECTION OR REEVALUATION.

(a) Assertion of substantial compliance. Following the Order on a facility, the Department shall:

(A) Within 15 business days of receiving the facility's written assertion of substantial compliance and request for reinspection, the Department shall reinspect or reevaluate the facility to determine if the facility has achieved substantial compliance.

(B) Notify the facility by telephone or electronic means of the findings of the reinspection or reevaluation within five business days after completion of the reinspection or reevaluation.

(C) Issue a written report to the facility within 30 business days after the reinspection or reevaluation notifying the facility of the Department's determinations.

(b) If the Department finds the facility has achieved substantial compliance and that systems are in place to ensure similar deficiencies do not reoccur, the Department shall withdraw the Order.

(c) If after reinspection or reevaluation, the Department determines the violation continues to exist, the Department may not withdraw the Order and is not obligated to reinspect or reevaluate the facility again for at least 45 business days after the first reinspection or reevaluation.

(A) The Department shall provide the facility notice of the decision not to withdraw the Order in writing.

(B) The notice shall inform the facility of the right to a contested case hearing pursuant to ORS chapter 183.

(d) If the Department does not meet the requirements of this section, a license condition is automatically removed on the date the Department failed to meet the requirements of this section, unless the Director extends the applicable period for no more than 15 business days. The Director may not delegate the power to make a determination regarding an extension under this paragraph.

(e) Nothing in this section limits the Department's authority to visit or inspect the facility at any time.

(10) EXCEPTIONS TO ORDER IMPOSING LICENSE CONDITION. When a restriction of admissions is in effect pursuant to an Order, the Department, in its sole discretion, may authorize the facility to admit new residents for whom the Department determines that alternate placement is not feasible.

(11) Conditions may be imposed for the duration of the licensure period (two years) or limited to some other shorter period of time. If the condition corresponds to the licensing period, the reasons for the condition will be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the condition will be indicated on the attachment to the license.

Stat. Auth.: ORS 183, 410.070, 443.450
Stats. Implemented: ORS 183, 443.400 - 443.455, 443.991

411-054-0120 Civil Penalties *(Amended 6/29/2018)*

(1) For purposes of imposing civil penalties, facilities licensed under ORS 443.400 to 443.455 and ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) For purposes of this rule:

(a) "Person" means a licensee under ORS 443.420 or a person who the Department finds shall be so licensed, but does not include any employee of such licensee or person.

(b) "Resident rights" means that each resident must be assured the same civil and human rights accorded to other citizens as described in OAR 411-054-0027.

(c)"Monitoring" means when a residential care or assisted living facility is surveyed, inspected, or investigated by an employee or designee of the Department or an employee or designee of the State Fire Marshal.

(d) As used in this rule:

(A) "Harm" means a measurable negative impact to a resident's physical, mental, financial, or emotional well-being.

(B) "Minor harm" means harm resulting in no more than temporary physical, mental or emotional discomfort or pain without loss of function, or in financial loss of less than $1,000.

(C) "Moderate harm" means harm resulting in temporary loss of physical, mental or emotional function, or in financial loss of $1,000 or more, but less than $5,000.

(D) "Serious harm" means harm resulting in long-term or permanent loss of physical, mental or emotional function, or in financial loss of $5,000 or more.

(E) "Financial loss" means loss of resident property or money as a result of financial exploitation, as defined in ORS 124.050. Financial loss does not include loss of resident property or money that results from action or inaction of an individual not employed or contracted with the facility, or that arises from the action or inaction of an individual employed or contracted with the facility if the action or inaction occurs while the individual is not performing employment or contractual duties.

(e) The Director shall assess the severity of a violation using the following criteria:

(A) Level 1 - is a violation that results in no actual harm or in potential for only minor harm.

(B) Level 2 - is a violation that results in minor harm or potential for moderate harm.

(C) Level 3 - is a violation that results in moderate harm or potential for serious harm.

(D) Level 4 - is a violation that results in serious harm or death.

(f) The Director shall assess the scope of a violation using the following criteria:

(A) An isolated violation occurs when one or a very limited number of residents or employees are affected or a very limited area or number of locations within a facility are affected.

(B) A pattern violation occurs when more than a very limited number of residents or employees are affected, or the situation has occurred in more than a limited number of locations but the locations are not dispersed throughout the facility.

(C) A widespread violation occurs when the problems causing the deficiency are pervasive and affect many locations throughout the facility or represent a systemic failure that affected, or has the potential to affect, a large portion or all of the residents or employees.

(3) Determining Civil Penalties.

(a) When the Director is considering imposition of a civil penalty under ORS 443.455(2)(a), ORS 441.710, or Or Laws 2017, ch 679, § 4 on a residential care or assisted living facility the Director shall comply with the requirements of this section.

(b) When imposing a civil penalty on a facility pursuant to this section, the Director shall consider:

(A) Any prior violations of laws or rules pertaining to the facility and, as a mitigating factor, whether violations were incurred under prior ownership or management of the facility.

(B) The financial benefits, if any, realized by the facility as a result of the violation.

(C) The facility's past history of correcting violations and preventing the reoccurrence of violations.

(D) The severity and scope of the violation.

(4) Civil Penalty Amounts.

(a) The Director may impose civil penalties as follows, for a:

(A) Level 1 violation, the Director may not impose a civil penalty.

(B) Level 2 violation, the Director may impose a penalty in an amount no less than $250 per violation, not to exceed $500 per violation.

(C) Level 3 violation, the Director may impose a civil penalty in an amount no less than $500 per violation, not to exceed $1,500 per violation.

(D) Level 4 violation, the Director may impose a civil penalty in an amount no less than $1,500 per violation, not to exceed $2,500 per violation.

(E) Failure to report abuse of a resident to DHS as required by state law, the Director may impose a civil penalty in an amount of no more than $1,000 per violation.

(b) The penalties imposed under paragraph (a)(A) to (D) of this section may not exceed $20,000 in the aggregate for violations occurring in a single facility within any 90-day period.

(c) In imposing civil penalties under this section, the Director may take into account the scope of the violation.

(5) Additional Civil Penalties. The Department shall impose a civil penalty of not less than $2,500 and not more than $15,000 for each occurrence of substantiated abuse that resulted in the death, serious injury, rape, or sexual abuse of a resident. The civil penalty may not exceed $40,000 for all violations occurring in a single facility within any 90-day period.

(a) To impose this civil penalty, the Department shall establish all of the following occurred:

(A) The abuse arose from deliberate, or other than accidental action or inaction.

(B) The conduct resulting in the abuse was likely to cause a negative outcome by a person with a duty of care toward a resident of a facility.

(C) The abuse resulted in the serious injury, rape, sexual abuse, or death of a resident.

(b) For purposes of this civil penalty, the following definitions apply:

(A) "Negative Outcome" include serious injury, rape, sexual abuse, or death.

(B) "Serious injury" means a physical injury that creates a substantial risk of death or that causes serious disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

(C) "Rape" means rape in the first degree as defined in ORS 163.375, rape in the second degree as defined in ORS

163.365, and rape in the third degree as defined in ORS 163.355.

(D) "Sexual Abuse" means any form of sexual contact between an employee of a residential care facility or a person providing services in the facility and a resident of that facility, including, but not limited to:

(i) Sodomy.

(ii) Sexual coercion.

(iii) Taking sexually explicit photographs.

(iv) Sexual harassment.

(6) A notice of a civil penalty shall be sent by registered or certified mail and shall include:

(a) A reference to the specific sections of the statute, rule, standard, or order involved.

(b) A short and plain statement of the matters asserted or charged.

(c) A statement of the amount of the penalty or penalties imposed.

(d) A statement of the party's right to request a hearing.

(e) A description of specific remediation the facility must make in order to achieve substantial compliance.

(f) A statement specifying the amount of time for the elimination of the violation.

(A) The time specified shall not exceed 30 calendar days after the first notice of a violation; or

(B) In cases where the violation requires more than 30 days to correct, a reasonable time shall be specified in a plan of correction, as found acceptable by the Director.

(7) For a level 2 or level 3 violation, the Department shall hold in abeyance the penalty proposed for the period of time specified in the Notice pursuant to subsection (6)(f) above.

(8) Hearing Requests. The person to whom the notice is addressed shall have 10 calendar days from the date specified in the Notice pursuant to subsection (6)(f) of this rule to make written application for a hearing before the Department.

(9) All hearings shall be conducted pursuant to the applicable provisions of ORS chapter 183.

(10) If the person notified fails to request a hearing within the time specified in the notice, an order may be entered by the Department assessing a civil penalty.

(11) If, after a hearing, the Department prevails, an order may be entered by the Department assessing a civil penalty.

(12) A civil penalty imposed by the Department shall be remitted or reduced in a manner consistent with the public health and safety, as follows:

> (a) The Department shall reduce the penalty by not less than 25 percent if the facility self-reports abuse that results in less than serious harm.
>
> (b) The Department shall withdraw some or all of the penalty if the facility achieves substantial compliance for a level 2 or 3 violation.

(13) If the order is not appealed, the amount of the penalty is payable within 10 calendar days after the order is entered. If the order is appealed and is sustained, the amount of the penalty is payable within 10 calendar days after the court decision. The order, if not appealed or sustained on appeal, shall constitute a judgment and may be filed in accordance with the provisions of ORS 18.005 to 18.428. Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(14) A violation of any general order or final order pertaining to a residential care or assisted living facility issued by the Department, other than a Level 1 violation, is subject to a civil penalty.

(15) Judicial review of civil penalties imposed under ORS 441.710 shall be as provided under ORS 183.480, except the court may, in its discretion, reduce the amount of the penalty.

(16) All penalties recovered under ORS 443.455, Or Laws 2017, ch 679, § 4, and ORS 441.710 to 441.740 shall be paid to the Quality Care Fund.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 441.705 - 441.745, 443.400 - 443.455, 443.991

411-054-0125 Inactive and Provisional Licenses
(Repealed 10/1/2009)

411-054-0130 Non-Renewal, Denial, Suspension, or Revocation of License *(Amended 12/15/2021)*

(1) The Department may deny, suspend, revoke, or refuse to renew a license under the following conditions:

(a) Where the Department finds there has been substantial failure to comply with these rules;

(b) Where the State Fire Marshal or authorized representative certifies there is failure to comply with all applicable ordinances and rules relating to safety from fire;

(c) If the licensee fails to implement a plan of correction or comply with a final order of the Department imposing an administrative sanction, including the imposition of a civil penalty;

(d) Failure to disclose requested information on the application or provision of incomplete or incorrect information on the application;

(e) Where imminent danger to the health or safety of residents exists;

(f) When the facility has interfered with an employee or volunteer who has made a good faith disclosure of information as described in 411-054-0028(4) and 411-054-0105(2);

(g) Abandonment of facility operation;

(h) Loss of physical possession of the premise;

(i) Loss of operational control of the facility; or

(j) Appointment of a receiver, trustee, or other fiduciary by court order.

(2) Such revocation, suspension, denial, or non-renewal shall be done in accordance with the rules of the Department and ORS chapter 183.

(3) Nothing in this rule is intended to preclude the Department from taking other regulatory action on a suspended licensee for violation of the licensing regulations in these rules.

Stat. Auth.: ORS 410.070, 443.417, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0133 Temporary Manager *(Adopted 7/1/2010)*

(1) APPOINTMENT. The Division, with the consent of the licensee, may appoint a temporary manager to assume control of the day-to-day operation of the facility in accordance with Oregon Laws 2009, chapter 539, sections 14 through 18. The appointment may be for a period not to exceed six months.

(2) CRITERIA. A temporary manager may be appointed if the Division determines that the health or safety of residents in the facility are, or in the immediate future shall be, in jeopardy based upon:

(a) The licensee’s unwillingness or inability to comply with Department rules in the operation of the facility;

(b) The imminent insolvency of the facility;

(c) The Division's revocation or suspension of the license of the facility; or

(d) The Division's determination that the licensee intends to cease operations and to close the facility without adequate arrangements for the relocation of the residents.

(3) DUTIES AND POWERS. The temporary manager has all of the duties and powers, as agreed upon between the Division and the licensee that are necessary to ensure the safety and well-being of the residents and the continued operation of the facility.

(4) QUALIFICATIONS. In order to qualify for appointment as temporary manager, the prospective appointee must:

(a) Be, or employ a person who is, qualified to serve as administrator for the type of facility being served;

(b) Be familiar with the Division's rules for the operation of the facility to be served;

(c) Be familiar with the needs of the resident population in the facility to be served; and

(d) Have a demonstrated history (five year minimum) of operating and managing a similar facility in substantial compliance with Department rules.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0135 Criminal Penalties *(Adopted 11/1/2007)*

(1) Violation of any provision of ORS 443.400 to 443.455 is a Class B misdemeanor.

(2) Violation of any provision of ORS 443.881 is a Class C misdemeanor.

Stat. Auth.: ORS 443.455
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0140 Additional Authority *(Adopted 11/1/2007)*

SPD may commence a suit in equity to enjoin operation of a facility when:

(1) A facility is operated without a valid license; or

(2) Notice of revocation has been given and a reasonable time has been allowed for placement of individuals in other facilities.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0200 Residential Care Facility Building Requirements *(Amended 6/29/2018)*

A residential care facility (RCF) and a conversion facility (CF), as defined by OAR 411-054-0005, shall be built to the following requirements and may have individual or shared living units, unless specifically exempted.

(1) Applicability for 411-054-0200 shall apply to the following:

(a) A RCF not licensed prior to 01/15/2015, with the exception of 411-054-0200(5)(a) related to lockable doors. This will apply to all existing and new construction on the effective date as indicated.

(b) A major alteration to a RCF for which plans were not submitted to Facilities, Planning, and Safety (FPS) prior to 01/15/2015; or

(c) OAR 411-054-0200 shall apply only to the major alteration and shall not apply to any other area of the facility.

(2) BUILDING CODES. Each RCF must meet the requirements of the facility standards set forth in these rules and with the building codes in effect at the time of original licensure.

(a) Subsequent modifications made to a RCF after original licensure, including, but not limited to demolition, remodeling, construction, maintenance, repair, or replacement must comply with all applicable

state and local building, electrical, plumbing, and zoning codes in place at the time of the modification.

(b) If a change in use and building code occupancy classification occurs, license approval shall be contingent on meeting the requirements of the building codes.

(c) A RCF must comply with FPS program requirements for submission of building drawings and specifications as described in OAR 333-675-0000 through 333-675-0050.

(3) GENERAL BUILDING EXTERIOR.

(a) All exterior pathways and accesses to the RCF common-use areas, entrance, and exit ways must be made of hard, smooth material, be accessible, and maintained in good repair.

(b) A RCF must take measures to prevent the entry of rodents, flies, mosquitoes, and other insects. There must be locked storage for all poisons, chemicals, rodenticides, and other toxic materials. All materials must be properly labeled.

(c) RCF grounds must be kept orderly and free of litter and refuse. Garbage must be stored in covered refuse containers.

(d) As described in OAR 411, division 057, memory care communities licensed as a RCF must be located on the ground floor. A CF cannot be endorsed as a memory care community.

(e) A RCF must provide storage for all maintenance equipment, including yard maintenance tools, if not provided by a third-party contract.

(f) A RCF must provide an accessible outdoor recreation area. The outdoor recreation area must be available to all residents. Lighting must be equal to a minimum of five foot candles. Memory Care Communities must provide residents with direct access to a secure outdoor recreation area as described in OAR chapter 411, division 057.

(g) Outdoor perimeter fencing may not be secured to prevent exit unless the RCF has written approval from the Department for an exception or the RCF is in compliance with OAR chapter 411, division 057 (Memory Care Communities) or OAR 309-019-0100 through 309-019-0220.

(h) A RCF must have an entry and exit drive to and from the main building entrance that allows for a vehicle to pick up and drop off residents and mail deliveries without the need for vehicles to back up.

(4) GENERAL BUILDING INTERIOR. The design of a RCF must emphasize a residential appearance while retaining the features required to support special resident needs as outlined in this rule.

(a) RECEPTION AREA. A reception area must be visible and accessible to residents and visitors when entering the doors of the main entrance to the RCF.

(b) CORRIDORS. Resident-use areas and units must be connected through temperature controlled common corridors.

(A) Resident-use corridors exceeding 20 feet in length to an exit or common-use area, must have a minimum width of 72 inches. A CF may request an exception to this requirement, which shall be reviewed and decided on a case-by-case basis.

(B) Corridors shall not exceed 150 feet in length from any resident unit to a seating or other common-use area. A CF may request an exception to this requirement, which shall be reviewed and decided on a case-by-case basis.

(C) Handrails must be installed at one or both sides of resident-use corridors.

(c) FLOORS.

(A) Hard surface floors and base must be free from cracks and breaks.

(B) Carpeting and other floor materials must be constructed and installed to minimize resistance for passage of wheelchairs and other ambulation aids.

(C) Thresholds and floor junctures must be maintained to allow for the passage of wheelchairs and to prevent a tripping hazard.

(d) INTERIOR DOORS. Lever-type door handles must be provided on all doors used by residents.

(e) EXIT DOORS. Exit doors may not include locks that delay evacuation except as specified by the building codes. Such locks may not be installed except with written approval of the Department.

(A) Exit doors may not include locks that prevent evacuation.

(B) If an electronic code must be entered to use an exit door that code must be clearly posted for residents, visitors, and staff use.

(f) WALLS AND CEILINGS. Walls and ceilings must be cleanable in kitchen, laundry, and bathing areas. Kitchen walls must be finished smooth per OAR 333-150-0000 (Food Sanitation Rules).

(g) ELEVATORS. A RCF with residents on more than one floor must provide at least one elevator that meets Oregon Elevator Specialty Code (OESC) requirements.

(h) The interior of the facility must be free from unpleasant odors.

(i) All interior and exterior materials and surfaces (e.g., floors, walls, roofs, ceilings, windows, and furniture) and all equipment necessary for the health, safety, and comfort of the resident will be kept clean and in good repair.

(5) RESIDENT UNITS. Resident units may be limited to a bedroom only, with bathroom facilities centrally located off common corridors. Each resident unit shall be limited to not more than two residents.

(a) Resident units must have a lockable door with lever type handles, effective 01/15/2017. This applies to all existing and new construction.

(b) For bedroom units, the door must open to an indoor, temperature controlled common-use area or common corridor. Residents may not enter a room through another resident's bedroom.

(c) Resident units must include a minimum of 80 square feet per resident, exclusive of closets, vestibules, and bathroom facilities and allow for a minimum of three feet between beds;

(d) All resident bedrooms must be accessible for individuals with disabilities and meet the requirements of the building codes. Adaptable units are not acceptable.

(e) A lockable storage space (e.g., drawer, cabinet, or closet) must be provided for the safekeeping of a resident's small valuable items and funds. Both the administrator and resident may have keys.

(f) WARDROBE CLOSET. A separate wardrobe closet must be provided for each resident's clothing and personal belongings. Resident wardrobe and storage space must total a minimum volume of 64 cubic feet for each resident. The rod must be adjustable for height or fixed for reach ranges per building codes. In calculating useable space closet height may not exceed eight feet and a depth of two feet.

(g) WINDOWS.

> (A) Each sleeping and living unit must have an exterior window that has an area at least one-tenth of the floor area of the room. A CF must have at least one exterior window with a minimum size of 8 square feet per resident.
>
> (B) Unit windows must be equipped with curtains or blinds for privacy and control of sunlight.

(C) Operable windows must be designed to prevent accidental falls when sill heights are lower than 36 inches and above the first floor.

(h) RESIDENT UNIT BATHROOMS. If resident bathrooms are provided within a resident unit, the bathroom must be a separate room and include a toilet, hand wash sink, mirror, towel bar, and storage for toiletry items. The bathrooms must be accessible for individuals who use wheelchairs.

(i) UNIT KITCHENS. If cooking facilities are provided in resident units, cooking appliances must be readily removable or disconnect-able and the RCF must have and carry out a written safety policy regarding resident-use and nonuse. A microwave is considered a cooking appliance.

(6) COMMON-USE AREAS.

(a) BATHING FACILITIES. Centralized bathing fixtures must be provided at a minimum ratio of one tub or shower for each ten residents not served by fixtures within their own unit.

(A) At least one centralized shower or tub must be designed for disabled access without substantial lifting by staff.

(B) Bathing facilities must be located or screened to allow for resident privacy while bathing and provide adequate space for an attendant.

(C) A slip-resistant floor surface in bathing areas is required.

(D) Grab bars must be provided in all resident showers.

(E) Showers must be equipped with a hand-held showerhead and a cleanable shower curtain.

(b) TOILET FACILITIES. Toilet facilities must be located for resident-use at a minimum ratio of one to six residents for all residents not served by toilet facilities within their own unit. Toilet facilities must include a toilet, hand wash sink, and mirror.

(A) Toilet facilities for all of the licensed resident capacity must be accessible to individuals with disabilities in accordance with the building codes.

(B) A RCF licensed for more than 16 residents must provide at least one separate toilet and hand wash lavatory for staff and visitor use.

(c) DINING AREA. The dining area must be provided with the capacity to seat 100 percent of the residents. The dining area must provide a minimum of 22 square feet per resident for seating, exclusive of serving carts and other equipment or items that take up space in the dining area. A RCF must have policies and equipment to assure food is served fresh and at proper temperatures. If a CF provides a minimum of 30 square feet per resident for a combined dining, activities, and living area, the CF may apply for an exception to this subsection.

(d) SOCIAL AND RECREATION AREAS. A RCF must include lounge and activity areas for social and recreational use totaling a minimum of 15 square feet per resident. If a CF provides a minimum of 30 square feet per resident for a combined dining, activities, and living area, the CF may apply for an exception to this subsection.

(e) COOKING STOVE. If a stove is provided in the activities or common-use area, and is available for resident-use, a keyed, remote switch, or other safety device must be provided to ensure staff control.

(7) SUPPORT SERVICE AREAS.

(a) MEDICATION STORAGE. A RCF must have a locked and separate closed storage area for medications, supportive of the distribution system utilized including:

(A) A method for refrigeration of perishable medications that provides for locked separation from stored food items;

(B) Medications must be stored in an area that is separate from any poisons, hazardous material, or toxic substance; and

(C) A RCF licensed for more than 16 residents must provide a medication sink.

(b) HOUSEKEEPING AND SANITATION.

(A) A RCF must have a secured janitor closet for storing supplies and equipment, with a floor or service sink.

(B) The wall base shall be continuous and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects or moisture.

(c) LAUNDRY FACILITIES. Laundry facilities may be located to allow for both resident and staff use, when a time schedule for resident-use is provided and equipment is of residential type. When the primary laundry is not in the building or suitable for resident-use, a RCF must provide separate resident-use laundry facilities. A CF is not required to provide resident-use laundry services.

(A) Laundry facilities must be operable and at no additional cost to the resident.

(B) Laundry facilities must have space and equipment to handle laundry-processing needs. Laundry facilities must be separate from food preparation and other resident-use areas.

(C) On-site laundry facilities, used by staff for facility and resident laundry, must have capacity for locked storage of chemicals and equipment.

(D) The wall base shall be continuous and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects or moisture.

(d) SOILED LINEN PROCESSING. For the purpose of this rule, "soiled linens and soiled clothing," means linens or clothing

contaminated by an individual's bodily fluids (for example, urine, feces, or blood).

(A) There must be a separate area with closed containers that ensure the separate storage and handling of soiled linens and soiled clothing. There must be space and equipment to handle soiled linen and soiled clothing processing needs that is separate from regular linens and clothing.

(B) Arrangement must provide a one-way flow of soiled linens and soiled clothing from the soiled area to the clean area and preclude potential for contamination of clean linens and clothing.

(C) The soiled linen room or area, must include a flushing rim clinical sink with a handheld rinsing device and a hand wash sink or lavatory.

(D) When washing soiled linens and soiled clothing, washers must have a minimum rinse temperature of 140 degrees Fahrenheit unless a chemical disinfectant is used.

(E) Personnel handling soiled laundry must be provided with waterproof gloves.

(F) Covered or enclosed clean linen storage must be provided and may be on shelves or carts. Clean linens may be stored in closets outside the laundry area.

(G) The wall base shall be continuous and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects or moisture.

(e) KITCHEN AND FOOD STORAGE. Kitchen facilities and equipment in residential care facilities with a capacity of 16 or fewer may be of residential type except as required by the building codes. Residential care facilities licensed for a capacity of more than 16, must comply with OAR 333-150-0000 (Food Sanitation Rules). The following are required:

(A) Dry storage space, not subject to freezing, for a minimum one-week supply of staple foods.

(B) Refrigeration and freezer space at proper temperature to store a minimum two days' supply of perishable foods.

(C) Storage for all dishware, utensils, and cooking utensils used by residents must meet OAR 333-150-0000 (Food Sanitation Rules).

(D) In facilities licensed to serve 16 or fewer residents, a dishwasher must be provided (may be residential type) with a minimum final rinse temperature of 140 degrees Fahrenheit (160 degrees recommended), unless a chemical disinfectant is used in lieu of the otherwise required water temperature. In facilities of 17 or more capacity, a commercial dishwasher is required meeting OAR 333-150-0000 (Food Sanitation Rules).

(E) In residential care facilities with a capacity of 16 or fewer, a two compartment sink or separate food preparation sink and hand wash lavatory must be provided. In residential care facilities with 17 or more capacity, a triple pot wash sink (unless all pots are sanitized in the dishwasher), a food prep sink, and separate hand wash lavatory must be provided.

(F) Food preparation and serving areas must have smooth and cleanable counters.

(G) Stove and oven equipment for cooking and baking needs.

(H) Storage in the food preparation area for garbage must be enclosed and separate from food storage.

(I) Storage for a mop and other cleaning tools and supplies used for dietary areas must be separate from those used in toilet rooms, resident rooms, and other support areas. In residential care facilities with a capacity of 17 or more, a separate janitor closet or alcove must be provided with a floor or service sink and storage for cleaning tools and supplies.

(J) Storage must be available for cookbooks, diet planning information, and records.

(K) The wall base shall be continuous and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects or moisture.

(8) HEATING AND VENTILATION SYSTEMS. A RCF must have heating and ventilation systems that comply with the building codes in effect at the time of facility construction.

(a) TEMPERATURE. For all areas occupied by residents, design temperature for construction must be 75 degrees Fahrenheit.

(A) A RCF must provide heating systems capable of maintaining 70 degrees Fahrenheit in resident areas. Required minimum temperatures are no less than 70 degrees Fahrenheit during the day and 60 degrees Fahrenheit during sleeping hours.

(B) During times of extreme summer heat, fans must be made available when air conditioning is not provided.

(b) EXHAUST SYSTEMS. All toilet and shower rooms must be equipped with a mechanical exhaust fan or central exhaust system that discharges to the outside.

(c) FIREPLACES, FURNACES, WOODSTOVES, AND BOILERS. Where used, installation must meet standards of the building codes in effect at the time of construction. The glass and area surrounding the fireplace must not exceed 120 degrees Fahrenheit.

(d) WALL HEATERS. Covers, grates, or screens of wall heaters and associated heating elements may not exceed 120 degrees Fahrenheit when they are installed in locations that are subject to incidental contact by people or with combustible material. Effective 01/15/2015, wall heaters are not acceptable in new construction or remodeling.

(9) PLUMBING SYSTEMS. Plumbing systems must conform to the building codes in effect at the time of facility construction.

(a) Hot water temperature in residents' units must be maintained within a range of 110 - 120 degrees Fahrenheit.

(b) Hot water temperatures serving dietary areas must meet OAR 333-150-0000 (Food Sanitation Rules).

(c) An outside area drain and hot and cold water hose bibs must be provided for sanitizing laundry carts, food carts, and garbage cans.

(10) ELECTRICAL REQUIREMENTS.

(a) WIRING SYSTEMS. All wiring systems must meet the building codes in effect at the date of installation and shall be maintained and in good repair.

(b) The use of extension cords and other special taps is not allowed.

(c) LIGHTING. Lighting fixtures must be provided in each resident bedroom and bathroom, and be switchable and near the entry door.

(A) Each resident bedroom must have illumination of at least 20-foot candles measured at three feet above the floor for way finding from the room entrance, to each bed, and to the adjoining toilet room, if one exists.

(B) Lighting in toilet rooms and bathing facilities used by residents must be at least 50-foot candles, measured at the hand wash sink and three feet above the shower floor with the curtain open.

(C) Corridor lighting must equal a minimum of 20-foot candles measured from the floor.

(D) Table height lighting in dining rooms must equal a minimum of 25-foot candles, without light from windows.

(11) CALL SYSTEM. A RCF must provide a call system that connects resident units to the care staff center or staff pagers. Wireless call systems are allowed.

(a) A manually operated emergency call system must be provided in each toilet and bathing facility used by residents and visitors.

(b) EXIT DOOR ALARMS. An exit door alarm or other acceptable system must be provided for security purposes and to alert staff when residents exit the RCF. The door alarm system may be integrated with the call system.

(c) Security devices intended to alert staff of an individual resident's potential elopement may include, but not be limited to, electronic pendants, bracelets, pins.

(12) TELEPHONES. Adequate telephones must be available for resident, staff, and visitor use, including those individuals who have physical disabilities. If the only telephone is located in a staff area, it must be posted that the telephone is available for normal resident-use at any time and that staff shall ensure the resident's uninterrupted privacy. Staff may provide assistance when necessary or requested.

(13) TELEVISION ANTENNA OR CABLE SYSTEM. A RCF must provide a television antenna or cable system with an outlet in each resident unit.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0300 Assisted Living Facility Building Requirements
(Amended 1/15/2015)

An assisted living facility (ALF), as defined by OAR 411-054-0005, shall be built to the following requirements and have individual living units that have a lockable door, private bathroom, and kitchenette.

(1) Applicability for 411-054-0300 shall apply to the following:

(a) An ALF not licensed prior to 01/15/2015; or

(b) A major alteration to an ALF for which plans were not submitted to Facilities, Planning, and Safety prior to 01/15/2015;

(c) OAR 411-054-0300 shall apply only to the major alteration and shall not apply to any other area of the facility.

(2) BUILDING CODES. Each ALF must meet the requirements of the facility standards set forth in these rules and with the building codes in effect at the time of original licensure.

(a) Subsequent modifications made to an ALF after original licensure, including, but not limited to, demolition, remodeling, construction, maintenance, repair, or replacement must comply with all applicable state and local building, electrical, plumbing, and zoning codes in place at the time of the modification.

(b) If a change in use and building code occupancy classification occurs, license approval shall be contingent on meeting the requirements of the building codes.

(c) An ALF must comply with FPS program requirements for submission of building drawings and specifications as described in OAR 333-675-0000 through 333-675-0050.

(3) GENERAL BUILDING EXTERIOR.

(a) All exterior pathways and accesses to the ALF's common-use areas, entrance, and exit ways must be made of hard, smooth material, be accessible, and maintained in good repair.

(b) An ALF must take measures to prevent the entry of rodents, flies, mosquitoes, and other insects. There must be locked storage for all poisons, chemicals, rodenticides, and other toxic materials. All materials must be properly labeled.

(c) ALF grounds must be kept orderly and free of litter and refuse. Garbage must be stored in covered refuse containers.

(d) As described in OAR chapter 411, division 057, memory care communities licensed as an ALF must be located on the ground floor.

(e) An ALF must provide storage for all maintenance equipment, including yard maintenance tools, if not provided by third party contract.

(f) An ALF must provide an accessible outdoor recreation area. The outdoor recreation area must be available to all residents. Lighting must be equal to a minimum of five foot candles. Memory care communities must provide residents with direct access to a secure outdoor recreation area as described in OAR chapter 411, division 057.

(g) Outdoor perimeter fencing may not be secured to prevent exit unless the ALF has received written approval from the Department or the ALF is in compliance with OAR chapter 411, division 057 (Memory Care Communities) or OAR 309-032-1500 through 309-032-1565 (Enhanced Care Services).

(h) An ALF must have an entry and exit drive to and from the main building entrance that allows for a vehicle to pick up and drop off residents and mail deliveries without the need for vehicles to back up.

(4) GENERAL BUILDING INTERIOR. The design of an ALF must emphasize a residential appearance while retaining the features required to support special resident needs as outlined in this rule.

(a) RECEPTION AREA. A reception area must be visible and accessible to residents and visitors when entering the doors of the main entrance to the ALF.

(b) CORRIDORS. Resident-use areas and units must be connected through temperature controlled common corridors.

(A) Resident-use corridors exceeding 20 feet in length to an exit or common-use area, must have a minimum width of 72 inches.

(B) Corridors shall not exceed 150 feet in length from any resident unit to a seating or other common-use area.

(C) Handrails must be installed at one or both sides of resident-use corridors.

(c) FLOORS.

(A) Hard surface floors and base must be free from cracks and breaks.

(B) Carpeting and other floor materials must be constructed and installed to minimize resistance for passage of wheelchairs and other ambulation aids.

(C) Thresholds and floor junctures must be maintained to allow for the passage of wheelchairs and to prevent a tripping hazard.

(d) INTERIOR DOORS. Lever-type door handles must be provided on all doors used by residents.

(e) EXIT DOORS. Exit doors may not include locks that delay evacuation except as specified by building codes. Such locks may not be installed except with written approval of the Department.

(A) Exit doors may not include locks that prevent evacuation.

(B) If an electronic code must be entered to use an exit door that code must be clearly posted for residents, visitors, and staff use.

(f) WALLS AND CEILINGS. Walls and ceilings must be cleanable in kitchen, laundry, and bathing areas. Kitchen walls must be finished smooth per OAR 333-150-0000 (Food Sanitation Rules).

(g) ELEVATORS. An ALF with residents on more than one floor must provide at least one elevator that meets Oregon Elevator Specialty Code (OESC) requirements.

(h) The interior of the facility must be free from unpleasant odors.

(i) All interior and exterior materials and surfaces (e.g. floors, walls, roofs, ceilings, windows, and furniture) and all equipment necessary

for the health, safety, and comfort of the resident must be kept clean and in good repair.

(5) RESIDENT UNITS. All resident units must be accessible per building codes. These apartments must have a lockable entry door with lever type handle, a private bathroom, and kitchenette facilities. Adaptable units are not acceptable.

(a) UNIT DIMENSIONS. New construction units must have a minimum of 220 net square feet, not including the bathroom. Units in pre-existing structures being remodeled must have a minimum of 160 square feet, not including the bathroom.

(b) RESIDENT STORAGE SPACE.

(A) Each unit must provide usable space totaling at least 100 cubic feet for resident clothing and belongings and include one clothes closet with a minimum of four linear feet of hanging space.

(B) The rod must be adjustable for reach ranges per building codes. In calculating useable space, closet height may not exceed eight feet and a depth of two feet.

(C) Kitchen cabinets must not be included when measuring storage space.

(D) A lockable storage space (e.g., drawer, cabinet, or closet) must be provided for the safekeeping of a resident's small valuable items and funds. Both the administrator and resident may have keys.

(c) WINDOWS.

(A) Each resident's living room and bedroom must have an exterior window that has an area at least one-tenth of the floor area of the room.

(B) Unit windows must be equipped with curtains or blinds for privacy and control of sunlight.

(C) Operable windows must be designed to prevent accidental falls when sill heights are lower than 36 inches and above the first floor.

(d) DOORS. Each unit must have an entry door that does not swing into the exit corridor.

(A) A locking device must be included that is released with action of the inside lever. Locks for the entry door must be individually keyed, master keyed, and a key supplied to the resident.

(B) The unit exit door must open to an indoor, temperature controlled, common-use area or common corridor.

(e) BATHROOM. The unit bathroom must be a separate room with a toilet, sink, a roll-in curbless shower, towel bar, toilet paper holder, mirror, and storage for toiletry items.

(A) The door to the bathroom must open outward or slide into the wall.

(B) Showers must have a slip-resistant floor surface in front of roll-in showers, a hand-held showerhead, cleanable shower curtains, and appropriate grab bar.

(f) KITCHENS OR KITCHENETTES. Each unit must have a kitchen area equipped with the following:

(A) A sink, refrigerator, and cooking appliance that may be removed or disconnected. A microwave is considered a cooking appliance.

(B) Adequate space for food preparation.

(C) Storage space for utensils and supplies.

(D) Counter heights may not be higher than 34 inches.

(6) COMMON-USE AREAS.

(a) PUBLIC RESTROOMS. There must be accessible public restrooms for visitor, staff, and resident-use, convenient to dining and recreation areas.

(A) The public restroom must contain a toilet, sink, waste container, and a hand drying means that cannot be reused.

(B) There must be a manually operated emergency call system in the public restrooms.

(b) DINING AREA. The building must have a dining area with the capacity to seat 100 percent of the residents. The dining area must provide 22 square feet per resident for seating, exclusive of service carts and other equipment or items that take up space in the dining area. This rule is exclusive of any separate private dining areas.

(c) SOCIAL AND RECREATION AREAS. An ALF must include lunge and activity areas for social and recreational-use totaling a minimum of 15 square feet per resident.

(d) COOKING STOVE. If a stove is provided in the activities or common-use area, and is available for resident-use, a keyed, remote switch, or other safety device must be provided to ensure staff control.

(e) RESIDENT LAUNDRY FACILITIES. Laundry facilities must be operable and at no additional cost to the resident. Resident laundry facilities must have at least one washer and dryer.

(f) MAILBOX. Each resident or unit must be provided a mailbox that meets US Postal Service requirements.

(7) SUPPORT SERVICE AREAS.

(a) MEDICATION STORAGE. An ALF must provide a secure space for medication storage, with access to a sink and cold storage in the same area. Space for necessary medical supplies and equipment must be provided.

(b) HOUSEKEEPING AND SANITATION.

(A) An ALF must have a secured janitor closet for storing supplies and equipment, with a floor or service sink.

(B) The wall base shall be continuous and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects or moisture.

(c) LAUNDRY FACILITIES. Laundry facilities may be located to allow for both resident and staff use when a time schedule for resident-use is provided and equipment is of residential type.

(A) If the primary laundry facility is not suitable for resident-use, an ALF must provide separate resident laundry facilities.

(B) Laundry facilities must be separate from food preparation and other resident-use areas.

(C) On-site laundry facilities, used by staff for facility and resident laundry, must have capacity for locked storage of chemicals and equipment.

(D) An ALF must provide covered or enclosed clean linen storage that may be on shelves or carts. Clean linens may be stored in closets outside the laundry area.

(E) The wall base of the laundry facilities must be continuous and coved with the floor, tightly sealed to the wall and constructed without voids that may harbor insects or moisture.

(d) SOILED LINEN PROCESSING. For the purpose of this rule, "soiled linens and soiled clothing," means linens or clothing contaminated by an individual’s bodily fluids (for example, urine, feces, and blood).

(A) There must be a separate area with closed containers that ensure the separate storage and handling of soiled linens and soiled clothing. There must be space and equipment to handle

soiled linen and soiled clothing processing needs that is separate from regular linen and clothing.

(B) Arrangement must provide a one-way flow of soiled linens and soiled clothing from the soiled area to the clean area and preclude potential for contamination of clean linens and clothing.

(C) The soiled linen area must include a flushing rim clinical sink with a handheld rinsing device and a hand wash sink or lavatory.

(D) When washing soiled linens and soiled clothing, washers must have a minimum rinse temperature of 140 degrees Fahrenheit unless a chemical disinfectant is used.

(E) Personnel handling soiled laundry must be provided with waterproof gloves.

(F) Covered or enclosed clean linen storage must be provided and may be on shelves or carts. Clean linens may be stored in closets outside the laundry area.

(G) The wall base of the laundry facilities must be continuous and coved with the floor, tightly sealed to the wall and constructed without voids that may harbor insects or moisture.

(e) KITCHEN AND FOOD STORAGE. An ALF must comply with OAR 333-150-0000 (Food Sanitation Rules), for food handling and primary meal preparation areas. Each ALF must have:

(A) Dry storage space, not subject to freezing, for a minimum one-week supply of staple foods.

(B) Refrigeration and freezer space at the proper temperature to store a minimum two days' supply of perishable foods.

(C) Storage for all dishware, utensils, and cooking utensils used by residents must meet OAR 333-150-0000 (Food Sanitation Rules).

(D) Storage for a mop, other cleaning tools, and supplies used for dietary areas. Such tools must be separate from those used in toilet rooms, resident rooms, and other support areas.

(E) A separate janitor closet or alcove with a floor or service sink and storage for cleaning tools and supplies.

(F) Storage in the food preparation area for garbage must be enclosed and separate from food storage.

(G) Storage must be available for cookbooks, diet planning information, and records.

(H) All kitchen and food storage areas must have a wall base that is continuous and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects or moisture.

(8) HEATING AND VENTILATION SYSTEMS. An ALF must have heating and ventilation systems that comply with the building codes in effect at the time of facility construction.

(a) TEMPERATURE. For all areas occupied by residents, design temperature for construction must be 75 degrees Fahrenheit.

(A) An ALF must provide heating systems capable of maintaining 70 degrees Fahrenheit in resident areas. Required minimum temperatures are no less than 70 degrees Fahrenheit during the day and 60 degrees Fahrenheit during sleeping hours.

(B) During times of extreme summer heat, fans must be made available when air conditioning is not provided.

(C) Each unit must have individual thermostatic heating controls.

(b) EXHAUST SYSTEMS. All toilet and shower rooms must be equipped with a mechanical exhaust fan or central exhaust system that discharges to the outside.

(c) WALL HEATERS. Covers, grates, or screens of wall heaters and associated heating elements may not exceed 120 degrees Fahrenheit when they are installed in locations that are subject to incidental contact by individuals or with combustible material. Effective 01/15/2015 wall heaters are not acceptable in new construction or remodeling.

(d) VENTILATION. Ventilation in each unit must occur via an open window to the outside, or with a mechanical venting system capable of providing two air changes per hour with one-fifth of the air supply taken from the outside.

(9) PLUMBING SYSTEMS. Plumbing systems must conform to the building codes in effect at the time of facility construction.

(a) Hot water temperature in residents' units must be maintained within a range of 110 - 120 degrees Fahrenheit.

(b) Hot water temperatures serving dietary areas must meet OAR 333-150-0000 (Food Sanitation Rules).

(c) An outside area drain and hot and cold water hose bibs must be provided for sanitizing laundry carts, food carts, and garbage cans.

(10) ELECTRICAL SYSTEMS.

(a) WIRING SYSTEMS. All wiring systems must meet the building codes in effect at the date of installation and devices shall be maintained and in good repair.

(b) The use of extension cords and other special taps is not allowed.

(c) LIGHTING. Each unit must have general illumination in the bath, kitchen, living space, and sleeping area. The general lighting intensity in the unit for way finding must be at least 20-foot candles measured from the floor.

(A) Lighting in the unit bathroom must be at least 50-foot candles measured from the height of the hand-wash basin and three feet above the shower floor with the curtain open.

(B) Task lighting at the unit food preparation or cooking area must be at least 50-foot candles measured from counter height.

(C) Corridor lighting must equal a minimum of 20-foot candles measured from the floor.

(D) Table height lighting in the dining room must equal a minimum of 25-foot candles without light from windows.

(11) CALL SYSTEM. An ALF must provide a call system that connects resident units to the care staff center or staff pagers. Wireless call systems are allowed.

(a) A manually operated emergency call system must be provided at each resident bathroom, central bathing rooms, and public-use restrooms.

(b) EXIT DOOR ALARMS. Exit door alarms or other acceptable systems must be provided for security purposes and to alert staff when residents exit the ALF. The door alarm system may be integrated with the call system.

(c) Security devices intended to alert staff of an individual resident's potential elopement may include, but not be limited to, electronic pendants, bracelets, pins.

(12) TELEPHONES.

(a) RESIDENT PHONES. Each unit must have at least one telephone jack to allow for individual phone service.

(b) PUBLIC TELEPHONE. There must be an accessible local access public telephone in a private area that allows a resident or another individual to conduct a private conversation.

(13) TELEVISION ANTENNA OR CABLE SYSTEM. An ALF must provide a television antenna or cable system with an outlet in each resident unit.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0320 Quality Measurement Program and Council *(Amended 12/15/2021)*

(1) The purpose of the Quality Measurement Program is to allow facilities and the public to compare residential care and assisted living facility performance on each quality metric. The Department shall provide and maintain a web-based report based on metrics defined in Or Laws 2017, ch 679, § 15(1) and any other metrics determined by the Quality Measurement Council. The first report from this program will be published July 1, 2021.

(2) Quality Measurement Council. The Quality Measurement Council is appointed by the Governor, and consists of the following members:

(a) One individual representing the Oregon Patient Safety Commission.

(b) One individual representing residential care facilities or assisted living facilities.

(c) One consumer representative from an Alzheimer's advocacy organization.

(d) One licensed health care practitioner with experience in geriatrics.

(e) Two individuals associated with academic institutions who have expertise in research data and analytics and community-based care and quality reporting.

(f) The Long-Term Care Ombudsman or a designee of the Long-Term Care Ombudsman.

(g) One direct care worker or a representative of a direct care worker who works in a residential care facility.

(h) One individual representing the Department.

(3) A staff coordinator shall be assigned by the Department to support the council. The staff coordinator will assist the council as needed and ensure the annual report required by Or Laws 2017, ch 679, § 15(3) and (4) are implemented.

(4) The council shall determine the form and manner for facilities to report metrics for the prior calendar year. Data that identifies a resident is excluded from this requirement.

(a) In developing quality metrics, the council shall consider whether:

(A) Reported data reflects and promotes quality care; and

(B) Reporting the data is unnecessarily burdensome on residential care and assisted living facilities.

(b) On or after January 1, 2022, the council may update, by rule, the quality metrics to be reported by residential care and assisted living.

(5) Annual facility reports.

(a) All residential care and assisted living facilities shall report required metrics to the Department no later than January 31 of each year. The first reports are due January 31, 2021.

(b) Each facility shall report the following quality metrics for the prior calendar year:

(A) Retention of direct care staff.

(B) Falls resulting in physical injury.

(C) Use of antipsychotic medication for nonstandard purposes.

(D) Facility compliance with staff training requirements.

(E) Results of an annual resident satisfaction survey conducted by an independent entity.

(F) A metric that measures the quality of the resident experience.

(G) Any other metrics determined by the council.

(6) Annual report from the Department.

(a) The Department shall develop an annual report by July 1st that is based on the information provided by all reporting residential care and assisted living facilities. This report shall be made available online to each facility. The first report is due July 1, 2021.

(b) The report shall be in a standard format and written in plain language.

(c) The report must include data compilation, illustration, and narratives. The report also must:

(A) Describe statewide patterns and trends that emerge from the collected data.

(B) Describe compliance data maintained by the Department.

(C) Identify facilities that substantially fail to report data as required.

(D) Allow facilities and the public to compare a facility's performance on each quality metric, by demographics, geographic region, facility type, and other categories the Department believes may be useful to consumers and facilities.

(E) Show trends in performance for each quality metric.

(F) Identify patterns of performance by geographic regions, and other categories the Department believes will be useful to consumers.

(G) Identify the number, severity, and scope of regulatory violations by each geographic region.

(H) Show average timelines for surveys and investigations of abuse or regulatory noncompliance.

(d) Quality metric data reported to the Department under this section may not be used against the facility, as required under Or Laws 2017, ch 679, § 15(7). This section does not exempt a facility from complying with state law. Also, the Department may use quality metric data obtained during the normal course of business or compliance activity, as required by Or Laws 2017, ch 679, § 15(8).

(7) Online Training. The Department shall develop online training modules for facilities and the public.

(a) Training modules shall address the top two statewide issues identified by surveys or reviews of facilities during the prior year.

(b) Training modules shall be available and accessible by January 1, 2019.

(c) The Department shall post and regularly update the data used to prepare the report.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: Or Laws 2017, ch 679, §15