

Oregon

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Licensure Term Assisted Living Facility and Residential Care Facility

Opening Statement The Oregon Department of Human Services (DHS) licenses two types of residential care—assisted living facilities and residential care facilities. General licensing requirements are the same for both types of facilities. The major distinction between the two settings pertains to the building requirements. Assisted living facilities must provide a private apartment, private bath, and kitchenette, whereas residential care facilities may have shared rooms and shared baths, or private apartments. The following requirements apply to both types of facilities unless otherwise noted.

Oregon also licenses Endorsed Memory Care Communities (MCC). Such communities must meet the licensing requirements for the applicable licensed setting (i.e., residential care, assisted living, or nursing facility) and meet additional requirements specified in the MCC rules. Any facility that offers or provides care for residents with dementia in a memory care community must obtain an “endorsement” on its facility license. The rules emphasize person-directed care, resident protection, staff training specific to dementia care, and physical plant and environmental requirements. Residents moving into these specialized, secured settings must have a diagnosis of dementia.

Legislative and Regulatory Update

In 2019, the Oregon legislature passed SB 815, which requires assisted living facilities and residential care communities to provide a written notice to applicants for admission and upon request a summary explanation of the services provided, the type of care the community does not provide, move out policy and procedures specifically related to when residents care exceed the service capability of the community, appeal rights related to move out notices, and information on whether the community provides hospice services. The information must be in written, plain language, explained to the individual or representative and provided separate

from all other disclosure and residency documentation.

The 2019 Legislature also passed HB2600 which will require annual kitchen inspections for assisted living and residential care communities. Licensing inspections are conducted every 24 months. The bill also enhances current infection control pre-service training requirements for administrators and staff. The Department of Human Service in consultation with the Oregon Health Authority will draft rules to prescribing training requirements which must include; (a) how to properly prevent and contain disease outbreaks based on the current best evidence in the field of infection and disease outbreak identification, prevention and control; and (b) the responsibility of staff members to report disease outbreaks. The bill further directs that a community must establish and maintain infection prevention and control protocols designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of communicable diseases, and designate an individual to be responsible for carrying out the infection prevention and control protocols and to serve as the primary point of contact for the department regarding disease outbreaks. The designated individual must be qualified by education, training, and experience or certification and complete a specialized infection prevention training. This bill goes into full effect January 1, 2021.

In 2018, the state amended many sections of the assisted living and residential care facility regulations to comply with legislation passed in 2017. These changes, which are mandated in statute, affect a variety of requirements, such as medications and treatments, restraints and supportive devices, and direct care staff dementia pre-service and annual inservice training requirements.

In 2017, Oregon's legislature passed HB 3359, which included a number of provisions that affect assisted living and residential care facilities. The bill increased and enhanced existing requirements including that: assisted living and residential care communities annually report quality metrics to DHS starting in January 2020 for the 2019 calendar year [which was then amended in the 2019 legislative session to January 2021 for 2020]; direct care staff in non-memory care and memory care communities must complete training on specified topics prior to providing care to residents; direct care workers must complete six hours annually specific to dementia care; and residential care facilities must have a means of measuring demonstration of competency in the subject areas. The bill directs the DHS to make available a web-based acuity-based

staffing tool. It also includes provisions related to prescription drug packaging, enhanced oversight and supervision, immediate suspension, DHS enforcement accountability, conditions on licensure, increasing fines and fees, and independent licensure for administrators. Several of the bill elements required regulations to be amended by January 2018, while the quality metrics requirements have a longer implementation timeline.

The Department of Human Services also revised the Home and Community-Based Services (HCBS) rules effective July 1, 2017 and June 29, 2018, in order to meet the state's HCBS transition plan.

Definition

Assisted Living Facility: 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 facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living (ADL), health, and social needs of the residents. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, and independence.

Residential Care Facility: 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 facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the ADL, health, and social needs of the residents as described in the rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, individuality, and independence.

Disclosure Items

As described in the "Legislative and Regulatory Update" section, SB 815 passed in 2019 to require additional information to an individual applying for admission, and upon request. This new requirement will go into effect 90 days after the state legislature adjourns. Conforming regulations will need to be promulgated.

Currently, there is a state-designated uniform disclosure statement that must be provided to each person who requests information about a facility. In addition to the uniform disclosure statement, a residency agreement and following disclosure information must be provided to all potential residents prior to move in. Information required in the disclosure statement includes:

(1) Terms of occupancy, including policy on the possession of

firearms and ammunition;

(2) 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;

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

(4) Policy for increases, additions, or changes to the rate structure. 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;

(5) Refund and proration conditions;

(6) A description of the scope of services available according to Oregon Revised Statutes (OR) 411-054-0030 (Resident Services);

(7) A description of the service planning process;

(8) Additional available services;

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

(10) Resident rights and responsibilities;

(11) The facility system for packaging medications and that residents may choose a pharmacy that meets the requirements of ORS 443.437;

(12) Criteria, actions, circumstances, or conditions that may result in a move-out notification or intra-facility move;

(13) Residents' rights pertaining to notification of move-out;

(14) Notice that DHS has the authority to examine residents' records as part of the evaluation of the facility; and

(15) Staffing plan.

Additionally each resident and resident's designated representative,

if appropriate, must be given a copy of the resident's rights and responsibilities prior to moving into the facility.

The following information must be provided to individuals and their families prior to admission to a Memory Care Community:

- (1) The philosophy of how care and services are provided to the residents;
- (2) The admission, discharge, and transfer criteria and procedures;
- (3) The training topics, amount of training spent on each topic, and the name and qualifications of the individuals used to train the direct care staff; and
- (4) The number of direct care staff assigned to the unit during each shift.

Facility Scope of Care

Facilities may care for individuals with all levels of care needs. Facilities must provide a minimum scope of services to include: three nutritious, palatable meals with snacks; personal and other laundry services; daily social and recreational activities; resources for activity needs; ADL assistance; medication administration; and household services.

Third Party Scope of Care

Facilities must provide or arrange for transportation for medical and social services, as well as ancillary services for medically-related care—such as physician, therapy, barber or beauty services, hospice or home health—and other services necessary to support the resident.

Admission and Retention Policy

Facilities may care for individuals with all levels of care needs. Residents may be asked to move out in certain situations. Thirty-day notification must be provided in most situations but there is a provision for less than 30-day notification when there are urgent medical and psychiatric needs. Facilities must demonstrate attempts to resolve the reason for the move out. The following are specific reasons that a facility could request that a resident seek other living arrangements:

- (1) The resident's needs exceed the level of ADL services the facility provides as specified in the facility's disclosure information;
- (2) The resident engages in behavior or actions that repeatedly and substantially interferes with the rights, health, or safety of residents or others;

(3) 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;

(4) The facility is unable to accomplish resident evacuation in accordance with OAR 411-054-0090 (Fire and Life Safety);

(5) The resident exhibits behavior that poses a danger to self or others;

(6) The resident engages in illegal drug use or commits a criminal act that causes potential harm to the resident or others; or

(7) There is non-payment of charges.

Resident Assessment

A resident evaluation must be performed before the resident moves into the facility and at least quarterly thereafter. A standardized assessment form is used by state caseworkers to determine Medicaid eligibility and service level payment. Providers are not required to use a Department-designated form but must address a common set of evaluation elements including specified resident routines and preferences; physical health status; mental health issues; cognition; communication and sensory abilities; ADLs; independent ADLs; pain; skin condition; nutrition habits, fluid preferences, and weight if indicated; treatments including type, frequency and level of assistance needed; indicators of nursing needs, including potential for delegated nursing tasks; and a review of risk indicators.

Medication Management

Psychoactive medications may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use. Facility administered psychoactive medications may be used only when required to treat a resident's medical symptoms or to maximize a resident's functioning. The facility must not request psychoactive medication to treat a resident's behavioral symptoms without a consultation from a physician, nurse practitioner, registered nurse, or mental health professional. Prior to administering any psychoactive medications to treat a resident's behavior, all direct care staff administering medications for the resident must know: the specific reasons for the use of the psychoactive medication for that resident; the common side effects of the medications; and when to contact a health professional regarding side effects.

Square Feet Requirements	<p>Assisted Living Facility: Newly constructed private resident units must be a minimum of 220 square feet (not including the bathroom) and must include a kitchen and fully accessible bathroom. Pre-existing facilities being remodeled must be a minimum of 160 square feet (not including the bathroom). Other extensive physical plant requirements apply.</p> <p>Residential Care Facility: Resident units may be limited to a bedroom only, with bathroom facilities centrally located off common corridors. In bedroom units, the door must open to an indoor, temperature-controlled common area or common corridor and residents must not enter a room through another resident's bedroom. 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.</p>
Residents Allowed Per Room	<p>Assisted Living Facility: Resident units may only be shared by couples or individuals who choose to live together.</p> <p>Residential Care Facility: Each resident unit may house no more than two residents.</p>
Bathroom Requirements	<p>Assisted Living Facility: Private bathrooms are required.</p> <p>Residential Care Facility: 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.</p>
Life Safety	<p>All buildings must have an automatic sprinkler system, smoke detectors, and an automatic and manual fire alarm system.</p> <p>Facilities must have a written emergency procedure and disaster plan for meeting all emergencies and disasters that must be approved by the state fire marshal. A minimum of one unannounced fire drill must be conducted and recorded every other month. Each month that a fire drill is conducted, the time (day, evening, and night shifts) and location of the drill must vary. Fire and life safety instruction to staff must be provided on alternate months. In addition to routine fire drills, the facility must conduct a drill of the emergency preparedness plan at least twice a year.</p>
Unit and Staffing Requirements for Serving Persons with Dementia	<p>In 2010, Oregon revised new rules for the endorsement of Memory Care Communities, formerly known as Alzheimer's Care Units. To achieve endorsement, a Memory Care Community must meet underlying licensing requirements for Assisted Living and Residential Care as well as the endorsement rules. Endorsement rules focus on person-centered care, consumer protection, and staff</p>

training specific to caring for people with dementia, and include enhanced physical plant and environmental requirements. A Memory Care Community is defined as a special care unit in a designated separate area for individuals with Alzheimer's disease or other dementia that is locked, segregated, or secured to prevent or limit access by a resident outside the designated or separated area.

Applicants for endorsement must demonstrate their capacity to operate a Memory Care Community, taking into account their history of compliance and experience in operating any care facility. Applicants without sufficient experience must employ a consultant or management company for at least the first six months of operation.

Communities that are not endorsed may not advertise or imply that they have an endorsement. In addition to the residency agreement, an endorsed community must provide a Memory Care Community Uniform Disclosure Statement to residents or their representatives prior to move-in.

Staffing levels must comply with licensing rules and be sufficient to meet the scheduled and unscheduled needs of residents. Staffing levels during nighttime hours shall be based on sleep patterns and needs of residents. Required policies and procedures include philosophy of how memory care services are provided and promotion of person-directed care, evaluation of behavioral symptoms and design for supports for an intervention plan, resident assessment for the use and effects of medications including psychotropic medications, wandering and egress prevention, and description of family support programs. Minimum services are specified including an individualized nutritional plan, an activity plan, evaluation of behavioral symptoms that negatively impact the resident or others in the community, support to family and other significant relationships, and access to outdoor space and walkways.

The physical design should maximize functional abilities, accommodate behavior related to dementia, promote safety, encourage dignity, and encourage independence. Specific elements for new construction or remodels include: SR-2 occupancy classification; lighting requirements that meet the ANSI/IESNA RP-28-07; and a secure outdoor recreation area.

All Memory Care Community staff must be trained in required topics addressing the needs of people with dementia prior to providing care and services to residents and within 30 days of hire.

They also must receive six hours of dementia-specific in-service training annually (in addition to licensing requirements or annual training). For an administrator of a Memory Care Community, 10 of the 20 hours of required annual continuing education must be related to the care of individuals with dementia.

Staffing Requirements

Facilities must employ a full-time administrator who must be scheduled to be on site for at least 40 hours per week. While there are no staffing ratio requirements, the Department retains the right to require minimum staffing standards based on acuity, complaint investigation or survey inspection. The facility must have qualified staff sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident and an adequate number of nursing hours relevant to the census and acuity of the resident population. Based on resident acuity and facility structural design, there must be adequate caregivers present at all times to meet the fire safety evacuation standards as required by the fire authority or DHS.

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 and mental needs of the residents. A minimum of two caregivers must be scheduled and available at all times whenever a resident requires the assistance of two caregivers for scheduled and unscheduled needs. 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.

Facilities must have a written, defined system to determine appropriate numbers of caregivers and general staffing based on resident acuity and service needs. Such systems may be either manual or electronic. Guidelines for systems must also consider physical elements of a building, use of technology, if applicable, and staff experience. Facilities must be able to demonstrate how their staffing system works.

Staff under 18 years of age may not assist with medication administration or delegated nursing tasks and must be supervised when providing bathing, toileting, or transferring services.

Administrator Education/Training

The administrator is required to be at least 21 years of age, and:

(1) Possess a high school diploma or equivalent; and

(2) Have two years of professional or management experience that has occurred within the last 5 years in a health or social service related field or program; or

(3) Have a combination of experience and education; or

(4) Possess an accredited bachelor's degree in a health or social service related field.

Additionally, all administrators must:

(1) Complete a state-approved training course of at least 40 hours; or

(2) Complete a state-approved administrator training program that includes both a classroom training of less than 40 hours and a state-approved 40-hour internship with a state-approved administrator.

Administrators must complete 20 hours of continuing education per year. MCC administrators must complete 10 continuing education hours on dementia related topics each year.

Formal licensing by the Oregon Health Authority, Health Licensing Office (OHA HLO) commenced in May 2019. By July 1, 2019, current Administrators and individuals who meet qualification standard could apply for a permanent administrator license without taking an exam. Between July 1, 2019 and January 1, 2022, individuals can apply for a license and by January 1, 2022 all administrators of record in Oregon must be licensed by OHA HLO.

Staff Education/Training

Prior to beginning their job responsibilities all employees must complete an orientation that includes: residents' rights and the values of community-based care; abuse and reporting requirements; standard precautions for infection control; and fire safety and emergency procedures. If staff members' duties include preparing food, they must have a food handler's certificate.

Prior to providing care to residents, direct care staff in both non-memory care and memory care communities must complete an approved training on: 1) education on the dementia disease process, including the progression of the disease, memory loss, psychiatric and behavioral symptoms; 2) techniques for understanding and managing symptoms, including but not limited to reducing the use of anti-psychotic medications for non-standard use; 3) strategies for addressing the social needs of persons with

dementia and providing meaningful activities, and 4) information on addressing specific aspects of dementia care and ensuring the safety of residents with dementia, including, but not limited to how to: address pain, provide food and fluids; and prevent wandering and elopement.

The facility must have a training program that has a method to assess competency through observation, written testing or verbal testing. The facility is responsible to assure that caregivers have demonstrated satisfactory performance in any duty they are assigned. Knowledge and performance must be demonstrated in all areas within the first 30 days of hire, including, but not limited to:

- (1) The role of service plans in providing individualized resident care;
- (2) Providing assistance with ADLs;
- (3) Changes associated with normal aging;
- (4) Identification of changes in the resident's physical, emotional, and mental functioning, and documentation and reporting on the resident's changes of condition;
- (5) Conditions that require assessment, treatment, observation, and reporting;
and
- (6) General food safety, serving, and sanitation.

If the caregiver'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.

Prior to providing personal care services for a resident, caregivers must receive an orientation to the resident, including the resident's service plan. 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.

Staff must be trained in the use of the abdominal thrust and first aid. CPR training is recommended, but not required.

Direct caregivers must have 12 hours of in-service training annually, including six hours specific to dementia care.

**Entity Approving
CE Program**

Office of Safety, Oversight and Quality

**Medicaid Policy and
Reimbursement**

Medicaid covers services in assisted living and residential care facilities under 1915(k) Community First Choice authority. It is a tiered system of reimbursement based on the services provided.

Citations

Oregon Administrative Rules, Chapter 411, Division 54: Residential Care and Assisted Living Facilities. [June 29, 2018]
http://www.dhs.state.or.us/policy/spd/rules/411_054.pdf

Oregon Administrative Rules, Chapter 411, Division 57: Memory Care Communities. [November 1, 2010]
http://www.dhs.state.or.us/policy/spd/rules/411_057.pdf

Oregon Department of Human Services, Seniors and People with Disabilities. Home and Community-Based Services.
<http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/index.aspx>

House Bill 3359. 79th Oregon Legislative Assembly.
<https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB3359/C-Engrossed>

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