Oregon

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Licensure Term

Assisted Living Facility and Residential Care Facility

Opening Statement

The Oregon Department of Human Services (ODHS) licenses two types of Community-Based Care Settings—Assisted Living facilities (ALFs) and Residential Care facilities (RCFs). 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.

ODHS also endorses 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

By July 1, 2022, all ALFs and RCFs were required to implement an Acuity-Based Staffing Tool (ABST) to determine the appropriate number and qualifications of staff necessary to meet the scheduled and unscheduled needs of all facility residents at all times. ODHS has developed a model ABST that can be utilized at state option.

Beginning July 1, 2022, the Department will regulate staffing; the Department will review facilities' acuity levels to determine if staffing levels are adequate.

Facilities are prohibited from interfering with or retaliating against any staff member or volunteer who, in good faith, discloses any information concerning mistreatment in the RCF.

By January 1, 2022, all administrators were required to have a Residential Care Administrator License issued by the Oregon Health Authority's Health Licensing Office.

In 2023, the Department will be required to report to the Legislature on the following financial indicators:

- What is total cost of providing care to residents?
- Does reimbursement paid to facilities cover costs?
- What is the average wage of direct care workers?

The Department will collaborate with a new Governor's Council to fund local public sector pilot projects that aim to:

- Fund "innovative strategies" for addressing emergency situations
- Reduce the overall costs of senior EMS while promoting quality.
- Encourage unique community-based responses to challenges faced by local communities in meeting their residents' needs for senior EMS.

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 (ADLs), health, and social needs of the residents. A person-centered 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 daily health and social needs of the residents as described in the rules. A person-centered program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, individuality, and independence.

Disclosure Items

Oregon requires four specific individual documents to be provided prior to move-in.

1. Uniform disclosure statement: This state specific document (SDS9098a for ALF and SDS9098mc for Memory Care) highlights details around required services, other services and amenities offered by the community, deposits and fees, medication administration, staffing, staff training, and discharge transfer information.
2. Consumer Summary statement: This document must be submitted to ODHS and is posted on the ODHS website for consumer reference. This document must contain community information around the following key points.
    - Summary of the care and services provided
    - Summary explanation of the types of care and services not provided
    - If a resident needs exceed the care and services provided, the provider may ask the resident to move out.
    - If a resident leaves a community to receive acute medical, psychiatric, nursing facility or other care, the provider must conduct an evaluation before the resident can return to the community
    - Residents have the right to ask for an administrative hearing if they disagree with the facilities decision to issue the resident an involuntary move out notice.
    - How the facility arranges for or coordinates hospice care
3. Residency agreement that incorporates all of the topics outlined in OAR 411-054-0026(2), including terms of occupancy, payment provisions, policy for increases, additions or changes to the rate structure, scope of resident services available, criteria for move-out, and community's staffing plans.
4. Resident Rights that incorporate all items as outlined in OAR 411-054-0027, including the right to be free from neglect/abuse, to be free from discrimination, be given informed choice and opportunity to select

	or refuse services and accept responsibility for the consequences, to participate in the development of the service plans, and prompt access to review of records.
Facility Scope of Care	Facilities may care for individuals with various levels of care needs. Facilities must provide a minimum scope of services to include: three nutritious, palatable meals with snacks available 24/7; personal and other laundry services; daily social and recreational activities; resources (e.g., equipment, supplies) for activity needs; assistance with ADLs 24 hours per day; 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 various 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, at 30 days after move-in, at 90 days after move-in and at least quarterly thereafter. Resident evaluations must also be updated with a significant change in condition 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. For those providers offering Medicaid services, a standardized assessment form is used by state caseworkers to determine Medicaid eligibility and service level payment.

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

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. 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.
Residents Allowed Per Room	Assisted Living Facility: Resident units may only be shared by couples or individuals who choose to live together. Residential Care Facility: Each resident unit may house no more than two residents.
Bathroom Requirements	Assisted Living Facility: Private bathrooms are required. 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.
Life Safety	All buildings must have an automatic sprinkler system, smoke detectors, and an automatic and manual fire alarm system. Building must have a heating and ventilation system that complies with building codes and are capable of maintaining the specified temperatures outlined in rules. 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.

Unit and Staffing Requirements for Serving Persons with Dementia

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 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 forms of dementia that is 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. An endorsed community must provide a Memory Care Community Uniform Disclosure Statement (SDS 9098mc) 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 secured 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 RP28-07; 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. Dementia care training must reflect current standards for dementia care and be informed by the best evidence in the care and treatment of 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. Facilities must provide an Oregon licensed nurse who is regularly scheduled for onsite duties at the facility and who is available for phone consultation. In addition, facilities must designate an individual to be the facility's Infection Control Specialist, who is responsible for carrying out the facility's infection prevention and control protocols and serves as the point of contact for the Department in case there are disease outbreaks. The Infection Control Specialist must be qualified for the role through education, training and experience, or certification, and complete specialized training within three months of being designated if such training has not been completed within the 24-month period prior to the designation. While there are no specific staffing ratio requirements, facilities must have a written, acuity-based staffing tool that determines the appropriate numbers of caregivers and general staffing based on resident acuity and service needs. ODHS offers a tool for providers to use. If a provider chooses to use their own tool, it must meet the criteria outlined in OAR 411-054-0037 (5). This staffing tool must be updated after each resident move in, whenever there is a resident change in condition, and no less than quarterly. This acuity-based staffing tool will provide information to develop the facility's

staffing plan which is required to be posted in a public area. Such systems may be either manual or electronic. Guidelines for the acuity-based staffing tool must also consider physical elements of a building, fire/safety evacuation needs, use of technology, if applicable, and staff experience.

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 be able to demonstrate how their staffing system works. The Department retains the right to require minimum staffing standards based on acuity, complaint investigation or survey inspection.

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 administrator training program that includes both a classroom training of no less than 40 hours; and
(2) Administrators must complete 20 hours of continuing education per year. MCC administrators must complete 10 continuing education hours on dementia related topics each year.
All ALF and RCF administrators must be licensed by the Oregon Health Authority, Health Licensing Office (OHA

HLO). Potential administrators must complete the criteria above as well as a tuberculous screening, background check, and pass the proficiency licensing exam prior to becoming an administrator.

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; department- specific infectious disease prevention training; 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. All dementia care training provided to direct care staff must be approved by the Department. Staff must have annual training on infectious disease and infection control.
Entity Approving CE Program	The Oregon Health Licensing Office
Medicaid Policy and Reimbursement	Medicaid covers services in assisted living and residential care facilities via K Plan which is authorized under the Section 1915(k) Community First Choice state plan option authority. It is a tiered system of reimbursement based on the services provided.
COVID-19 Public Health Emergency	Oregon requires all healthcare providers and healthcare staff who work in a healthcare setting to be fully vaccinated against COVID-19, unless the individual has a medical or religious exemption. In addition, facilities must provide weekly reporting under OAR Chapter 411, Division 61 to the Oregon Health Authority, including the number of staff and residents who are fully vaccinated, who have only received one dose of an available two-dose vaccine, and who have a medical contraindication to the receipt of a COVID-19 vaccine. OAR Chapter 411, Division 60 outlines the testing protocols required in facilities, including

admission and readmission testing, routine staff testing requirements and outbreak prevention testing.

Citations

Oregon Administrative Rules, Chapter 411, Division 54: Residential Care and Assisted Living Facilities. [January 1, 2020]
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. https://www.oregon.gov/dhs/SENIORS-DISABILITIES/HCBS/Pages/index.aspx

79th Oregon Legislative Assembly. House Bill 3359. https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/HB3359