OREGON

Licensure Terms

Assisted Living Facility, Residential Care Facility, Memory Care Community

General Approach

The Oregon Department of Human Services, Office of Licensing and Regulatory Oversight, licenses two types of residential care--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. ALFs must provide a private apartment, private bath, and kitchenette, whereas RCFs may have shared rooms and shared baths, or private apartments.

Oregon has a separate set of rules, for memory care communities (previously called Alzheimer's care units) that are either licensed as an ALF, a RCF, or a nursing facility. Such communities must meet the licensing requirements for the applicable licensed setting and additional requirements specified in the memory care community 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.

Adult Foster Care (AFC). The Department of Human Services licenses adult foster homes, which provide care and services to five or fewer adults in a setting that protects and encourages resident dignity, choice, and decision-making while addressing residents' needs in a manner that supports and enables them to maximize their ability to function at the highest possible level of independence. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end*.

This profile includes summaries of selected regulatory provisions for ALFs and RCFs. The complete regulations can be viewed online using the links provided at the end.

Definitions

Assisted living facility 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 home-like surroundings. The facility offers and coordinates a range of supportive services available on a 24-hour basis to

meet residents' health and social needs, including assistance with activities of daily living (ADLs).

Residential care facility means a building, complex, or distinct part thereof, consisting of shared or individual living units in a home-like 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 residents' health and social needs, including assistance with ADLs.

Memory care community means a special care unit in a designated, separate area for individuals with Alzheimer's disease or other dementias that is locked, segregated, or secured to prevent or limit access by a resident outside the designated or separated area.

Resident Agreements

The residency agreement must include the following:

- Terms of occupancy and discharge policies and procedures, payment provisions, refund and proration conditions, and policy for increases, additions, or changes to the rate structure.
- The method for evaluating a resident's service needs and assessing the costs for the services provided.
- The staffing plan, medication policies, and the facility system for packaging medications.
- A description of the scope of services available, the service planning process, and how health care and ADL services are provided.
- Residents' rights and responsibilities, including the right to choose a pharmacy.

Disclosure Provisions

A written disclosure statement must be provided to prospective residents. A Uniform Disclosure Statement template, available on the Department website, includes sections on costs, services, and operations.

Memory care communities must have a written policy of pre-admission screening, and admission and discharge procedures, including policies for moves to a different unit within the facility. Prior to admission, the facility must provide the resident or the resident's legal guardian (if any) and/or a member of the resident's family (if appropriate), with a copy of the disclosure statement.

Admission and Retention Policy

The Department encourages facilities to support residents' choice to remain in the facility while recognizing that some residents may no longer be appropriate for community-based care due to safety or medical limitations. Involuntary discharge is permitted for urgent medical and psychiatric needs or if a facility discovers that a resident was convicted of sex crimes that were not previously disclosed. Other reasons for discharge include the following:

- The resident's needs exceed the level of ADL services the facility provides as specified in the disclosure information.
- The resident engages in behavior or actions that repeatedly and substantially interferes with the rights, health, or safety of residents or others.
- 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.
- The facility is unable to accomplish resident evacuation in accordance with fire and life safety rules.
- The resident engages in illegal drug use or commits a criminal act that causes potential harm to the resident or others.

Only individuals with a diagnosis of dementia who are in need of support for the progressive symptoms of dementia for physical safety or physical or cognitive functioning may reside in a memory care community.

Services

Facilities provide supervision or assistance to help, develop, increase, maintain, or maximize the resident's level of independent psychosocial and physical functioning.

Minimum required services include laundry; a program of social and recreational activities; assistance with ADLs, including one-person transfers; medication administration; and household services. Facilities must also provide or arrange for social and medical transportation, and ancillary services for related medical care (i.e., physician, pharmacy, therapy, and podiatry appointments).

The facility must provide health services and have systems in place to respond to residents' 24-hour care needs. The systems must include medical emergency response policies and procedures, and access to a licensed nurse who is regularly scheduled for

on-site duties at the facility and who is available for phone consultation. Required nursing services include:

- Assessing resident health and well-being.
- Delegating and teaching staff to perform tasks in accordance with Board of Nursing rules.
- Participating on the service planning team, as needed.
- Providing health care teaching and counseling based on service plans.
- Providing intermittent direct nursing services, as needed.

Memory care communities must deliver services that are required under the facility license in a manner that addresses the needs of persons with cognitive or physical limitations due to dementia. Daily structured and unstructured activities must be provided and can include chore-related tasks; entertainment; and individual, group, sensory stimulation, physical, and outdoor activities.

Service Planning

A resident evaluation is required before admission and must be updated during the first 30 days of residence and at least quarterly after, or following a change of condition. The evaluation must assess resident routines and preferences, physical health, mental health, cognition, communication and sensory limitations, ADLs, instrumental activities of daily living, pain treatments, skin condition, nutrition habits, treatment types, nursing needs, and risk indicators (e.g., fall history, emergency evacuation ability, complex medication regimen, elopement history, smoking, and alcohol and drug use).

The service planning team includes two or more individuals who assist the resident in determining what services and care are needed, preferred, and may be provided. When applicable, a registered nurse (RN), the resident's family, a state or Area Agency on Aging case manager (if the resident receives publicly funded services), and/or the resident's physician or other health practitioner must be included. The service plan must reflect the resident's needs identified in the evaluation and describe who will provides services, and what, when, how, and how often services will be provided. The resident must actively participate in the development of the service plan to the extent of his/her ability to do so. The service plan is reviewed and updated at least quarterly.

When a resident's actions or choices pose a potential risk to that resident's health or well-being, a managed risk agreement may be developed to identify potential consequences of a resident's actions and possible alternatives. The risk plan must explain the cause of concern, possible negative consequences, possible alternatives, and services provided by the facility to minimize the risk. The resident's preferences take precedence over those of family member(s). A managed risk plan cannot be entered into or continued with on behalf of a resident who is unable to recognize the consequences of his/her behavior or choices. The risk plan is reviewed at least quarterly or when there is a change of condition.

Behavioral symptoms that negatively impact the resident and others in a memory care community must be evaluated, and approaches for addressing them must be included in the service plan.

Third-Party Providers

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.

Medication Provisions

Facilities may administer medications to residents and must have medication and treatment administration systems in place that are approved by a pharmacist consultant, RN, or physician. The facility administrator is responsible for ensuring adequate professional oversight of the medication and treatment administration system. Direct care staff may administer medications. Appropriate facility staff, in accordance with applicable regulations, must document that they have observed and evaluated the staff person's ability to safely administer medications and treatments unsupervised.

Residents may keep over-the-counter and prescription medications in their unit if they are capable of self-administration. Residents who self-administer prescription medications must have a physician's or other legally recognized practitioner's written order of approval and be evaluated by the facility as well for ability and safety in medication administration. When two residents share a unit, a safety evaluation must be conducted.

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. Psychoactive medications may be used to treat a resident's medical symptoms and/or improve functioning and not for the facility's convenience. Staff who administer psychoactive medications must understand the reasons for use, common side effects, and when to contact a health professional regarding side effects. Medications administered as-needed (PRN) to treat behavior must have a written, resident-specific parameter that defines use.

Food Service and Dietary Provisions

Facilities must provide three meals a day and snacks in accordance with the recommended dietary allowances of the U.S. Department of Agriculture Food Guide Pyramid, appropriate to residents' needs and choices. Modified special diets must be provided and include but are not limited to small frequent meals, no added salt, reduced or no added sugar, and textural modifications.

Staffing Requirements

Type of Staff. Each facility must employ a full-time *administrator* and *caregivers* who provide assistance with ADLs, medication administration, resident-focused activities, supervision, and support. Caregivers who have additional duties, such as housekeeping, laundry, or food service, are called *universal workers*. A *licensed nurse* must be available, either on staff, or as a consultant.

Staff Ratios. *No minimum ratios*. The facility must have sufficient qualified awake staff to meet residents' 24-hour scheduled and unscheduled needs. If a facility employs universal workers, staffing must be increased to maintain adequate resident care and services. Direct care staffing must be calculated based on resident acuity, staff training, facility census, and facility structural design (e.g., to meet the fire safety evacuation standards).

The number of licensed nurse hours that are scheduled must be relevant to the census and acuity of the resident population.

Training Requirements

All staff must receive an orientation on residents' rights and the values of community-based care, abuse and reporting requirements, standard precautions for infection control, and fire safety and emergency procedures. Within the first 30 days of hire, staff must demonstrate knowledge and performance in several areas, including but not limited to the following:

- The role of service plans in providing individualized resident care.
- Providing assistance with ADLs.
- Changes associated with normal aging, and identifying changes in the resident's physical, emotional, and mental functioning.
- Conditions that require assessment, treatment, observation, and reporting.
- Understanding residents' actions and behavior as a form of communication.
- Understanding and providing support for residents with dementia.
- Food safety, serving, and sanitation.

All staff must be trained in the use of the abdominal thrust and first-aid; training in cardiopulmonary resuscitation is recommended.

Administrators must complete 20 hours of approved continuing education and direct caregivers must complete 12 hours of in-service training annually.

Provisions for Apartments and Private Units

Assisted Living Facilities. All resident units are individual apartments with a lockable door, private bathroom, and kitchenette conforming to relevant state and federal building codes as well as the Americans with Disabilities Act and Fair Housing Act. Shared units are allowed by resident choice. Unit bathrooms must have a toilet, sink, and a roll-in, and curbless shower. Each unit must have a kitchen area equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, space for food preparation, and storage space. All units must have an escape window that opens directly onto a public street, public alley, yard, or exit court.

Residential Care Facilities. Units may be private or shared by no more than two residents. Resident units may be limited to a bedroom only; if so, the door must open to an indoor, temperature controlled common area/corridor. Bathroom facilities may be centrally located off common corridors.

If the unit has a bathroom, it must include a toilet, hand-washing sink, mirror, and towel bar, and must be accessible for persons who use wheelchairs. If cooking facilities are provided, cooking appliances must be readily removable or able to be disconnected.

In facilities that do not provide full bathrooms in each unit, centralized bathing rooms must be provided at a minimum ratio of 1:10 residents. At least one centralized shower/tub must be accessible without requiring substantial lifting by staff.

Provisions for Serving Persons with Dementia

Dementia Care Staff. For memory care communities, staffing rules for the applicable licensed facility--assisted living, residential care, and nursing facilities--apply.

Dementia Staff Training. Staff in memory care communities must be specially trained to work with persons who have dementia. Administrators must complete at least 10 hours of their required continuing education on dementia care.

Dementia Facility Requirements. A memory care community is a designated separate unit that is locked, segregated, or secured to prevent or limit access by a resident outside the unit. The licensing rules include requirements for lighting, floor and wall finishes, common areas, resident rooms, exit doors, outdoor recreation areas, building codes, and fire safety.

Background Checks

Facility owners, administrators, and staff must satisfy a criminal records clearance. A fingerprint check may be required for conducting a national background check.

Inspection and Monitoring

Department staff visit and inspect every facility at least once every 2 years to determine whether they are maintained and operated in accordance with the licensing rules.

Public Financing

The state's Medicaid Aged and Disabled 1915(c) Waiver program pays for services for eligible residents of ALFs and RCFs (and also adult foster homes).

Room and Board Policy

In 2015, the room and board cap is $570 for Medicaid-eligible residents and the personal needs allowance is $163. The state does not provide an optional state supplement. In 2009, family supplementation was not permitted.[1]

Location of Licensing, Certification, or Other Requirements

Oregon Administrative Rules, Chapter 411, Division 54: Residential Care and Assisted Living Facilities. [November 1, 2007]
http://www.dhs.state.or.us/policy/spd/rules/411_054.pdf

Oregon Department of Human Services, Seniors and People with Disabilities: Uniform Disclosure Statement, Assisted Living/Residential Care Community.
https://apps.state.or.us/Forms/Served/se9098a.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 Administrative Rules, Chapter 411, Division 50: Adult Foster Homes. [September 1, 2013]
http://www.dhs.state.or.us/policy/spd/rules/411_050.pdf

[1] Mollica, R.L. (2009). *State Medicaid Reimbursement Policies and Practices in Assisted Living*, National Center for Assisted Living, American Health Care Association.
http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf. Current information about family supplementation policy, was not available online or from other sources.

Information Sources

Linda Kirschbaum
Oregon Health Care Association

Ruth Gulyas
Leading Age Oregon

Cory Oace
Department of Human Services
Office of Licensing and Regulatory Oversight

COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

Files Available for This Report

FULL REPORT

Executive Summary	http://aspe.hhs.gov/execsum/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-executive-summary
HTML	http://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition
PDF	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition

SEPARATE STATE PROFILES

[***NOTE***: These profiles are available in the full HTML and PDF versions, as well as each state available as a separate PDF listed below.]

Alabama	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alabama-profile
Alaska	http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-alaska-profile
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