

OREGON

Citation Assisted living and residential care facilities: OAR Division 56: 411-054-0000

General Approach and Recent Developments

A four year review of the rules produced major changes. Oregon retains two types of residential care -- ALFs and RCFs. The new chapter consolidates requirements but maintain separate requirements for living units. Other requirements are the same for both categories. The major distinction between ALFs and RCFs is that ALFs have private apartments whereas RCFs have both private and shared rooms and private and shared baths. The state does not allow providers to market themselves as assisted living unless they offer residents private apartments and are licensed as assisted living. The rules for ALFs and RCFs establish standards that promote the availability of appropriate services for elderly and disabled persons in a home-like environment that enhances the dignity, independence, individuality, privacy, choice, and decision making ability of the resident. Language about the philosophy is also contained in sections dealing with management responsibilities and service planning.

The moratorium on the licensing of new ALFs and RCFs was extended until June 30, 2009. Licenses may be issued to: applicants who submitted construction plans prior to August 16, 2001; facilities applying for a renewal license or changing ownership, but are not increasing capacity; facilities that are relocating within the service area; or a Continuing Care Retirement Community that provides care to residents within its closed system. New applicants requesting licensure must demonstrate that the proposed facility will serve a population for whom insufficient services exist in the service area. The rule now allows facilities to request an increase in capacity by 10%.

Effective August 1, 2004, ALFs and RCFs are required to develop and implement policies on the possession of firearms and ammunition within the facility. Such policies must be disclosed to residents.

A consumer guide (http://www.dhs.state.or.us/seniors/publications/oregon_consumer_guide.pdf) is available and a uniform disclosure form (<http://afsforms.hr.state.or.us/Forms/Served/SE9098A.pdf>) was developed.

Adult Foster Care

Adult foster homes, which are licensed by the Seniors and People with Physical Disabilities (SPD) Division, means any family home or other facility in which residential care is provided in a home-like environment for compensation to five or fewer adults who are elderly or physically disabled and are not related to the licensee or resident manager by blood, marriage or adoption. For the purpose of this rule, adult foster home does not include any house, institution, hotel or

other similar living situation that supplies room or board only, if no resident thereof requires any element of care. Rules are available at http://www.dhs.state.or.us/policy/spd/rules/411_050.pdf.

Web Address	Content
http://egov.oregon.gov/DHS/spwpd/ltc/ltc_guide/whataremychoices.shtml#alf	Guide, list
http://www.dhs.state.or.us/policy/spd/rules/411_054.pdf	Rules

Category	Supply					
	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living facilities	202	13,589	190	12,566	180	11,998
Residential care facilities	227	8,541	236	8,504	220	8,227

Definition

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 persons with disabilities may reside. The facility offers and coordinates a range of supportive personnel available on a 24-hour basis to meet the ADL, health services, and social needs of the residents described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence.”

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 persons with disabilities may reside. The facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the ADLs, 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.”

No facility may establish, maintain, conduct, or operate a RCF or ALF, use the term RCF or ALF, or hold itself out as being a RCF or ALF or as providing residential care or assisted living services, without being duly licensed as such.

Unit Requirements

Assisted living facility. An ALF must have individual living units that have a lockable door, private bathroom, and kitchenette, and must meet the requirements of the facility standards set forth in these rules, the Oregon Structural Specialty Code (OSSC), and the Oregon Fire Code (OFC) in effect at the time of original licensure. Facilities must comply with Title III of the ADA, FHA, and Fair Housing Design Guidelines where applicable. All resident units must be comprised of individual adaptable and accessible apartments with a lockable door, private bathroom and kitchenette facilities conforming to the requirement of the OSSC, FHA and the facility standards set forth in these rules. Units must provide 220 square feet of space, not including a private bathroom. Buildings must meet applicable zoning and building codes. Pre-existing structures must provide 160 square feet excluding the bathroom. The unit bathroom

must be a separate room with a toilet, sink, a roll-in, curbless shower, have at least one towel bar (36 inch height), one toilet paper holder, one accessible mirror and storage for toiletry items. The door to the bathroom must open outward or slide into the wall.

Residential care facility. Resident units may have individual or shared living units. Facilities must include a minimum of 80 square feet per resident and limit occupancy to two residents per unit. Centralized bathing facilities must be provided for every ten residents who do not have private bathing. Toilets must be provided for every six residents. Facilities licensed, constructed or renovated after April 1, 2004 will meet accessibility requirements of the ADA under Title III as a public accommodation and the OSSC, as enforced by the Oregon Building Codes Division and local jurisdictions having authority.

Admission/Retention Policy

Facilities may, but are not required to, ask residents to move, with a 30-day notice, if their needs exceed the level of ADL services available; the resident exhibits behaviors or actions that repeatedly interfere with the rights or well-being of others; 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 OAR 411-054-0090 (Fire and Life Safety); the resident exhibits behavior that poses a danger to self or others; the resident engages in illegal drug use, or commits a criminal act that causes potential harm to the resident or others; or non-payment of charges. Facilities are allowed to ask residents to leave with less than a 30-day notice, but not less than a 14-day notice if the resident exhibits behavior that is an immediate danger to self or others. A resident who leaves the facility to receive urgent medical or psychiatric care may return to the facility unless, at the time the resident is to return, facility staff have re-evaluated the resident's needs and have determined that the resident's needs cannot be met at the facility.

Nursing Home Admission Policy

Regulations set priorities for services based on the amount of assistance needed with a specified ADL or combination of specified ADLs and cognition. Due to recent budget constraints, the priority thresholds have been changed. Eligibility had been limited to Levels 1-11 but was expanded to Levels 12 and 13 July 1, 2004.

1. Dependent in mobility, eating, toileting, and eating and cognition;
2. Dependent in mobility, eating, and cognition;
3. Dependent in mobility or cognition or eating;
4. Dependent in toileting;
5. Substantial assistance with mobility, assistance with toileting and eating;
6. Substantial assistance with mobility, and assistance with eating;
7. Substantial assistance with mobility, and assistance with toileting;
8. Minimal assistance with mobility, and assistance with eating and toileting;
9. Assistance with eating and toileting;

10. Substantial assistance with mobility;
11. Minimal assistance with mobility, and assistance with toileting;
12. Minimal assistance with mobility, and assistance with eating;
13. Assistance with toileting;
14. Assistance with eating;
15. Minimal assistance with mobility;
16. Full assistance with bathing and dressing;
17. Assistance in bathing or dressing; and
18. Independent in the above levels, but requires structured living for supervision for complex medical programs or a complex medication regimen.

Services

Prior to the resident moving in, an appropriate staff person 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 while considering the needs of the other residents and the facility's overall service capability.

A service planning team (including the resident or legal representative, any person of the residents choice, the facility administrator or designee and at least one other staff person who is familiar with or provides services to, the resident. When applicable a RN if the resident receives nursing services, state or AAA case manager, and the resident's physician or other health practitioner must be included.

Required services include three nutritional meals and snacks a day; personal and other laundry services; a program of social and recreational activities; services to assist with ADLs; medication administration and household services. Facilities must provide or arrange for social and medical transportation, and ancillary services for related medical care (i.e., physicians, pharmacy, therapy, podiatry).

Required health services include providing a licensed RN to conduct health assessments and periodic monitoring, assigning the basic tasks of nurse delegation, providing intermittent nursing services for residents with stable and predictable medical needs, and oversight and monitoring of residents' health status. Facilities also coordinate the provision of health services with outside service providers such as hospice, home health, physicians' offices, etc. Other health services include health care teaching and counseling, and emergency response systems that respond to health and medical needs 24-hours a day.

The service plan describes who provides services, what, when, how, and how often services are provided and, if applicable, the desired outcome. The resident shall 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.

A managed risk process is used when a resident exhibits high-risk behavior or choices. The process includes presenting to the resident alternatives to and consequences of the behavior.

The resident's decision to modify the behavior or accept the consequences is documented. The resident's preferences take precedence over those of family member(s). A managed risk plan cannot be entered into or continued with or on the behalf of a resident who is unable to recognize the consequences of his/her behavior or choices. The plan is reviewed at least quarterly.

Dietary

Residential care facility and assisted living facility. Three meals a day and snacks in accordance with the recommended dietary allowances of the USDA Food Guide Pyramid and modified special diets appropriate to the residents' needs and choices are provided.

Agreements

Residential care facility and assisted living facility. All facilities must use a uniform disclosure form. The resident agreement includes payment provisions, including the basic rental rate, cost of additional services, billing method, payment system and due dates, deposits and non-refundable fees, if applicable; the method for evaluating a resident's service needs and assessing the costs for the services provided; policy for increases, additions or changes to the rate structure. Disclosure must address the minimum requirement of 30 days prior written notice of any facilitywide 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; refund and proration conditions; a description of the scope of services available according to OAR 411-054-0030 (Resident Services); a description of the service planning process; additional available services; The philosophy of how health care and ADL services are provided to the resident; resident rights and responsibilities; the facility system for packaging medications and the resident's right to choose a pharmacy; criteria, actions, circumstances or conditions that may result in a move-out notification or intra-facility move; resident's rights pertaining to notification of involuntary move-out; notice that Department of Human Services has the authority to examine resident's records as part of the evaluation of the facility; and the staffing plan.

Provisions for Serving People with Dementia

Residential care facility and assisted living facility. Oregon has a separate set of rules for Alzheimer's Care Units (Chapter 411, Division 057) which apply to nursing facilities, RCFs, and ALFs with the exception of adult foster homes.

Any facility that offers or provides care for residents with Alzheimer's disease or other dementia in an Alzheimer's Care Unit must obtain an endorsement on its facility license. The Alzheimer's Care Unit must be designed to accommodate residents with dementia in a home-like environment. The design and environment of a unit should assist residents in their ADLs; enhance their quality of life; reduce tension, agitation, and problem behaviors; and promote their safety. The rules further clarify physical plant standards.

Staffing. Every effort must be made to provide residents with familiar and consistent staff members in order to minimize resident confusion. All direct care staff assigned to the Alzheimer's Care Unit must be specially trained to work with residents with Alzheimer's disease and other dementias. Staffing must be sufficient to meet the needs of the residents and outcomes identified by the individual care plan and sufficient to implement the full day and evening care program. Staffing levels on the night shift depend on the sleep patterns and needs of residents (without control of sleep by medications).

Training. Facilities must provide an orientation program to all new employees assigned to the unit. Orientation must include the facility's philosophy related to the care of residents with Alzheimer's disease and other dementias in the Alzheimer's Care Unit; a description of Alzheimer's disease and other dementias; the facility's policies and procedures regarding care provided in the unit, including therapies provided and general approach; treatment modalities; admission, discharge and transfer criteria; basic services provided within the unit; policies regarding physical restraints, wandering/egress control, and medication management; staff training; and family activities; and common behavior problems and recommended behavior management. On-going in-service training shall be provided to all medical and non-medical staff who may be in direct contact with residents of the unit. Staff training shall be provided at least quarterly. The rules further identify the required content of the in-service trainings.

Admission/Retention Policy. Facilities with Alzheimer's Care Units must have a written policy of preadmission screening, admission and discharge procedures. Admission criteria shall require, at a minimum, a physician's diagnosis of Alzheimer's disease or other dementia. The policy shall include criteria for moving residents from within the facility, into or out of the unit. When moving a resident within the facility or transferring a resident to another facility or placement, the facility shall take into account the resident's welfare.

Agreements. Prior to admission into the Alzheimer's Care Unit, the facility shall provide the resident or the resident's legal guardian and a member of the resident's family (if appropriate), with a copy of the disclosure statement.

Services. Within seven working days of admission, the interdisciplinary staff must review the care needs of the new resident. Within 14 days of admission, the interdisciplinary staff must develop an individualized care plan which shall describe the resident's needs, choices, problems to be worked on, the desired outcomes or interventions, and the names of the staff who are to be primarily responsible for implementing the care plan. The care plan must reflect the resident as a person, with family, history and interests. Individual care plans must be developed and written by the interdisciplinary staff and signed by each member of the staff. Each care plan must be reviewed, evaluated for its effectiveness, and updated at least quarterly or more frequently if indicated by changing needs of the resident. Outcomes for the individual care of each resident shall include: promoting remaining abilities for self-care; encouraging independence while recognizing limitations; providing safety and comfort; maintaining dignity by respecting the need for privacy, treating the resident as an adult and avoiding talking as if the resident is not present; and at least one issue of a psycho-social nature related to the resident's preferred manner of living and receiving care.

All facilities with Alzheimer's Care Units must provide for activities appropriate to the needs of the individual residents. Activities which must be offered to the residents at least weekly include:

- Gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.);
- Self care activities (e.g., dressing, personal hygiene/grooming);
- Social activities (e.g., games, music);
- Crafts (e.g., decorations, pictures, etc.);
- Sensory enhancement activities (e.g., distinguishing, pictures and picture books, reminiscing, and scent and tactile stimulation, etc.); and
- Outdoor activities (e.g., walking outdoors, field trips, etc.).

A social worker or an assigned staff shall provide social services to both the resident and support to family members.

Medication Administration

Residential care facility and assisted living facility. The regulations allow residents to 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.

Facilities are allowed to administer medications. Facilities must have safe medication and treatment administration systems in place that are approved by a pharmacist consultant, RN, or physician. The administrator is responsible for ensuring adequate professional oversight of the medication and treatment administration system. Medications administered by the facility must be set-up or poured and documented by the same person who administers the medications. The staff person who administers the medication must visually observe the resident take (e.g., ingest, inhale, apply, etc.) the medication unless the prescriber's order for that specific medication states otherwise.

Medication and treatment administration systems must be approved by a pharmacist consultant, RN, or physician.

Public Financing

The state contracted with 172 ALFs and served 3,870 beneficiaries compared to 170 facilities and 3,731 beneficiaries in December 2004. The program also contracted with 156 RCFs and served 2,113 residents in 2007. The state has an active program to identify and relocate nursing home residents to assisted living and other community settings. Beneficiaries relocating from nursing homes may receive cash grants or may be granted income exemptions to pay for transition expenses.

Assisted living. For residents who meet the nursing home LOC criteria, the state provides five levels of payment. The levels are assigned based on a service priority score determined through an assessment. (See table below.) ADLs include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control, and behavior. Critical ADLs are toileting, eating, behavior.

Medicaid Service Priority Categories & Payment Rates: Assisted Living (January 1, 2007)				
Impairment Level	Service Priority	Service	R&B	Total Rate
Level 5	Dependent in 3-6 ADLs OR dependent in behavior and 1-2 other ADLs.	\$2,010	\$483.70	\$2,493.70
Level 4	Dependent in 1-2 ADLs OR assistance in 4-6 ADLs plus assistance in behavior.	\$1,628	\$483.70	\$2,111.70
Level 3	Assistance in 4-6 ADLs OR assistance in toileting, eating, and behavior.	\$1,245	\$483.70	\$1,728.70
Level 2	Assistance in toileting, eating and behavior or behavior AND eating or toileting	\$942	\$483.70	\$1,425.70
Level 1	Assistance in 2 critical ADLs or assistance in any 3 ADLs or assistance in 1 critical ADL and 1 other ADL	\$712	\$483.70	\$1,195.70

Medicaid Participation						
	2007		2004		2002	
	Facilities	Participants	Facilities	Participants	Facilities	Participants
Assisted living facilities	172	3,870	170	3,731	172	3,600
Residential care facilities	156	2,113	165	1,127	NR	NR

The state uses the 300% option to determine financial eligibility. Residents pay \$483.70 for room and board, and keep \$141 for personal needs. Supplementation is not permitted.

Residential Care Facilities. Medicaid also pays for services for persons who meet the nursing home LOC criteria in Level 2 RCFs. In 2007, the RCF base service rate for all clients was \$949 per month. Depending on impairment level, there are three add-on levels. Base plus one add-on is \$1,181; base plus two add-ons is \$1,413; base plus three add-ons is \$1,645. The add-on is based primarily on how dependent a person is with ADLs.

Residents eligible for Medicaid have the same cost sharing requirements and PNA as those residing in ALFs.

Staffing

Each facility must have sufficient qualified awake staff to meet the 24-hour scheduled and unscheduled needs of each resident. If a facility employs universal workers whose duties include other tasks (i.e., housekeeping, laundry, food service, etc.), in addition to direct resident care, staffing must be increased to maintain adequate resident care and services..

Training

Administrators must meet the following training requirements prior to employment: complete a SPD approved classroom administrator training program of at least 40 hours; or complete a SPD approved administrator training program that includes both a classroom training of less than 40 hours and a SPD approved 40-hour internship program with a SPD approved administrator; or complete another SPD approved administrator training program.

Administrators must have 20 hours of documented SPD approved continuing education credits each year. The approved administrator training program fulfills the 20-hour continuing education requirement for the first year.

Staff. All staff receive an orientation that covers resident rights and the values of community-based care; abuse and reporting requirements; standard precautions for infection control; and fire safety and emergency procedures. If the staff member's duties include preparing food, they must have a food handler's certificate or equivalent food preparation training. Knowledge and performance must be demonstrated in all areas within the first 30 days of hire, including, but not limited to:

- The role of service plans in providing individualized resident care;
- Providing assistance with the ADLs;
- Changes associated with normal aging;
- Conditions that require assessment, treatment, observation and reporting;
- Understanding resident actions and behavior as a form of communication;
- Understanding and providing support for a person with dementia or related condition;
- General food safety, serving and sanitation; and
- 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.

Background Check

Facility owners, administrators, and staff must satisfy a criminal records clearance under OAR Chapter 410, Division 007, and sign a criminal record authorization, Form SDS 303. A fingerprint check may be required.

Monitoring

Staff of SPD will visit and inspect every facility at least, but not limited to, once every two years to determine whether it is maintained and operated in accordance with these rules. Facilities not in compliance with these rules must submit a plan of correction that satisfies SPD,

within ten days of receipt of the inspection report. SPD may impose sanctions for failure to comply with these rules. Monitoring staff may consult with and advise the facility administrator concerning methods of care, records, housing, equipment and other areas of operation. Facilities must develop and conduct an on-going QI program that evaluates services, resident outcomes and resident satisfaction.

Fees

\$60 per facility.

For Alzheimer's Care Units, there is a non-refundable endorsement fee that must accompany each application and upon license renewal. Fees are as follows:

- 16 or fewer residents: \$50
- 17-50 residents: \$75
- 100 or more residents: \$100

RESIDENTIAL CARE AND ASSISTED LIVING COMPENDIUM: 2007

Files Available for This Report

REPORT INTRODUCTION (*including Cover, Table of Contents, Acknowledgments, and Acronyms*)

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm>
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom.pdf>

SECTION 1. Overview of Residential Care and Assisted Living Policy

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.htm>
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.pdf>

SECTION 2. Comparison of State Policies

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.htm>
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.pdf>

SECTION 3. State Summaries

HTML: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.htm>
PDF: <http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.pdf>

Each state's summary can also be viewed separately at:

Alabama	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAL.pdf
Alaska	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAK.pdf
Arizona	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAZ.pdf
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North Carolina	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNC.pdf
North Dakota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomND.pdf
Ohio	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOH.pdf
Oklahoma	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOK.pdf
Oregon	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOR.pdf
Pennsylvania	http://aspe.hhs.gov/daltcp/reports/2007/07alcomPA.pdf
Rhode Island	http://aspe.hhs.gov/daltcp/reports/2007/07alcomRI.pdf
South Carolina	http://aspe.hhs.gov/daltcp/reports/2007/07alcomSC.pdf
South Dakota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomSD.pdf
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