The purpose of these rules is to control payment for nursing facility services provided to Medicaid residents.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0000 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 20-1990, f. & cert. ef. 10-4-90; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

As used in OAR chapter 411, division 070, the definitions in OAR 411-085-0005 and the following definitions apply:

(1) "Accrual Method of Accounting" means a method of accounting in which revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Active Treatment" means the implementation of an individualized care plan developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.

(3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life such as eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior.

(4) "Addictions and Mental Health (AMH) Division" means the Division, within the Department of Human Services, responsible for addictions and mental health services.

(5) "Alternative Services" mean individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.

(6) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and individuals with disabilities in a planning and service area. For the purpose of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in...
ORS 410.040 and described in 410.210 to 410.300.

(7) "Basic Flat Rate Payment" and "Basic Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident of a nursing facility except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the bundled payment rate unless the resident qualifies for the complex medical add-on rate (in addition to the basic rate) or the bundled pediatric rate (instead of the basic rate).

(8) "Capacity" means licensed nursing beds multiplied by number of days in operation.

(9) "Case Manager" means a Department of Human Services or Area Agency on Aging employee who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan and monitors the services delivered.

(10) "Cash Method of Accounting" means a method of accounting in which revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.

(11) "Categorical Determinations" mean the provisions in the Code of Federal Regulations {42 CFR 483.130} for creating categories that describe certain diagnoses, severity of illness, or the need for a particular service that clearly indicates that admission to a nursing facility is normally needed or that the provision of specialized services is not normally needed.

(a) Membership in a category may be made by the evaluator only if existing data on the individual is current, accurate, and of sufficient scope.

(b) An individual with mental illness or developmental disabilities may enter a nursing facility without PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a)–(2)(c).

(12) "Certification" and "Certification for the Categorical Determination of Exempted Hospital Discharge" means that the attending physician has written orders for the individual to receive skilled services at the nursing facility.

(13) "Certified Program" means a hospital, private agency, or an Area Agency on Aging certified by the Department of Human Services to conduct private admission assessments in accordance with ORS 410.505 through 410.530.

(14) "Change of Ownership" means a change in the individual or legal organization that is responsible for the operation of a nursing facility. Change of ownership does not include changes that are merely changes in personnel, e.g., a change of administrators. Events that change ownership include but are not limited to the following:

(a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The title to the nursing facility enterprise is transferred to another party;

(c) The nursing facility enterprise is leased or an existing lease is terminated;

(d) Where the owner is a partnership, any event occurs which dissolves the partnership;

(e) Where the owner is a corporation, it is dissolved, merges with another corporation that is the survivor, or consolidates with one or more other corporations to form a new corporation; or

(f) The facility changes management via a management contract.

(15) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator, or other employee. Compensation includes but is not necessarily limited to:

(a) Salaries paid or accrued;

(b) Supplies and services provided for personal use;

(c) Compensation paid by the facility to employees for the sole benefit of the owner;

(d) Fees for consultants, directors, or any other fees paid regardless of the label;
(e) Key man life insurance;

(f) Living expenses, including those paid for related persons; or

(g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.

(16) "Complex Medical Add-On Payment" and "Medical Add-On" means the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose service is reimbursed at the basic rate if the resident needs one or more of the medication procedures, treatment procedures, or rehabilitation services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident’s increased needs.

(17) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" means at least once per day, five days per week.

(18) "Costs Not Related to Resident Services" means costs that are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. Costs not related to resident services include, for example, cost of meals sold to visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.

(19) "Costs Related to Resident Services" mean all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident services include nursing costs, administrative costs, costs of employee pension plans, and interest expenses.

(20) "CPI" means the consumer price index for all items and all urban consumers.

(21) "Day of Admission" means an individual being admitted, determined as of 12:01 a.m. of each day, for all days in the calendar period for which an assessment is being reported and paid. If an individual is admitted and discharged on the same day, the individual is deemed present on 12:01 a.m. of that day.

(22) "Department" or "DHS" means the Department of Human Services.

(23) "Developmental Disability" means a disability that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional. Developmental disabilities include mental retardation, autism, cerebral palsy, epilepsy, or other neurological disabling conditions that require training or support similar to that required by individuals with mental retardation, and the disability:

(a) Originates before the individual reaches the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18;

(b) Originates and directly affects the brain and has continued, or must be expected to continue, indefinitely;

(c) Constitutes a significant impairment in adaptive behavior; and

(d) Is not primarily attributed to a mental or emotional disorder, sensory impairment, substance abuse, personality disorder, learning disability, or Attention Deficit Hyperactivity Disorder (ADHD).

(24) "Direct Costs" mean costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. Direct costs are further defined in OAR 411-070-0359 and 411-070-0465.

Examples: The person who feeds food to the resident is directly meeting the resident's needs, but the person who cooks the food is not. The person who is trained to meet the resident's needs incurs direct costs whereas the person providing the training is not. Costs for items that are capitalized or depreciated are excluded from this definition.

(25) "Division of Medical Assistance Programs (DMAP)" means a Division, within the Department of Human Services, responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan Medicaid demonstration, the State Children's Health Insurance Program, and several other programs.

(26) "DRI Index" means the "HCFA or CMS Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw-Hill in the publication, "Global Insight Health Care Cost Review".
"Exempted Hospital Discharge" for PASRR means an individual seeking temporary admission to a nursing facility from a hospital as described in OAR 411-070-0043(2)(a).

"Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Department of Human Services as a nursing facility. A nursing facility also means a Medicaid certified nursing facility only if identified as such.

"Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

"Generally Accepted Accounting Principles" mean the accounting principles approved by the American Institute of Certified Public Accountants.

"Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired, or the excess of the price paid for an asset over its fair market value.

"Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. Historical cost does not include "start-up costs" as defined in this rule.

"Hospital-Based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.

"Indirect Costs" mean the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). Indirect costs are further described in OAR 411-070-0359 and 411-070-0465.

"Individual" means a person who receives or expected to receive nursing facility services.

"Interrupted-Service Facility" means an established facility recertified by the Department of Human Services following decertification.

"Level I" means a component of the federal PASRR requirement. Level I refers to the identification of individuals who are potential nursing facility admissions who have indicators of mental illness or developmental disabilities {42 CFR 483.128(a)}.

"Level II" means a component of the federal PASRR requirement. Level II refers to the evaluation and determination of whether nursing facility services and specialized services are needed for individuals with mental illness or developmental disability who are potential nursing facility admissions, regardless of the source of payment for the nursing facility service {42 CFR 483.128(a)}. Level II evaluations include assessment of the individual's physical, mental, and functional status {42 CFR 483.132}.

"Level of Care Determination" means an evaluation of the intensity of a person’s health service needs. The level of care determination may not be used to require that the person receive services in a nursing facility.

"Medicaid Occupancy Percentage" means the total Medicaid bed days divided by total resident days.

"Medical Add-On" or "Complex Medical Add-On Payment" has the meaning provided in section (16) of this rule.

"Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV-TR) limited to schizophrenic, paranoid and schizoaffective disorders, bipolar (manic-depressive), and atypical psychosis. "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizoaffective disorders, or atypical psychosis) and treatment related to the diagnosis in the past two years. Diagnoses of dementia or Alzheimers are excluded.

"Mental Retardation" means significantly sub-average general intellectual functioning defined as IQ’s under 70 as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior that are manifested during the developmental period, prior to 18 years of age. Individuals of borderline intelligence, IQ’s 70-75, may be considered to have mental retardation if there is also significant impairment of adaptive behavior as diagnosed and measured by a qualified professional. The adaptive behavior must be directly related to the issues of mental retardation. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision.

(a) Mild mental retardation is used to describe the degree of retardation when intelligence test scores are 50 to 69. Individuals with IQ’s in the 70 to 75 range may be considered as having mental retardation if there is significant impairment in adaptive behavior as defined in OAR 411-320-0020.
(b) Moderate mental retardation is used to describe the degree of retardation when intelligence test scores are 35 to 49.

c) Severe mental retardation is used to describe the degree of retardation when intelligence test scores are 20 to 34.

d) Profound mental retardation is used to describe the degree of retardation when intelligence test scores are below 20.

(44) "Necessary Costs" mean costs that are appropriate and helpful in developing and maintaining the operation of resident facilities and activities. Necessary costs are usually costs that are common and accepted occurrences in the field of long-term nursing services.

(45) "New Admission" for PASRR purposes means an individual admitted to any nursing facility for the first time. It does not include individuals moving within a nursing facility, transferring to a different nursing facility, or individuals who have returned to a hospital for treatment and are being admitted back to the nursing facility. New admissions are subject to the PASRR process (42 CFR 483.106(b) (1), (3), (4)).

(46) "New Facility" means a nursing facility commencing to provide services to individuals.

(47) "Nursing Aide Training and Competency Evaluation Program (NATCEP)" means a nursing assistant training and competency evaluation program approved by the Oregon State Board of Nursing pursuant to ORS chapter 678 and the rules adopted pursuant thereto.

(48) "Nursing Facility Financial Statement (NFFS)" means Form SPD 35, or Form SPD 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Department of Human Services for reimbursement.

(49) "Occupancy Rate" means total resident days divided by capacity.

(50) "Ordinary Costs" mean costs incurred that are customary for the normal operation.

(51) "Oregon Medical Professional Review Organization (OMPRO)" means the organization that determines level of services, need for services, and quality of services.

(52) "Pediatric Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.

(53) "Perquisites" mean privileges incidental to regular wages.

(54) "Personal Incidental Funds" mean resident funds held or managed by the licensee or other person designated by the resident on behalf of a resident.

(55) "Placement" means the location of a specific place where health services can be adequately provided to meet the service needs.

(56) "Pre-Admission Screening (PAS)" means the assessment and determination of a potential Medicaid-eligible individual’s need for nursing facility services, including the identification of individuals who can transition to community-based service settings and the provision of information about community-based alternatives. This assessment and determination is required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement (42 CFR, Part 483, (C)-(E)), to identify individuals with mental illness or mental retardation or developmental disabilities.

(57) "Pre-Admission Screening and Resident Review (PASRR)" means the federal requirement, (42 CFR, Part 483, (C)-(E)), to identify individuals who have mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions.

(58) "Prior Authorization" means the local Seniors and People with Disabilities Division/Area Agency on Aging office participates in the development of proposed nursing facility care plans to assure that the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior-authorization.

(59) "Private Admission Assessment (PAA)" means the assessment that is conducted for non-Medicaid residents as established by ORS 410.505 to 410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated and information is provided about long-term service choices. A component of private admission assessment is the federal PASRR Level I requirement, (42 CFR, Part 483.128(a)), to identify individuals with mental illness or developmental disabilities.
(60) "Provider" means an entity, licensed by the Seniors and People with Disabilities Division, responsible for the direct delivery of nursing facility services.

(61) "Reasonable Consideration" means an inducement that is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(62) "Related Organization" means an entity that is under common ownership or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has 5 percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(63) "Resident" means a person who receives nursing facility services.

(64) "Resident Days" mean the number of occupied bed days.

(65) "Resident Review" means a review conducted by the Addictions and Mental Health Division for individuals with mental illness or by the Seniors and People with Disabilities Division for individuals with developmental disabilities who are residents of nursing facilities. The findings of the resident review may result in referral to PASRR Level II {42 CFR 483.114}.

(66) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with or direction by the donor to a specific purpose. Restricted fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund that is to be used for general operating or building purposes.

(67) "Seniors and People with Disabilities (SPD) Division" means the Division, within the Department of Human Services, responsible for the administration of community-based care and nursing facility services to eligible individuals.

(68) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.

(69) "Specialized Services for Mental Retardation or Developmental Disabilities" means:

(a) For individuals with mental retardation or developmental disabilities under age 21, specialized services are equal to school services; and

(b) For individuals with mental retardation or developmental disabilities over age 21, specialized services mean:

(A) A consistent and ongoing program that includes participation by the individual in continuous, aggressive training and support to prevent loss of current optimal function;

(B) Promotes the acquisition of function, skills, and behaviors necessary to increase independence and productivity; and

(C) Is delivered in community-based or vocational settings at a minimum of 25 hours a week.

(70) "Start-Up Costs" mean one-time costs incurred prior to the first resident being admitted. Start-up costs include administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. Start-up costs do not include such costs as feasibility studies, engineering studies, architect's fees, or other fees that are part of the historical cost of the facility.

(71) "Supervision" means initial direction and periodic monitoring of performance. Supervision does not mean that the supervisor is physically present when the work is performed.

(72) "These Rules" mean the rules in OAR chapter 411, division 070.

(73) "Title XVIII" and "Medicare" means Title XVIII of the Social Security Act.

(74) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.

(75) "Uniform Chart of Accounts (Form SPD 35)" means a list of account titles identified by code numbers established by the Department of Human Services for providers to use in reporting their costs.

[ED. NOTE: Forms referenced are available from the agency.]
Conditions for Payment

Nursing facilities must meet the following conditions in order to receive payment under Title XIX (Medicaid):

(1) CERTIFICATION.

(a) The facility must be in compliance with Title XIX federal certification requirements.

(b) Except as provided in section (1)(c) of this rule, all beds in the facility must be certified as nursing facility beds.

(c) A facility choosing to discontinue compliance with section (1)(b) of this rule may elect to gradually withdraw from Medicaid certification but must comply with all of the following:

(A) Notify SPD in writing within 30 days of the certification survey that it elects to gradually withdraw from the Medicaid Program;

(B) Request Medicaid reimbursement for any resident who resided in the facility, or who was eligible for right of return under OAR 411-088-0050 or right of readmission under OAR 411-088-0060, on the date of the notice required by this rule. If it appears the resident may be eligible within 90 days, such request may be initiated;

(C) Retain certification for any bed occupied by or held for any resident who is found eligible for Medicaid until the bed is vacated by:

(i) The death of the resident; or

(ii) The transfer or discharge of the resident pursuant to the transfer rules in OAR chapter 411, division 088.

(D) All Medicaid recipients exercising rights of return or readmission under the transfer rules must be permitted to occupy a Medicaid certified bed; and

(E) Notify in writing all persons applying for admission subsequent to notification of gradual withdrawal that, should the person later become eligible for Medicaid assistance, that reimbursement would not be available in that facility.

(2) CIVIL RIGHTS, MEDICAID DISCRIMINATION.

(a) The facility must meet the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(b) The facility must not discriminate based on source of payment. The facility must not have different standards of transfer or discharge for Medicaid residents except as required to comply with this rule.

(c) The facility must accept Medicaid payment as payment in full. The facility must not require, solicit, or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a "responsible party".

(d) No applicant may be denied admission to a facility solely because no family member, relative, or friend is willing to accept personal financial liability for any of the facility's charges.

(e) The facility may not request or require a resident, relative, or "responsible party" to waive or forego any rights or remedies provided under state or federal law, rule, or regulation.
(3) PROVIDER AGREEMENT, FACILITY PAYMENT.

(a) The facility must sign a formal provider agreement with SPD.

(b) The facility must file a NFFS with SPD within 90 days after the end of its fiscal year.

(c) The facility must bill SPD in accordance with established rules and guidelines.

Denial, Termination or Non-Renewal of Provider Agreement

(1) Failure to Comply. The Department reserves the right to deny, terminate or not renew contracts with providers who fail to comply with OAR 411-070-0000 through 411-070-0470 relating to nursing facility services.

(2) Notice. The Department will give the provider 30 day's written notice, by Certified Mail, before the effective date of the denial, termination or non-renewal. The notice will include the basis of the Department decision, advise the provider of the right to an informal conference to give the opportunity to refute the Department findings in writing.

(3) Information Conference:

(a) A request for an informal conference must be received by the Department prior to the effective date of the denial, termination or non-renewal;

(b) A written notice of the Department's decision reached in an informal conference will be sent to the provider by Certified Mail. This notice will also advise the provider of his or her right to a hearing, if requested within 30 days of mailing the notice.

(4) Hearing. When a hearing is requested, it will be conducted in accordance with OAR chapter 461, division 025.

On-Site Reviews

The facility must allow periodic on-site reviews of Medicaid residents as required by federal regulations.

Basic Flat Rate Payment (Basic Rate)

(1) PAYMENT. SPD may authorize payment at the basic rate if a Medicaid resident requires daily, intermittent licensed nurse observation and continuous nursing care and has a physician's order for nursing facility care. When determining the payment rate, SPD shall consider the stability of the medical condition, the health care needs of the individual, and the individual's ability to maintain themselves in a less restrictive setting. An individual who qualifies for reimbursement at the basic rate must:
(a) Have chronic medical problems that are stabilized but not cured and have a need for supervision in a structured environment to maintain or restore stability and prevent deterioration;

(b) Require assistance for a combination of health care needs either because of a physical or psycho-social disabling condition; or

(c) Have insufficient personal and community resources available to provide for either section (1)(a) or (1)(b) of this rule.

(2) DOCUMENTATION. The professional nursing staff of the nursing facility must keep sufficient documentation in the resident's clinic record to justify the basic rate payment determination in accordance with these rules and must make it available to SPD upon request.

DOCUMENTATION: The professional nursing staff of the nursing facility must keep sufficient documentation in the resident's clinic record to justify the basic rate payment determination in accordance with these rules and must make it available to SPD upon request.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; AFS 22-1978, f. & ef. 6-1-78; AFS 40-1979, f. 10-31-79, ef. 11-1-79; AFS 58-1981, f. & ef. 9-1-81; Renumbered from 461-017-0040, AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 8-1982, f. & ef. 6-30-82; SSD 8-1989(Temp), f. & cert. ef. 6-1-99; SSD 2-1990(Temp), f. & cert. ef. 1-10-99; SSD 8-1990, f. & cert. ef. 3-1-90; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0027

Complex Medical Add-On Payment Authorization

(1) PAYMENT. SPD may authorize payment for a complex medical add-on (in addition to the basic rate) when the resident requires one or more of the treatments, procedures, and services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident's increased needs.

(2) AUTHORIZATION. For a Medicaid resident whose condition or service needs meet the complex medical add-on criteria listed in OAR 411-070-0091, the complex medical add-on may be effective from the date the resident's condition or service needs meets the complex medical add-on criteria to the last date the resident's condition or service needs continues to meet the complex medical add-on criteria.

(a) Initial Authorization -- The facility must submit documentation to SPD's Complex Medical Add-On Coordinator for initial authorization of the complex medical add-on, using SPD's Complex Medical Add-On Procedure Code(s), to provide justification that the resident's service needs meet complex medical add-on criteria.

(b) Continued Payment -- SPD may continue to pay the complex medical add-on only as long as the resident's needs meet one or more of the treatments, procedures, and services listed in OAR 411-070-0091 and the facility maintains the required documentation.

(3) DOCUMENTATION. The licensed nursing staff of the nursing facility must keep sufficient documentation pertinent to the qualified complex medical add-on procedure code(s) in the resident's clinical record to justify the complex medical add-on payment determination in accordance with these rules (refer to OAR 411-070-0091) and must make it available to SPD upon request.

(4) COMPLEX MEDICAL ADD-ONS PROHIBITED. SPD may not provide complex medical add-on payments for a facility with a waiver that allows a reduction of eight or more hours per week from required licensed nurse staffing hours.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 20-1990, f. & cert. ef. 10-4-90; SSD 21-1990(Temp), f. & cert. ef. 10-5-90; SSD 6-1991, f. & cert. ef. 3-25-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0029

Pediatric Rate

(1) The pediatric rate shall be for those facilities meeting the criteria established in OAR 411-070-0452 as pediatric nursing facilities or as self-contained pediatric units.
The pediatric rate shall constitute the total rate payable by SPD on behalf of the individual.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0033

Post Hospital Extended Care Benefit

(1) The post hospital extended care benefit (OAR 410-120-1210(3)(a)(F)) is an Oregon Health Plan benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.

(2) The post hospital extended care benefit must be prior authorized by pre-admission screening for individuals not enrolled in managed care.

(3) To be eligible for the post hospital extended care benefit, the individual must meet all of the following:

(a) Be receiving Oregon Health Plan Plus or Standard, Fee-for-Service benefits;

(b) Not be Medicare eligible;

(c) Have a medically-necessary, qualifying hospital stay consisting of:

(A) A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.

(B) The stay must consist of three or more consecutive days, not counting the day of discharge.

(d) Transfer to a nursing facility within 30 days of discharge from the hospital;

(e) Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criteria that may be provided only in a nursing facility meaning:

(A) The individual would be at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;

(B) The individual's condition would require daily transportation to hospital or rehabilitation facility by ambulance; or

(C) It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.

(4) The individual may qualify for another 20 day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.

(5) Individuals eligible for the 20 day post-hospital extended care benefit are not eligible for long term care nursing facility or home and community-based waiver services unless the individual meets the eligibility criteria in OAR 411-015-0100 or 411-320-0020(28).

Stat. Auth.: ORS 409, 410.070 & 414.065
Stats. Implemented: 410.070 & 414.065
Hist.: SPD 4-2005, f. & cert. ef. 4-19-05; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0035

Complex Medical Add-On Notification, Effective Dates and Administrative Review

(1) NOTIFICATION. The nursing facility must notify SPD’s Complex Medical Add-On Coordinator by completing SPD’s Weekly Add-On Report to request authorization for complex medical add-on procedure code(s) (Refer to OAR 411-070-0091). SPD shall assign the facility a weekly report due date. The facility must accurately report, on a weekly basis, all of the following complex medical activity for the seven days prior to the report’s due date (excluding weekends, state holidays, and any business day the offices of the state of Oregon are closed by the Governor or the Governor’s designee):
(a) Admission of any Medicaid resident whose condition or service needs meet the criteria for a complex medical add-on procedure code(s). This includes a readmission or return of a Medicaid resident following a leave of absence from the nursing facility whose needs meet add-on criteria.

(A) The nursing facility must add these residents to the “new” section of the next weekly report filed after the resident’s condition or service needs meets the complex medical add-on criteria.

(B) Following a resident’s return from a leave of absence, the nursing facility must add these residents to the “new” section of the next weekly report filed after the resident’s return if their condition or service needs meet a complex medical add-on procedure code(s).

(C) If the nursing facility fails to add the resident to the next weekly report filed, or files the report more than two working days after it is due, SPD shall adjust the requested effective add-on date and pay the complex medical add-on from the date of notification only.

(D) For a resident whose condition or service needs meet a complex medical add-on procedure code(s), the complex medical add-on is effective only until the last date the resident’s condition or need continues to meet complex medical add-on procedure code(s) criteria.

(b) A Medicaid resident whose condition or service needs change and now meets the criteria for a complex medical add-on procedure code(s).

(A) The nursing facility must add these residents to the “new” section of the next weekly report filed after the resident’s condition or service needs meets the complex medical add-on criteria.

(B) If the nursing facility fails to add the resident to the next weekly report filed, or files the report more than two working days after it is due, SPD shall adjust the requested effective add-on date and pay the complex medical add-on from the date of notification only.

(C) For a resident whose condition or service needs meet a complex medical add-on procedure code(s), the complex medical add-on is effective only until the last date the resident’s condition or need continues to meet complex medical add-on procedure code(s) criteria.

(c) A Medicaid resident whose condition or service needs continue to meet the criteria for a complex medical add-on procedure code(s), only if that same complex medical add-on procedure code(s) has been approved or is pending approval by SPD’s Complex Medical Add-On Coordinator. The facility must add these residents to the “existing” section of the next weekly report filed after the resident’s condition or service needs has been approved or is pending approval.

(d) Discontinuation of a complex medical add-on procedure code(s) for a resident whose condition or service needs no longer meet the criteria for the complex medical add-on procedure code(s). This includes residents on a leave of absence from the nursing facility. The nursing facility must add these residents to the “discontinued” section of the next weekly report filed after the last date the resident’s condition or service needs continues to meet the complex medical add-on procedure code(s) criteria.

(2) NOTIFICATION FOR EMERGENT MEDICAL OR SURGICAL PROBLEMS AND EMERGENT BEHAVIOR PROBLEMS.

(a) For a resident with an emergent medical or surgical problem or an emergent behavior problem, the nursing facility must contact SPD’s Complex Medical Add-On Coordinator the next working day following the emergent medical, surgical, or behavior problem for pre-authorization of complex medical add-on.

(b) If the nursing facility fails to contact SPD in a timely manner, SPD shall pay the complex medical add-on from the date of notification only.

(c) For a resident whose condition or service needs change by an emergent medical, surgical, or behavior problem, the complex medical add-on is effective only until the last date the resident’s condition or need continues to meet complex medical add-on procedure code(s) criteria.

(3) ADMINISTRATIVE REVIEW. If a provider disagrees with the decision of SPD’s Complex Medical Add-On Coordinator to make or deny an adjustment in the complex medical add-on payment for a Medicaid resident, the provider may request from SPD an administrative review of the decision. The provider must submit its request for review in writing within 30 days of receipt of the notice to make or deny the adjustment. The provider must submit documentation, as requested by SPD, to substantiate its position. SPD shall notify the provider in writing of its informal decision within 45 days of SPD’s receipt of the provider’s request for review. SPD’s informal decision shall be an order in other than a contested case and subject to review pursuant to ORS 183.484.

(4) OVERPAYMENT FOR COMPLEX MEDICAL ADD-ONS. SPD shall collect monies that were overpaid to a facility for any
period SPD determines the resident’s condition or service needs did not meet the criteria for the complex medical add-on, or determines
the facility did not maintain the required documentation.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; AFS 40-1979, f. 10-31-79, ef. 11-1-79; AFS 58-1981, f. & ef. 9-1-81; Renumbered from 461-017-0050 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 10-1983, f. 10-19-83, ef. 11-1-83; SSD 8-1985, f. 6-13-85, ef. 6-15-85; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0040

Client Screening, Assessment and Review

(1) INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to
evaluate their service needs and preferences and must receive information about community-based, alternative services, and resources that
can meet the individual’s service needs and are safe, least restrictive, and potentially less costly than comparable nursing facility services.

(2) PRE-ADMISSION SCREENING. A pre-admission screening (PAS) as defined in OAR 411-070-0005 is required for potentially
Medicaid eligible individuals who are at risk for nursing facility services.

(a) PAS includes:

(A) An assessment;

(B) The determination of an individual’s service eligibility for Medicaid-paid long term care or post-hospital extended care services in a
nursing facility;

(C) The identification of individuals who can transition to community-based service settings;

(D) The provision of information about community-based services and resources to meet the individual’s needs; and

(E) Transition planning assistance as needed.

(b) PAS is conducted in conjunction with the individual and any representative designated by the individual.

(c) The PAS assessment shall be conducted by a case manager or other qualified SPD or AAA representative using SPD’s Client
Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.

(d) A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a
nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative
community-based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.

(e) Payment for nursing facility services may not be authorized by SPD until PAS has established that nursing facility services are required
based on the individual’s service needs and Medicaid financial eligibility has been established.

(3) PRIVATE ADMISSION ASSESSMENT. A private admission assessment (PAA) is required for individuals with private funding who
are referred to Medicaid-certified nursing facilities established by ORS 410.505 through 410.545 and OAR chapter 411, division 071.

(4) PRE-ADMISSION SCREENING AND RESIDENT REVIEW. A pre-admission screening and resident review (PASRR) as
described in OAR 411-070-0043 is required for individuals, regardless of payment source, with either mental illness or developmental
disabilities who need nursing facility services.

(5) RESIDENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing
facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:

(a) Staff associated with SPD are required to maintain service plans on all SPD residents in nursing facilities. The frequency of their service
plan update shall vary depending on such factors as the resident's potential for transition to home or community-based care and federal or
(b) Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility records. “Access” to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care, or alleged abuse. SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities.

(c) SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities.

(d) SPD or the authorized utilization review organization representatives must have the right to participate in facility staffings on SPD residents.

Pre-Admission Screening and Resident Review (PASRR)

(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or mental retardation or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in section (2) of this rule, are groupings of individuals with mental illness or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.

(2) CATEGORICAL DETERMINATIONS.

(a) Exempted hospital discharge:

(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or

(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and

(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and

(D) The individual’s attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.

(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or SPD staff.

(A) The individual requires nursing facility level of service; and

(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or

(C) Nursing facility admission is the result of protective services action.

(3) PASRR includes three components.

(a) PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual’s source of payment. The purpose of the screening is to identify indicators of mental illness or mental retardation or developmental disabilities that may require further evaluation {42 CFR
(A) PASRR Level I screening is performed by AAA/SPD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

(B) Documentation of PASRR Level I screening is completed using a SPD-designated form.

(C) If there are no indicators of mental illness or mental retardation or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.

(D) If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact AMHD and request a PASRR Level II evaluation.

(E) If PASRR Level I screening determines that an individual has indicators of mental retardation or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact SPD and request a PASRR Level II evaluation.

(F) Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual’s resident record.

(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or SPD office as required in OAR 411-070-0035.

(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident’s clinical record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or mental retardation or developmental disabilities who does not meet categorical determination criteria {42 CFR 483.128}.

(A) Individual’s identified with indicators or mental illness or mental retardation or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.

(B) PASRR Level II evaluations and determinations are conducted by AMHD for individuals with mental illness or by SPD for individuals with mental retardation or developmental disabilities.

(C) PASRR Level II evaluations result in a determination of an individual’s need for nursing facility services and specialized services {42 CFR 483.128-136} consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).

(D) Pursuant to 42 CFR 483.130(l), the written determination must include the following findings:

(i) Whether a nursing facility level of services is needed;

(ii) Whether specialized services are needed;

(iii) The placement options that are available to the individual consistent with these determinations; and

(iv) The rights of the individual to appeal the determination.

(E) The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.

(F) Denials of nursing facility service are subject to appeal {OAR 137-003, 461-025 & 42 CFR Subpart E}. 
(c) RESIDENT REVIEW. Resident reviews are conducted by AMHD for individuals with indicators of mental illness or SPD for individuals with mental retardation or developmental disabilities who are residents of nursing facilities. Based on the findings of the resident review, a PASRR Level II may be requested. \{42 CFR 483.114\}.

(A) All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.

(i) Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.

(ii) The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMHD, in accordance with OAR 411-086-0060.

(B) All individuals identified as having mental retardation or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation \{OAR 411-070-0043(2)(c)(A)-(C)\}, within 20 days if the nursing facility admission is due to other categorical determinations \{OAR 411-070-0043(2)(a)-(b)\}, and annually, or as dictated by changes in resident’s needs or desires.

(i) The resident review must be completed by SPD or designee.

(ii) The resident review must be completed using forms designated by SPD.

(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with mental illness are not provided in nursing facilities. Individuals with mental illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(b) Specialized services for individuals with mental retardation or developmental disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.

(c) Specialized services for individuals with mental retardation or developmental disabilities over age 21 are not provided in nursing facilities. Individuals with mental retardation or developmental disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(5) RESPITE CARE. Respite care in nursing facilities for individuals with mental illness, mental retardation, or developmental disabilities is approved under the following conditions:

(a) For individuals with mental illness, a nursing facility admission for respite care must be authorized by AMHD and for individuals with mental retardation or developmental disabilities, a nursing facility admission for respite care must be authorized by SPD Central Office;

(b) Nursing facility respite stay must be limited to no more than a total of 56 respite days within a calendar year although SPD may grant exceptions to this limit at its discretion;

(c) Nursing facility level of service must be required to meet a severe medical condition that excludes care needs due to mental illness, mental retardation, or developmental disabilities; and

(d) There must not be a viable community care setting available that is appropriate to meet the individual’s respite care needs as determined by section (5)(a) of this rule.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070, 535 & 414.065
Hist.: SSD 5-1989(Temp), f. & cert. ef. 4-20-89; SSD 15-1989, f. & cert. ef. 10-20-89; SSD 3-1994, f. 4-29-94, cert. ef. 5-1-94; SDSD 1-1998, f. 1-30-98, cert. ef. 2-1-98; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 12-2007, f. 8-30-07, cert. ef. 9-1-07; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0045
Facility Payments

(1) PRIOR AUTHORIZATION. The Department may reimburse a nursing facility for services provided to a Department resident only if prior authorized after the Department has participated in development of the placement plan and is satisfied that the placement is justified and most suitable for the person according to the Department care plan. The Department may not reimburse a nursing facility for services rendered prior to the date of referral to the Department. A nursing facility must verify that the local SPD/Type B AAA where the facility is located is involved in the placement.

(2) The facility must confirm an individual's financial eligibility for Medicaid payment of any nursing facility service with the local office. Medicaid eligibility is based on the requirements outlined in OAR chapter 461. The facility is responsible for collecting resident liability from the resident or their responsible party.

(3) PAYMENT TO PROVIDER. Provider payments will be made following the month of service. For billing, the Department will mail Form SDS 483, Invoice and Payment Authorization, to each facility.

(4) RESIDENT'S INCOME. A resident's income, exclusive of the authorized allowance for personal incidental needs and other prior authorized special needs, will be offset as a credit against the established Department rate paid to that facility.

(5) REDUCED PAYMENT FOR ABUSE.

(a) If abuse of a resident, according to the provisions of ORS 441.630 to 441.685, is substantiated by the Department, the Department may reduce the payment for the resident(s) for the month the abuse occurred, and until such time as the Department determines the conditions leading to the abuse have been corrected.

(A) The facility will receive payment for services provided for the resident as determined by the Department. This determination will be based on the absence of appropriate services that resulted in the substantiated abuse of a resident.

(B) The reduced payment may not be considered a reduction in benefits for the resident.

(b) The Department will notify the facility by certified mail at least 15 days prior to taking action to reduce payment.

(A) The notice will include the basis of the Department decision, the effective date of the reduced payment, the amount of the reduced payment, and will advise the facility of their right to request review by the Assistant Director if such request is made in writing within 30 days of the receipt of the notice.

(B) If a request for review is made, the Assistant Director will include the basis of the Department decision, the effective date of the reduced review and all material relating to the allegation of resident abuse and to the reduction in payment. The Assistant Director will include the basis of the Department decision, the effective date of the reduced determination, based upon review of the material, whether or not to sustain the decision to reduce payments to the facility and will notify the facility of the decision within 20 days of receiving the request for review.

(C) If the Assistant Director determines not to sustain the decision to reduce payments, the reduction will be lifted immediately. Otherwise, the reduction in payment will remain in effect until the Department determines the conditions leading to the abuse have been corrected.

(D) If the decision to reduce payment is sustained, the payment reduction will not be recovered in the year end settlement.

[ED. NOTE: Forms referenced are available from the agency.]
When the day of admission is the same as the day of discharge, the Department will only pay for one day.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0080 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1982(Temp), f. 4-26-82, ef. 5-1-82; SSD 8-1982, f. & ef. 6-30-82; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0075

Rates -- Facilities in Oregon

The daily rate of payment for Oregon facilities will be the basic rate plus the medical add-on, if determined to be appropriate, or the pediatric rate, if warranted.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0120 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97

411-070-0080

Out-of-State Rates

Out-of-state facilities in areas contiguous to Oregon shall be paid for eligible individuals who are receiving temporary care while alternative placement in Oregon is being located. Payment shall be made at the facility's Medicaid rate established by the state in which the facility is located, or the maximum rate paid to Oregon nursing facilities for a comparable payment level, whichever is less. The maximum rate for out-of-state purposes is Oregon's basic rate plus the complex medical add-on, if determined to be appropriate, or the pediatric rate, if warranted. The facility must submit a copy of the Assurance and Compliance (HHS 690), certifying its compliance with the Civil Rights Act of 1964. The facility must also submit their current approved nursing facility Medicaid rate to SPD. An Oregon resident shall be returned to Oregon when proper placement may be made and it is feasible to do so.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0130, AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0085

Bundled Rate

(1) PURPOSE. The nursing facility rate established for a facility is a bundled rate and includes all services, supplies and facility equipment required for services.

(2) SERVICES AND SUPPLIES.

(a) The following services and supplies required to provide services in accordance with each resident's care plan are included in the bundled rate:

(A) All nursing services defined in OAR 411-086-0110 through 411-086-0160;

(B) All support services and supplies associated with the required nursing services;

(C) All activity services, supplies and staffing as defined in OAR 411-086-0230;

(D) All social services, supplies and staffing as defined in OAR 411-086-0240;
(E) All dietary services, supplies and staffing as defined in OAR 411-086-0250;

(F) All professional consultant services;

(G) All services of the facility medical director;

(H) Management of resident funds, including purchase of items;

(I) Room and board, including:

(i) Special diets and non-pumped food supplements; and

(ii) Laundry, whether performed by the facility staff or an outside provider, including laundering and marking of resident's personal clothing and bedding;

(J) Miscellaneous services and supplies, including:

(i) Items stocked by the facility in gross supply and administered individually on physician's order;

(ii) Items owned or rented by the facility that are utilized by individual residents but are reusable and are routinely expected to be available in a nursing facility;

(iii) Shaves, haircuts, supplies and shampoos as required for grooming and cleanliness, whether performed by facility staff or by an outside provider; and

(iv) Transportation provided in vehicles that are owned or leased by the facility or by any person who holds an ownership interest in the facility.

(b) Items included within the bundled rate must meet all of the following criteria:

(A) Item(s) are medically appropriate;

(B) Item(s) are most effective and least costly means to meet the individuals’ needs; and

(C) Item(s) are allowed in the state plan.

(c) The Oregon Health Plan will continue to provide coverage for specified items and equipment in accordance with OAR chapter 410, division 122. No entitlement to any item is created for any resident in a nursing facility based solely on the listing of an item in OAR chapter 410, division 122, as potentially included in the nursing facility bundled rate. Oregon Health Plan limits on duration, scope and/or frequency of provision of the item(s) may not apply to the bundled rate if the facility needs to provide the item(s) in excess of the limits in order to meet resident needs. Nursing facilities are not required to purchase all specified codes, forms, sizes or varieties of the items listed in OAR chapter 410, division 122, so long as the residents’ service needs are met. Nursing facilities are not required to honor individual preferences for specific types of equipment and supplies.

(d) The bundled rate pays for all equipment and supplies, unless the item(s) is specified as not paid for by the bundled rate. Equipment and supplies paid for in the bundled rate include:

(A) Oxygen and oxygen equipment, including concentrators, unless the oxygen provided exceeds 1,000 liters in a 24-hour period;

(B) Glucose monitors and diabetic equipment;

(C) Nebulizers and nebulizer supplies;

(D) Ostomy supplies;

(E) Urological supplies;

(F) Resident lifts except as specified in Appendix A to this rule;

(G) Toilet supplies, except as specified in Appendix A to this rule;
(H) Miscellaneous supplies;

(I) Surgical dressings;

(J) Incontinence supplies;

(K) All medically necessary wheelchairs and wheelchair accessories except:

(i) As specified in Appendix A to this rule; or

(ii) If at the time of admission, the individual’s expected length of stay in the nursing facility is 30 days or less as confirmed on a written statement from the individual’s attending physician, and the individual has a physician’s order for the same wheelchair for on-going use in the individual’s home and meets Department of Medical Assistance Programs (DMAP) criteria for a tilt-in-space wheelchair;

(L) Suction pumps and supplies;

(M) Tracheostomy supplies;

(N) Canes and crutches;

(O) Standing and positioning aides;

(P) Walkers;

(Q) Hospital beds, except as specified in Appendix A to this rule or if an exception need exists as determined by the DMAP prior authorization process;

(R) Pressure reducing support services, except as specified in Appendix A to this rule;

(S) Hospital bed accessories, except as specified in Appendix A to this rule;

(T) Bath supplies; and

(U) Over the counter medications as defined in Appendix B to this rule.

(e) The following services and supplies are NOT included in the bundled rate:

(A) Therapy services provided to residents by outside providers;

(B) Medical services by physicians or other practitioners other than the services required by OAR 411-086-0200;

(C) Radiology services, laboratory services and podiatry services;

(D) Transportation for residents to and from medical services in vehicles that are not owned or leased by the facility or by any person who holds an ownership interest in the facility;

(E) Biologicals (e.g., immunization vaccines);

(F) Hyperalimentation;

(G) Prescription pharmaceuticals; or

(H) Ventilators.

Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0140, AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 1-1989, f. 1-27-89, cert. ef. 2-1-89; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 6-1995, f. 6-30-95, cert. ef. 7-1-95; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08
Complex Medical Add-On Services

(1) LICENSED NURSING SERVICES. If a Medicaid resident qualifies for payment at the basic rate and if the resident’s condition or service needs are determined to meet one or more of the procedures, routines or services listed in sections (1)(a) to (2) of this rule, and the nursing facility maintains documentation per OAR 411-070-0027, SPD may pay a complex medical add-on payment (in addition to the basic rate) for the additional licensed nursing services needed to meet the resident’s increased needs.

(a) Medication Procedures.

(A) M-1 -- Administration of medication(s) at least daily requiring skilled observation and judgment for necessity, dosage and effect, for example new anticoagulants, etc. (This category does not include routine medications, any oral medications or the infrequent adjustments of current medications). The facility must maintain a daily nursing note.

(B) M-2 -- Intravenous injections or infusions, heparin locks used daily or continuously for hydration or medication. The facility must maintain a daily nursing note. For total parenteral nutrition (TPN) the facility must maintain daily documentation on a flow sheet and must maintain a weekly nursing note.

(C) M-4 -- Intramuscular medications for unstable condition used at least daily. The facility must maintain a daily nursing note.

(D) M-5 -- External infusion pumps used at least daily. This does not include external infusion pumps when the resident is able to self bolus. The facility must maintain a daily nursing note.

(E) M-6 -- Hypodermoclysis -- daily or continuous use. The facility must maintain a daily nursing note.

(F) M-7 -- Peritoneal dialysis, daily. This does not include residents who can do their own exchanges. The facility must maintain a daily nursing note.

(b) Treatment Procedures.

(A) T-1 -- Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings. The facility must maintain daily information on a flow sheet and must maintain a weekly nursing note.

(B) T-2 -- Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, for a resident who is dependent on nursing staff to maintain airway. The facility must maintain a daily nursing note.

(C) T-3 -- Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more. The facility must maintain a daily nursing note.

(D) T-4 -- Ventilator dependence. Services for a resident who is dependent on nursing staff for initiation, monitoring and maintenance. The facility must maintain a daily nursing note.

(c) Skin/Wound.

(A) S-1 -- Is limited to Stage III or IV pressure ulcers that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note. The pressure ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident’s needs meet or continue to meet complex medical add-on criteria.

(i) Pressure ulcer means any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include decubitus ulcers.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.
(v) A healing Stage III or IV pressure ulcer that has the visual appearance of a Stage II pressure ulcer cannot be considered eligible for purposes of complex medical criteria.

(B) S-2 -- Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note.

(C) S-3 -- Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. The facility must maintain a weekly wound assessment and a weekly nursing note. The stasis ulcer is eligible for add-on until the last day the ulcer is visually equivalent to a Stage III, or if the stasis ulcer is an infected, chronic Stage III or IV, it is eligible for add-on until it is no longer infected and returns to previous chronic Stage III or IV state. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Stasis ulcer means a skin ulcer, usually in the lower extremities, caused by altered blood flow from chronic vascular insufficiency, also referred to as venous insufficiency, lymphedema, arterial insufficiency or peripheral vascular disease.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(v) A healing Stage III or IV stasis ulcer that has the visual appearance of a Stage II stasis ulcer cannot be considered eligible for purposes of complex medical criteria.

(vi) A chronic Stage III or IV stasis ulcer that is no longer infected and has returned to previous chronic Stage III or IV status cannot be considered eligible for purposes of complex medical criteria.

(d) O-4 -- Insulin Dependent Diabetes Mellitus (IDDM).

(A) Unstable IDDM in a resident who requires sliding scale insulin; and

(i) Exhibits signs or symptoms of hypoglycemia and/or hyperglycemia; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

(B) The facility must maintain a daily nursing note. A Medication Administration Record is required when sliding scale insulin or other medication related to the IDDM has been administered. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable. A resident with erratic blood sugars, without a need for further interventions does not meet this criteria.

(e) Other.

(A) O-1 -- Professional Teaching. Short term, daily teaching pursuant to discharge or self-care plan. The facility must maintain a teaching plan and a weekly nursing note.

(B) O-2 -- Emergent medical or surgical problems, requiring short term licensed nursing observation and assessment. This criteria requires pre-authorization from SPD’s Complex Medical Add-On Coordinator (Refer to OAR 411-070-0035). Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical or surgical problem. The facility must maintain a nursing note every shift.

(C) O-3 -- Emergent Behavior Problems -- Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and a care plan. This criteria requires pre-authorization from SPD’s Complex Medical Add-On Coordinator (Refer to OAR 411-070-0035). Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical problem. The facility must maintain a nursing note every shift.

(2) R-1 -- REHABILITATION SERVICES.
(a) Physical Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(b) Speech Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(c) Occupational Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(d) Any combination of physical therapy, occupational therapy and speech therapy at least five days every week qualifies. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation service(s) being provided.

(e) Respiratory Therapy -- At least five days every week by respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan or a third party payor. The facility must maintain the therapist's notes and a weekly nursing progress note.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SDSD 5-1998, f. 6-25-98, cert. ef. 7-1-98; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08

411-070-0095

Resident Funds

(1) Each Medicaid resident is allowed a monthly amount for personal incidental needs. For purposes of this rule, personal incidental funds (PIFs) include monthly payments as allowed and previously accumulated resident savings.

(2) FACILITY RESPONSIBILITY.

(a) The facility must not charge for items included in the bundled rate or for other items or services for which funding can be provided through the Medicaid agency or another non-resident source.

(b) The facility must hold, safeguard and account for a resident's funds if he or she requests such management; or if the case manager requests on Form SDS 0542 that the facility perform such management.

(c) The facility must maintain a record of the request by the resident, case manager or resident representative on Form SDS 0542, covering all funds it holds or manages for residents.

(d) The facility must manage resident funds in a manner in the resident's best interest.

(A) The facility must not charge the resident for holding, disbursing, safeguarding, accounting for, or purchasing from resident funds. Charges for these services are included in the Nursing Facility Financial Statement, Form SPD 35 or 35A and are considered allowable costs reimbursable through the bundled rate.

(B) The cost for items charged to resident funds must not be more than the actual purchase price charged by an unrelated supplier.

(C) The facility may not charge SPD residents or other sources for items or services furnished if all residents receiving such items or services are not charged. Charges must be for direct, identifiable services or supplies furnished to individual residents. A periodic "flat" charge for routine items, such as beverages, cigarettes, etc., is not allowed. Charges must be made only after services are performed or items are delivered.

(D) The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds.

(E) The nursing facility may request technical assistance from SPD/Type B AAA staff, however, responsibility for managing resident funds in the resident's best interest remains with the facility.

(F) When a facility is a resident's representative payee, it must fulfill its duties as representative payee in accordance with applicable federal regulations and state regulations that define those duties.

(G) Facilities holding resident funds must be insured to cover all amounts held in trust.
(3) DELEGATION OF AUTHORITY.

(a) The resident may manage his or her personal financial resources, including PIFs, and may authorize another person or the facility to manage them. If appropriate, the facility must, upon written authorization by the resident, resident representative, or case manager on the resident’s behalf, accept responsibility for holding, safeguarding, spending and accounting of the resident’s funds.

(b) At the time of admission, the facility must assure that the resident, or representative delegating such responsibility to the facility, completes Form SDS 0542, Designation of Management of Personal Incidental Funds. The facility must sign the form acknowledging responsibility. The facility must retain the original in the resident's account records, with copies to the resident and SPD.

(c) The resident wishing to change delegation must do so by completing a new Form SDS 0542 that must be available at the facility.

(d) SPD cannot be delegated to account for the resident's funds.

(4) RESIDENT ADMISSION.

(a) The facility must provide each resident or resident representative with a written statement at the time of admission that:

(A) States the facility's responsibility to pay for all services, supplies and facility equipment required for services (basic rate);

(B) Lists all services provided by the facility that are not included in the facility's basic rate;

(C) States that there is no obligation for the resident to deposit funds with the facility;

(D) Describes the resident's right to select how personal funds will be handled. The following alternatives must be included:

(i) The resident's right to receive, retain, and manage his or her personal funds or have this done by a legal guardian, or conservator;

(ii) The resident's right to delegate on the SDS 0542 another person to act for the purpose of managing his or her personal funds; and

(iii) The facility's obligation, upon written authorization by the resident or representative, to hold, safeguard and account for the resident's personal funds in accordance with these rules;

(E) States that any facility charge for this service is included in the facility's basic rate, and that the facility cannot charge for resident fund management or charge residents more than the actual purchase price of items at an unrelated supplier;

(F) States that the facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee; and

(G) States that if the resident becomes incapable of managing his or her personal funds and does not have a representative, the facility is required to manage his or her personal funds if requested on the Form SDS 0542 by the case manager.

(b) The facility must obtain documentation on the Form SDS 0542 of:

(A) Resident intention to manage own funds; or

(B) Resident, resident representative, or case manager delegation to another individual or the facility to manage the resident’s funds.

(5) RESIDENT ACCOUNT RECORDS.

(a) The facility must maintain a Resident Account Record (Form SDS 713), on an ongoing, day-to-day basis, for each resident for whom the facility is holding funds. Each receipt or disbursement of funds must be posted to the resident's account. Posting from supporting documentation must be done within seven days after the transaction date.

(b) The resident account record must show, in detail with supporting documentation, all monies received on behalf of the resident and the disposition of all funds so received. Persons shopping for residents must provide a list showing description and price of items purchased, along with payment receipts for these items.

(c) Individual resident accounts must be reconciled and listed by the facility at the end of each calendar month.

(d) Petty cash accounts must be reconciled within ten days of receipt of the bank statement.
(c) The facility must maintain a monthly list that separately lists the petty cash and savings account balances for each resident for whom the facility is managing funds.

(f) Records and supporting documentation must be retained for at least three years following the death or discharge of the resident.

(g) Accumulations of $50 or more.

(A) The facility must, within 15 days of receipt of the money, deposit in an individual interest-bearing account any funds held in excess of $50 for an individual resident, unless this money is being managed in a Trust and Agency Account by SPD.

(B) The account must be individual to the resident, must be in a form that clearly indicates that the facility does not have an ownership interest in the funds, and must be insured under federal or state law.

(h) Accumulations of Under $50.

(A) The facility may accumulate no more than $50 of a resident's funds in a pooled bank account or petty cash fund that must be separate from facility funds.

(B) The interest earned on any pooled interest-bearing account containing residents' petty cash must be either prorated to each resident on an actual interest-earned basis, or prorated to each resident on the basis of his or her end-of-quarter balance.

(6) RESIDENT RIGHTS.

(a) The resident must be allowed to manage his or her own funds, or to delegate their management to another, unless the resident has been determined to be incompetent by a court of law. A resident who was not adjudicated incompetent may always decide how to spend his or her own funds.

(b) Facility staff delegated to manage resident funds must follow guidelines outlined in this rule and other state and federal laws and regulations that may apply in order to assure that decisions not made by the resident are made in his or her best interest.

(c) The resident, family or friends has the right to be free from solicitation from the facility to purchase items that are included in the facilities daily rate.

(d) The resident must not be charged for any item included in the facility's daily rate unless the facility can show at least one of the following:

(A) The resident made an informed decision to purchase the item, understanding that a similar and appropriate item is included in the daily rate;

(B) The family requested that the facility purchase the item, understanding that a similar and appropriate item is included in the daily rate; or

(C) The resident is not currently able to make an informed decision to purchase the item, but did so prior to current incapacity.

(e) The resident, family or friends must not be charged for any drug designated by the Food and Drug Administration as less-than-effective unless it can show that both the physician and the resident made an informed decision to continue use of the drug.

(f) Prior to purchasing an item that is included in the facility's daily rate or is over $50, the facility must consult with the SPD/Type B AAA case manager.

(g) The facility must not charge resident funds for any item or service that benefits the facility, facility staff or relatives or friends of facility staff, unless it can show that the resident made an informed decision to purchase the item or service.

(h) When the facility or SPD is of the opinion that a resident is incapable of managing personal funds and the resident has no representative, the facility must refer the resident to the case manager in the local SPD/Type B AAA, who will consult with the resident regarding resident preference. If the attending physician agrees, as documented on the Form SDS 544, Physician's Statement of Resident's Capacity to Manage Funds, that the resident is incapable of handling funds, the case manager will attempt to find a suitable delegate to manage the resident's funds. If no delegate can be found, the facility must assume the responsibility. If the resident disagrees with the designation of a delegate, the designation cannot be made, and the resident retains the right to manage, delegate, and direct use of his own money, if not adjudicated incompetent.
7) ACCESS TO FUNDS, RECORDS.

(a) The facility must provide each resident or delegate reasonable access to his or her own financial records and funds. Reasonable access is defined as seven business days for records and one business day for funds.

(b) The facility must provide a written statement, at least quarterly, to each resident, delegate, or a person chosen by the resident to receive the statement. The quarterly statement must reflect separately all of the resident's funds that the facility has deposited in an interest-bearing account plus the resident funds held by the facility in a petty cash account or other account. The statement must include at least the following:

(A) Identification number and location of any account in which that resident's personal funds have been deposited;

(B) Balances at the beginning of the statement period;

(C) Total deposits with source and withdrawals with identification;

(D) Interest earned, if any;

(E) Ending balances; and

(F) Reconciliation.

(c) The facility must provide a quarterly Resident Account Record on Form SDS 713 to the local SPD/Type B AAA within 15 days following the end of the calendar quarter and provide a copy to the resident or an individual delegated by the resident to receive the copy.

(d) The resident or delegate must have access to funds in accordance with OAR 411-085-0350.

(e) Within ten business days of the resident's transfer or discharge, or appointment of a new delegate as documented on the Form SDS 0542, the facility must provide a final accounting and return to the resident, or the delegate, all of the resident's funds that the facility has received for holding, safeguarding, and accounting, and that are maintained in a petty cash fund or individual account.

8) CHANGE OF OWNERSHIP.

(a) The facility must give each resident or delegate a written accounting of any personal funds held by the facility before any transfer of facility ownership occurs, with a copy to the local SPD/Type B AAA.

(b) The facility must provide the new owner and the local SPD/Type B AAA with a written accounting of all resident funds being transferred and must obtain a written receipt for those funds from the new owner.

9) LOCAL SPD/TYPE B AAA RESPONSIBILITY. The local SPD/Type B AAA must:

(a) Monitor receipt of SDS 713 forms and review them quarterly for appropriateness of expenditures;

(b) Monitor resident resources for resources over the current Medicaid limit;

(c) For residents incapable of managing their own funds and having no one to delegate to do so, attempt to determine resident wishes, seek physician input on the physician statement, and find a delegate, delegating the facility if necessary and not in conflict with resident wishes;

(d) Notify the facility of inappropriate expenditures and report uncorrected problems to SPD Central Office and assist residents in obtaining legal counsel; and

(e) Track expensive or reusable items purchased for residents through resident funds or by SPD and assure their appropriate use after resident death.

10) DEATH OF RESIDENT.

(a) Within five business days following a resident's death, the facility must send a written accounting of the resident's funds to the executor or administrator of the resident's estate. If a deceased resident has no executor or administrator, the facility must provide the accounting to:
(A) The resident's next of kin;

(B) The resident's representative;

(C) The clerk of probate court of the county in which the resident died; and

(D) Estate Administration Unit, Seniors and People with Disabilities, P.O. Box 14021, Salem, OR 97309-5024.

(b) Within five business days following a resident's death, the facility must:

(A) Send a written accounting of the resident's funds and a listing of resident personal property, including wheelchairs, television sets, walkers, jewelry, etc., to the local SPD Estate Administration Unit;

(B) Hold personal property for 90 days, unless otherwise instructed by the SPD Estate Administration Unit; and

(C) Comply with the laws of Oregon regarding disbursal of resident funds, and any advance payments, or contact the Estate Administration Unit, SPD, for more detailed instructions.

[ED. NOTE: Forms referenced are available from the agency.]
(3) Personal Property. The resident's private property must be clearly marked with his or her name.

(4) Department Audit. These records are subject to the same audit criteria as all personal incidental funds in OAR 411-070-0100.

(5) Removal from Facility. The Department may remove copies of these records from the facility.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0180 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1984, f. 7-20-84, ef. 9-1-84; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0110

Temporary Absence from Facility (Bedhold)

(1) SPD does not pay for holding a resident's bed when the individual is absent from the facility.

(2) Personal incidental funds or payment from an individual's family may be used to hold a facility bed if there are no vacancies in the facility to which other residents of the same sex may be admitted and if there is no duplicate payment from SPD. Personal incidental funds may only be used if the resident so chooses.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0190 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1982, f. & ef. 4-26-82, ef. 5-1-82; SSD 8-1982, f. & ef. 6-30-82; SSD 10-1986, f. & ef. 7-1-86; SSD 13-1986(Temp), f. & ef. 10-13-86; SSD 1-1987, f. & ef. 4-13-87; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 9-1995, f. 8-31-95, cert. ef. 9-1-95; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0115

Transfer of Residents

(1) Prior Approval Required. A resident must not be transferred to another facility without prior approval by the resident, the attending physician, branch worker, and the facility's director of nursing services. Reassignment of rooms within the facility requires prior notice to the case manager. All transfers, both inter- and intra-facility, must be conducted in accordance with resident's rights as described in OAR chapter 411, division 085 and the transfer rules in OAR chapter 411, division 088.

(2) Emergency Transfer. In an emergency, consultation with the branch worker is waived. However, the branch worker must be notified by the facility of the resident's transfer at the earliest possible opportunity.

(3) Noncompliance. Failure on the part of the facility administration to comply with this rule can constitute a basis for withholding payment for care of the resident involved.

Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0200 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 9-1995, f. 8-31-95, cert. ef. 9-1-95; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0120

Discharge of Residents

When the attending physician indicates that the resident does not, or in the future will not, require long-term care, facility authorities must report this fact to the branch office no later than the first branch office working day following the physician's notification. Upon request, the branch office will assist the resident, facility, relatives, or guardian in developing plans and arrangements for discharge placement. Resident's refusal to be discharged will relieve the Department of responsibility for payment.

Stat. Auth.: ORS 410.070 & 414.065
411-070-0125

Medicare, (Title XVIII)

SPD shall pay on behalf of eligible individuals the coinsurance rate established under Medicare, Part A, Hospital Care, for care rendered from the 21st day through the 100th day of care in a Medicare certified nursing facility. SPD shall pay the appropriate rate as described in these rules for care beyond the 100th day. Payment shall be subject to documentation required for the rate.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; Renumbered from 461-017-0210 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0130

Medicaid Payment in Hospitals

(1) SWING BED ELIGIBILITY. To be eligible to receive a Medicaid payment under this rule, a hospital must:

(a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed provider agreement with SPD to receive Medicaid payment for swing-bed services.

(2) NUMBER OF BEDS.

(a) A critical access hospital (CAH) not located within a 30 mile geographic radius of a licensed nursing facility as of March 13, 2007 may receive Medicaid payment for up to 20 residents at one time. The CAH must maintain at least five beds or twice the average acute care daily census, whichever is greater, for exclusive acute care use.

(b) Other hospitals receiving payment for Medicaid services under this rule may not receive Medicaid payment for more than a total of five residents at one time. In addition, the residents must have a documented need for and receive services that meet the complex medical add-on requirements outlined in OAR 411-070-0091.

(c) If circumstances change so that a CAH receiving payment for Medicaid services pursuant to section (2)(b) of this rule meets the criteria set out in section (2)(a) of this rule after March 13, 2007, the CAH may petition SPD for authorization to receive such payment pursuant to section (2)(a) of this rule. SPD shall evaluate all available long-term care resources within a 30 mile geographic radius of the CAH and the amount of unmet long-term care need in the same area and determine if the CAH shall be authorized to receive payment pursuant to section (2)(a) of this rule.

(3) SERVICES PROVIDED. The daily Medicaid rate shall be for the services outlined in OAR 411-070-0085 (Bundled Rate).

(4) COMPLIANCE WITH MEDICAID REQUIREMENTS. Hospitals receiving Medicaid payment for swing-bed services must comply with federal and SPD rules and statutes that affect long-term care facilities as outlined in the facility's provider agreement with SPD.

(5) ADMISSION OF INDIVIDUALS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager must determine there is no nursing facility bed available to the individual within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" means a bed in a nursing facility that is available to the individual at the time the placement decision is made.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 7-1988, f. & ef. 7-1-88; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 1-2007, f. 3-12-07. & cert. ef. 3-13-07; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0140

Hospice Services

(1) Contract. The Department may enter into a contract (provider agreement) to reimburse Medicare certified hospice providers in Oregon for services provided in Medicaid certified nursing facilities under the following conditions:

(a) The Medicare-certified hospice provider must have a written contract with the nursing facility;

(b) A copy of the completed contract must be submitted to the Department; and

(c) The hospice provider must have a completed, written contract (provider agreement) with the Department for nursing facility-based hospice services prior to being determined eligible for reimbursement.

(2) Reimbursement:

(a) The Department will pay the hospice provider a rate equal to 95 percent of the rate that the nursing facility would otherwise receive;

(b) The hospice provider is solely responsible for reimbursing the nursing facility; and

(c) Reimbursement for services provided under this rule is available only if the recipient of such services is Medicaid-eligible, Medicare hospice eligible, and been found to need nursing facility care through the Pre-Admission Screening process.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 13-1993, f. 12-30-93, cert. ef. 1-1-94; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0300

Filing of Financial Statement

(1) The provider must file annually with the SPD, Financial Audit Unit, the Nursing Facility Financial Statement (NFFS) covering actual costs based on the facility's fiscal reporting period for the period ending June 30. A NFFS must be filed for other than a year only when necessitated by termination of a provider agreement with SPD, or by a change in ownership, or when directed by SPD. Financial reports containing up to 15 months of financial data shall be accepted for the reasons above or with SPD's permission prior to filing.

(2) The NFFS is due within three months of the end of the fiscal reporting period, change of ownership, or withdrawal from the program.

(a) The report must be postmarked on or before the due date to be considered timely.

(b) A one month extension may be obtained if a written request for an extension is postmarked prior to the expiration of the original three months. SPD shall respond in writing to these requests.

(c) When a NFFS is not postmarked within three months, or within four months if an extension under section (2)(b) of this rule was obtained, a penalty shall be assessed and collected. The amount of the penalty shall be $5 per licensed nursing facility bed per day for each State of Oregon business day the NFFS is late. The total penalty must not exceed $50,000 per fiscal reporting period. For purposes of this section, the number of licensed nursing facility beds shall be the number licensed on the last day of the fiscal reporting period that the facility failed to submit its report.

(d) SPD may assess interim penalties and deduct the amount of the interim penalties from the next Medicaid payment payable to the facility. Each interim penalty must be the amount of the penalty that has accrued under section (2)(c) of this rule to the date of assessment, and has not already been assessed as an interim penalty.

(e) A facility may request an informal conference or contested case hearing pursuant to ORS 183.413 through 183.470 within 30 days of receiving a letter from SPD informing the facility of assessment of an interim penalty or a penalty under this rule. OAR 411-070-0435 applies to such requests and sets forth the procedures to be followed. If no request for an informal conference or contested case hearing is requested, the penalty shall be assessed and enforced.

arcweb.sos.state.or.us/.../411_070.html
made within 30 days of receiving such a letter, the interim penalty or penalty becomes final in all respects, including liability for payment of and the amount of the interim penalty or penalty.

(3) Improperly completed or incomplete Nursing Facility Financial Statements shall be returned to the facility for proper completion.

(4) FORMS.

(a) Form SPD 35 is a uniform cost report to be used by all nursing facility providers, except those that are hospital based.

(b) Form SPD 35A is a uniform cost report to be used by all nursing facility providers that are hospital based.

(c) Forms SPD 35 and SPD 35A must be completed in accordance with the Medicaid Nursing Facility Services Provider Guide and Audit Manual.

(5) If a provider knowingly or with reason to know files a report containing false information, such action constitutes cause for termination of its agreement with SPD. Providers filing false reports may be referred for prosecution under applicable statutes.

(6) Each required NFFS must be signed by a company or corporate officer or a person designated by the corporate officers to sign. If the NFFS is prepared by someone other than an employee of the provider, the individual preparing the NFFS must also sign and indicate his or her status with the provider.

(7) Facilities with fewer than 1000 Medicaid resident days during a twelve-month reporting period or fewer than 2.74 Medicaid resident days per calendar day, for facilities with reporting periods of less than a year, are not required to submit a SPD 35 or SPD 35A, but must submit a letter to SPD's Financial Audit Unit indicating they will not be submitting a financial statement. This letter is due the same day the financial statement would have been due.

(8) A NFFS must be filed annually by each facility for the fiscal reporting period that ends June 30. The NFFS filed for the period that ends June 30 is required to cover actual costs during the previous state fiscal year from July 1 through June 30.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0300 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1985, f. 5-31-85, ef. 6-1-85; SSD 10-1986, f. & ef. 7-1-86; SSD 8-1988, f. & cert. ef. 7-1-88; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0302

Filing of Revised Financial Statements

(1) Revised Nursing Facility Financial Statements may only be filed with prior written authorization from the Department.

(2) An amended report must be postmarked within six months of the end of the fiscal reporting period.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070
Hist.: SSD 6-1985, f. 5-31-85, ef. 6-1-85; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0305

Accounting and Record Keeping

(1) Nursing Facility Financial Statements are to be prepared in conformance with generally accepted accounting principles and the provisions of these rules. The Department has the option to prescribe and interpret these rules in conformance with generally accepted...
accounting principles.

(2) Financial Statements must be filed using the accrual method of accounting except governmental facilities using the cash method of accounting may file reports using the cash method.

(3) The provider must maintain, for a period of not less than three years following the date of submission of the Nursing Facility Financial Statement, financial and statistical records that are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved audit questions at the end of this three-year period, the records must be maintained until the questions are resolved. The records must be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules.

(4) Expenses reported as allowable costs must be adequately documented in the financial records of the provider or they will be disallowed.

(5) The Department will maintain each required Nursing Facility Financial Statement submitted by a provider for three years following the date of submission of the report. In the event there are unresolved audit questions at the end of this three-year period, the statements will be maintained until such questions are resolved.

(6) The records of the provider must be available for review by authorized personnel of the Department and of the U.S. Department of Health and Human Services during normal business hours at a location in the State of Oregon specified by the provider.

(7) Accrued expenses that are forgiven by a creditor will be considered as income to the facility and offset against expenses in the subsequent period. Accruals that are settled at less than full value will have the forgiven amount considered as income and offset against expenses.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; AFS 29-1979, f. 8-30-79, ef. 9-1-79; Renumbered from 461-017-0305 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0310

Auditing

(1) All Nursing Facility Financial Statements are subject to desk review and analysis within six months after proper completion and filing.

(2) The desk review will determine, to the extent possible:

(a) That the provider has properly included its costs on the Nursing Facility Financial Statement in accordance with generally accepted accounting principles and the provisions of these rules; and

(b) That the provider has properly applied the cost finding method specified by the Department to its allowable costs determined in subsection (2)(a) of this rule; and

(c) Whether further auditing of the provider’s financial and statistical records is needed.

(3) All filed Nursing Facility Financial Statements are subject to a field audit, normally to be completed within one year from the date of filing.

(4) The field audit will, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to; and

(b) Reported data are in agreement with supporting records; and

(c) The Nursing Facility Financial Statement is reconcilable to the appropriate IRS report and payroll tax reports.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
411-070-0315

Maximum Allowable Compensation of Administrator and Assistant Administrator

(1) The maximum compensation of a full-time (40 hours per week) licensed administrator to a nursing facility may be allowable at the lower of compensation actually received or the maximum allowable administrator compensation amount determined annually using the calculation in section (4) of this rule.

(2) The maximum compensation of not more than one full-time (40 hours per week) assistant administrator to a nursing facility with at least 80 licensed beds may be allowable at the lower of compensation actually received or seventy-five percent of the allowable administrator compensation for the number of licensed beds in the nursing facility. The Department will not allow the cost of an assistant administrator in a facility with less than 80 beds.

(3) If either of the above individuals works less than 40 hours in the average week, allowable compensation must be the lower of actual compensation received or the maximum allowable administrator compensation determined annually based on the calculation in section (4) of this rule, multiplied by the percentage of 40 hours worked in the average week. The provider must maintain adequate records to demonstrate time actually spent.

(4) The maximum allowable administrator compensation may be adjusted each year and will be effective as of January 1 each year. The rates must be established using the gross allowable compensation in Account 411 (Administrator Compensation) of the Nursing Facility Financial Statement for non-owner administrators. The applicable compensation amounts will be inflated by the U.S. CPI from the mid point of each facility's fiscal year to July 1. The 75th percentile of each bed-size category, 1-49, 50-79, 80-99, 100 and over, will be the ceiling for each grouping.

(5) When a single individual serves as the administrator of both a nursing facility and a hospital, the salary will be pro-rated to both functions. The nursing facility portion will then be compared to the pro-rated share of the allowable administrator compensation to determine the amount to be included as allowable.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0315 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0320

Consultants

(1) Costs for direct care and dietitian consultant services to the staff of the facility will be allowed.

(2) No other consultant costs will be allowed.

(3) Payment for treatment and evaluation provided directly to an individual resident by medical providers will not be paid by Seniors and People with Disabilities Division.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0320 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 2-1985, f. & ef. 3-5-85; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0330


Owner Compensation

(1) Reasonable compensation for services performed by owners (whether sole proprietors, partners, or stockholders) is an allowable cost, provided the services are actually performed, documented, and are necessary, and the provisions of this rule are met.

(2) The allowance of compensation for services of sole proprietors and partners is the amount determined by the Department to be the reasonable value of the services rendered as long as compensation was paid in conformance with this rule.

(3) Compensation for services performed by owners may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and rendered in connection with resident care. Services rendered in connection with resident care include both direct and indirect activities in the provision and supervision of resident care, such as administration, management, and overall supervision of the institution. Services which are not related to either direct or indirect resident care; e.g., those primarily for the purpose of managing or improving the owner's financial investment are not recognized as an allowable cost. Costs related to the owner's management and overall supervision of the facility will be reported in Account 436.

(4) Payments to an owner that represent a return on equity capital are not allowable costs for reimbursement purposes. Such payments are not considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

(5) The compensation allowance will be an amount as would ordinarily be paid for comparable services in other nursing facilities, as defined by section (6) of this rule. This determination will be made by the Department depending upon the facts and circumstances of each case.

(6) For purposes of determining whether the compensation paid to or claimed by an owner is reasonable, the total of all benefits and remuneration such as travel allowance or key-man insurance, regardless of the form, will be considered. The Department has established the 75th percentile ranking of average compensation paid, in all facilities by job category, as being reasonable.

(7) Accrued compensation of an owner, if not paid within 75 days after the end of the Nursing Facility Financial Statement reporting period, may not be included as an allowable expense.

(8) An owner must not be compensated for services in excess of 40 hours in one week. This rule applies even if an owner may provide services in more than one area.

(9) The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

(10) Compensation paid to an employee who is an immediate relative of the owner of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives": Husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; and grandparent and grandchild, uncle, aunt, nephew, niece, and cousin.

(11) Where an owner provides services for more than one facility or is engaged in other occupations or business activities, allowable compensation may be adjusted to reflect an appropriate allocation of time spent in each area based on the combined total of resident days.

(12) Where an owner functions as an administrator or assistant administrator, the rules governing compensation of these positions apply, in addition to the requirements of this rule.

Stat. Auth.: ORS 414.065 & 410
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0330 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1985, f. 5-31-85, ef. 6-1-85; SSD 10-1986, f. & ef. 7-1-86; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0335

Related Party Transactions

(1) Costs applicable to services and supplies furnished to a provider by organizations related to the provider by common ownership or
control are allowable at the lower of cost excluding profits and markups to the related party or charge to the facility. Such costs are allowable to the extent that they relate to resident care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. Documentation of costs to related parties (including those identified in OAR 411-070-0330(10)) must be made available at time of audit. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(2) An exception is provided to the general rule in section (1) of this rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the Department:

(a) That the supplying organization is a separate legal entity; and

(b) That a substantial part of the supplying organization's business activity, of the type carried on with the provider, is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. Prices paid by the provider may not be in excess of what would be paid by a prudent cost-conscious buyer.

(3) If the provider takes the position that an exception as stated in section (2) of this rule applies, then the provider must:

(a) Make available the books and records of the related organization to SPD auditors; and

(b) Maintain a receiving report signed by personnel of the nursing facility for services or supplies furnished by the related organization.

(4) Rental expense paid to related organizations for facilities may be allowable to the extent the rental does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of these rules. The exception listed in section (2) of this rule does not apply to rental expense paid for facilities.

Chain Operations

(1) A chain organization consists of a group of two or more health care facilities that are owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains but also chains operated by various religious and other charitable organizations.

(2) Although the home office of a chain is normally not a provider in itself, it may furnish to the individual provider central administration or other service such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services is includable in the provider's allowable costs under the program.

(3) Home office costs that are not otherwise allowable costs when incurred directly by the provider are not allowable as home office costs to be allocated to providers. Where the home office is a mere holding company and provides no services related to resident care, no costs of the home office are allowable to the providers in the chain or single facility.

(4) Where an owner receives compensation from the home office for services to the facility, the compensation is allowable only to the extent that it is related to resident care and to the extent that it is reasonable as defined under owner's compensation.

Allocation of Home Office and Regional Office Costs
(1) The initial step in the allocation of home office and regional office costs is direct allocation of all allowable costs directly attributable to a particular nursing facility (such as construction interest, salary where the administrator of a nursing facility in the chain is paid directly by the home office, etc.) or non-nursing facility activity.

(2) Other allowable costs must appropriately be allocated among the providers (and to any non-provider activities in which the home office or regional office may be engaged) on the basis of beds, resident days, or other bases, whichever most equitably allocates such costs. Revenues are not generally appropriate for distributing these costs. Where possible, allocation of costs are to be based on function and, consequently, the bases of allocation may appropriately be different, say for accounting costs and for personnel costs. Where the home office or regional office incurs costs for activities not related to resident care in the chain's participating providers, the allocation basis must provide for all allocation of costs such as rent, administrative salaries, other general overhead costs, organization costs, etc., that are attributable to non-resident care as well as resident care activities.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0345 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1985, f. 5-31-85, ef. 6-1-85; SSD 10-1989, f. 6-30-89, cert. ef. 7-1-89; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0350

Management Fees

Management fees are an allowable expense if they are necessary, reasonable, non-duplicative of facility personnel and functions, and documented by a binding contract with a non-related party defining the items, services, and activities provided. If the administrator or assistant administrator is supplied as part of the contract, the rules governing their compensation in these rules apply. Documentation demonstrating that the services were actually performed is required. Management fees paid to a related organization are subject to the rules governing related parties (OAR 411-070-0335), chain operations (OAR 411-070-0340), and allocation of home office costs (OAR 411-070-0345). The allowable salary paid to the administrator and assistant administrator is included in the total facility management fee calculation. Total management fees for allowable management and supervisory services may not exceed the limits established for the administrator and the assistant administrator in OAR 411-070-0315 plus $5,000 allowable for other management fees per year.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0350 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 10-1989, f. 6-30-89, cert. ef. 7-1-89; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0359

Allowable Costs

(1) ALLOWABLE COSTS. Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident services.

(a) Accounting, Auditing, and Data Processing -- The costs of recording, summarizing, and reporting the results of operations are allowable.

(b) Advertising -- Help wanted advertising and the expense related to the alphabetical listing in the yellow pages of a phone directory are allowable.

(c) Allowable Workers Compensation Dividends (Refunds) or Billings of the nursing facility are those dated in the fiscal reporting period.

(d) Auto and Travel Expense -- Expense of maintenance and operation of a vehicle and travel expense related to resident services are reimbursable. The allowance for mileage reimbursement must not exceed the amount determined reasonable by the Internal Revenue Service for the period reported. Allowable out-of-state travel is restricted to Washington, Idaho, and Northern California, no farther south than San Francisco. One out of state/contiguous area trip per year for two employees shall be allowed, as long as it relates to resident...
(e) Bad Debts -- Bad debts related to Title XIX recipients are allowable.

(f) Bank and Finance Charges -- Charges for routine maintenance of accounts are allowable.

(g) Communications -- Charges for routine telephone service, including pagers, and cable television fees, are allowable.

(h) Compensation of Owners -- Owner's compensation in accordance with OAR 411-070-0330 is allowable.

(i) Consultant Fees -- Consultant fees are allowable provided they meet the criteria as outlined in OAR 411-070-0320.

(j) Criminal Records Checks -- Costs of criminal records checks of facility employees if mandated by federal or state law are allowable.

(k) Depreciation and Amortization -- Depreciation schedules on buildings and equipment must be maintained. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Depreciation and amortization must be calculated on a straight-line basis and prorated over the estimated useful life of the asset. Effective July 1, 2003, these costs must be reported in accordance with OAR 411-070-0365, 411-070-0375, and 411-070-0385.

(l) Education and Training -- Registration, tuition, and book expense associated with education and training of personnel is allowed provided it is related to resident services. The costs associated with training and certifying nurse aides are not allowable for inclusion in the annual NFFS. These costs are reimbursed separately by SPD per OAR 411-070-0470.

(m) Employee Benefits -- Employee benefits that are made available to all employees, are for the primary use of the employees, are generally considered by the industry as reasonable and important benefits to provide for employees, are not taxable as wages, and are allowable to the extent of employer participation.

(n) Food -- Food products and supplements used in food preparation are allowable.

(o) Home Office Costs -- Home office costs are allowable in accordance with OAR 411-070-0345.

(p) Insurance -- Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to resident services. Self-insurance costs are allowable only when expense is actually incurred.

(q) Interest -- Interest on debt related to the provision of resident services is an allowable expense, except on or after July 1, 1984, interest expense related to that portion of the acquisition price of a long-term facility that exceeds the depreciable basis (OAR 411-070-0375) will not be reimbursable.

(r) Legal Fees -- Legal fees directly related to resident services are allowable. Legal fees related to non-allowable costs are not allowable. Legal fees claimed as related to resident services must be explained and listed on Schedule A. Fees related to legal and administrative actions to resolve a disagreement with the state shall be allowable if the action is resolved in the provider's favor, and the judge or hearings officer does not order the state to pay the provider's legal fees.

(s) Licenses, Dues, and Subscriptions -- Fees for facility licenses, dues in professional associations, and costs of subscriptions for newspapers, magazines, and periodicals provided for resident and staff professional use are allowable.

(t) Linen and Bedding -- Linen and bedding costs for the facility are allowable.

(u) Management Fees -- Management fees are allowable provided they meet the criteria for OAR 411-070-0350.

(v) Postage and Freight -- Postage expense is considered an office supply cost. Freight must be posted to the same account as the item purchased.

(w) Property Costs -- Costs related to purchase or lease of a facility are to be reported in Accounts 452 through 459 and 461.

(x) Purchased Services -- Services that are received under contract arrangements are reimbursable to the extent that they are related to resident services and the sound conduct and operation of the facility.

(y) Rent or Lease Payments -- Payments for the lease or rental of land, buildings, and equipment are to be reported. Payments for lease agreements entered into with a related party are limited to the lower of actual costs or the lease payments.
Repairs and Maintenance -- Costs of maintenance and minor repairs are allowable when related to the provision of resident services.

Salaries (Except Owners and Related Parties) -- Salaries and wages of all employees engaged in resident service activities or overall operation and maintenance of the facility, including support activities of home offices and regional offices, are allowable.

Supplies -- Cost of supplies used in resident services or providing services related to resident services are allowable.

Taxes -- Property taxes on assets used in rendering resident services are allowable. Long term facility taxes paid on resident days are allowable, effective July 1, 2003.

Utilities -- Costs for facility heating, lighting, water-sewer, and garbage provisions are allowable.

Utilization Review -- Costs incurred for utilization review are Medicare related and are not allowable for Medicaid reimbursement.

EXCEPTIONS. Exceptions to the items listed in section (1) of this rule must be approved in writing to be allowable. Exceptions shall not be granted for the following items:

Amortization of non-competitive agreement;

Goodwill;

Federal and other governmental income taxes;

Penalties and fines;

Costs of services and items otherwise reimbursable through DMAP, other third party payors (see section (3) of this rule), or the resident's personal funds;

The cost related to the functioning of Corporate Boards of Directors;

Advertising for purposes of soliciting potential residents, except for listings in the yellow pages (see section (1)(b) of this rule);

The cost of salaries and supplies devoted to religious activities; or

Gifts and contributions.

THIRD PARTY PAYORS. The purpose of this section is to assure that facilities are not paid twice, once through the Medicaid bundled rate and again through a third party payor, for providing a service. This section includes both allowed and non-allowable costs.

Facilities must bill third party payors for nursing facility services whenever payment from a third party payor is or may be available. Examples of such payors are Medicare, Veterans Administration, insurance companies, or a private resident when the items are not included in the basic rate.

Failure to bill or collect from third party payors whenever appropriate may not cause these expenses to be considered allowable.

The cost of services incurred for therapy services performed by non-employee therapists are reimbursable through a third party payor or DMAP and are non-allowable on the NFFS.

The cost of supplies and equipment medically necessary in the performance of therapy services that are reimbursable through a third party payor or DMAP, are non-allowable on the NFFS.

Stat. Auth.: ORS 410.070 & 414.065
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 5-1985, f. & ef. 5-1-85; SSD 10-1986, f. ef. 7-1-86; SSD 11-1986, f. 8-29-86, ef. 9-1-86; SSD 10-1989, f. 6-30-89, cert. ef. 7-1-89; SSD 11-1989, f. & cert. ef. 4-1-91; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 4-1992, f. & cert. ef. 6-24-92; SSD 13-1992, f. 12-31-92, cert. ef. 1-1-93; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 11-2004(Temp), f. & cert. ef. 5-28-04 thru 11-24-04; SPD 36-2004, f. 12-23-04, cert. ef. 12-28-04; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09
Capital Assets

(1) The following costs must be capitalized and depreciated: Expenses for depreciable assets with historical cost in excess of $1,000 per unit, or in aggregate, and a useful life greater than one year from the date of purchase.

(2) Repair costs in excess of $1,000 on equipment or buildings must be capitalized.

(3) The provider must maintain schedules of capital assets and depreciation, on a straight line basis, to document amounts on the Nursing Facility Financial Statement.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0360 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 10-1986, f. & ef. 7-1-86; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0370

Depreciable Assets

(1) Tangible assets of the following types in which a provider has an economic interest through ownership are subject to depreciation:

(a) Buildings -- The basic structure or shell and additions thereto;

(b) Building Fixed Equipment -- Attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, and air conditioning system. The general characteristics of this equipment are:

(A) Affixed to the building and not subject to transfer;

(B) A fairly long life but shorter than the life of the building to which affixed.

(c) Movable Equipment -- Such items as beds, wheelchairs, desks, vehicles, and other depreciable items. The general characteristics of these equipment are:

(A) Capable of being moved;

(B) Subject to control and meeting the definition of a capital asset.

(d) Land Improvements -- Such items as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the provider;

(e) Leasehold Improvements -- Betterments and additions made by the lessee to the leased property that become the property of the lessor after the expiration of the lease.

(2) Land is not Depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, and the cost of curbs and side walks, replacement of which is not the responsibility of the provider.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0360 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 10-1986, f. & ef. 7-1-86; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0375

Depreciation Basis

(1) Purchase of a Nursing Home:
(a) New Facility -- The depreciation basis of a new facility must be the historical cost of building the facility, including preparation for use, or the purchase price from an unrelated organization not to exceed the fair market value, including preparation for use, less salvage value;

(b) Ongoing Facility -- The depreciation basis of the purchase of an ongoing facility from an unrelated organization is limited to the lower of the following:

(A) The allowable acquisition cost of such asset to the first owner of record on or after July 18, 1984; or

(B) The acquisition cost of such asset to the new owner.

(c) To properly provide for costs or valuations of fixed assets, an appraisal by an appraisal expert will be required if the provider has no historical cost records, or has incomplete records of depreciable fixed assets, or purchases a facility without designation of purchase price for the classification of assets acquired. The appraisal is subject to the approval of the Department. In any case, the Department may require such an appraisal to establish the fair market value of the provider assets;

(d) If the purchase is from a related organization, the cost basis is the lower of the cost basis of the related organization or the cost basis as determined in subsections (b) and (c) of this section, less depreciation as determined by the provisions of these rules.

(2) The depreciation basis of other assets must be the historical cost to the provider from an unrelated organization plus set-up costs, less salvage value. In the case of a trade-in, the historical cost will consist of the sum of the book value of the trade-in plus the cash paid. In a case where the asset is purchased from a related organization, the depreciation basis must not exceed the asset's book value to the related organization as determined under the provisions of this guide.

(3) The depreciation basis of donated assets, defined as an asset acquired without making any payment for it in the form of cash, property, or services, must be the lessor of:

(a) Fair market value at the date of donation adequately documented in the provider's records or by appraisal by an appraisal expert, less salvage value; or

(b) If from a related organization, the depreciation basis must be the lesser of:

(A) Fair market value; or

(B) The depreciation basis the related party had or would have had for the asset under the program.

Depreciation Lives

(1) The provider must use the "Estimated Useful Lives of Depreciable Hospital Assets" Revised 2004 guidelines for asset lives when computing depreciation.

(2) For assets not covered by the guidelines and with costs of more than $1,000 per unit, or in aggregate, the lives established by the provider are subject to approval by the Department.

(3) Depreciation and amortization schedules must be maintained.

(4) Depreciation expense is not allowed on land.

(5) Depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset.

[Publications: Publications referenced are available from the agency.]
Equity

Equity is not an allowable expense for reimbursement but must be reported. Equity capital is the net worth of the provider (owner's equity in the net assets as determined under these rules), adjusted for those assets and liabilities that are not related to the provision of resident care:

(1) Generally accepted accounting principles are to be used unless otherwise specified in these rules for computing owner's equity.

(2) Assets and liabilities not related to providing resident care are not includable in the provider's equity capital.

(3) Loans from owners or related entities are considered as invested equity capital of the provider.

(4) Owner's equity in assets leased from related entities is includable in the equity capital of a proprietary provider.

(5) Goodwill is not includable as part of owner's equity.

(6) Invested funds that are diverted to income producing activities that are not resident related for more than six months will not be included as part of owner's equity.

(7) Amounts deposited in a funded depreciation account and the earnings on deposits are not included in equity capital. Interest earned on these funds is not offset against interest expense.

(8) Land, buildings, and other assets acquired in anticipation of expansion are not includable in equity capital. Construction-in-process and liabilities related to such construction are not includable in equity capital.

(9) Prepaid premiums on life insurance carried by a provider on officers and key employees, where the provider is designated as the beneficiary, are not included when computing equity capital.

(10) The costs of noncompetitive agreements are not includable in equity capital.

(11) The amount deposited and the earnings on self-insurance reserve funds are not includable in equity capital.

(12) When an asset is totally or partially destroyed by a casualty, the unrecovered loss is not included in equity capital.

(13) Working capital, defined as the difference between current assets and current liabilities, must be adjusted by any amount considered to be excessive for the necessary and proper operation of resident care activities. The excessive amount will not be included in equity capital.

(14) The cash surrender value of insurance is not includable in equity capital.

(15) Imputed salaries for proprietors will be offset in computing the equity capital.

(16) Any portion of an acquisition cost, incurred on or after July 18, 1984, that exceeds the depreciable basis is not includable in the owner's equity calculation.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0395 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 2-1985, f. 3-5-85; SSD 10-1986, f. & ef. 7-1-86; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0415
Offset Income

(1) Income is offset against expenses unless specifically excluded in section (2) of this rule. If an adjustment is for a revenue producing activity representing a non-allowable cost, the revenue must be offset against the appropriate expense if the revenue is less than 2 percent of the total provider expense (sum of cost areas). Where the revenue is greater than 2 percent of the total provider expense (sum of cost areas), costs must be allocated to this area as described in OAR 411-070-0430, Allocation Methods.

(2) Income items that may not be offset are:

(a) Ancillary income and charges for routine services or supplies that are included in the bundled rate but charged to other residents (except as required in OAR 411-070-0359(3));

(b) Grants, unless designated for paying a specific operating cost; and

(c) Donations, unless designated for paying a specific operating cost.

(3) Revenue received for pediatric residents shall be offset against expenses. These revenues may not be subject to the 2 percent limitation established in section (1) of this rule. The revenue shall be offset against cost centers in the same ratio as reported by the facility in accordance with OAR 411-070-0452.

(4) Mental health revenues received from local governments to provide extra care to Medicaid residents must be reported in SPD Account 819, directly offset against the related expense and explained on Schedule A.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0410 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SS 2-1981, f. 12-31-81, ef. 1-1-82; SSD 5-1985, f. & ef. 5-1-85; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0417

Treatment of Complex Medical Add-Ons

(1) The complex medical add-on reflects the additional costs of providing skilled nursing services for certain residents due to their needs.

(2) The complex medical add-on is added to the basic rate.

(3) When calculating per resident day care compensation cost, the treatment of the complex medical add-on is as follows:

(a) The allowable care compensation costs for both the basic rate and the complex medical add-on are divided by total basic rate resident days.

(b) Revenue from the complex medical add-on received for eligible individuals is divided by the number of Medicaid basic rate resident days.

(c) The per resident day amounts computed in section (3)(a) of this rule are reduced by the per Medicaid resident day amounts computed in section (3)(b) of this rule. The result is defined as care compensation per resident day and shall be used in determining the prospective base rate.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0420

Base Year Cost Finding
(1) The provider must report its gross costs and must make reclassifications and adjustments to costs as provided in these rules. This process will determine net allowable costs on the Nursing Facility Financial Statement that includes a uniform chart of accounts provided by the Department. The gross costs and revenues must agree with the statement of earnings and expenses or profit and loss statement of the provider. Revenues are to be reported in the same manner as costs on the Nursing Facility Financial Statement. The provider must also use the balance sheet provided to report its gross assets, gross liabilities, and gross equity, make reclassifications and adjustments as provided by these rules.

(2) The per diem costs of care must be used to determine each provider's allowable per diem costs and must be effective for the same period as covered by the Nursing Facility Financial Statement.

(3) The per diem costs of each facility will be used to establish the basic rate on July 1 of each odd numbered year.

(4) Costs, revenues, assets, liabilities, and owner's equity attributable from a home office or regional office to a provider under OAR 411-070-0345 will be included on the Nursing Facility Financial Statement in the Home Office column. The home office financial data must be reconcileable to the home office financial statements and records.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0415 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1985, f. 5-31-85, ef. 6-1-85; SSD 10-1986, f. & ef. 7-1-86; SSD 11-1986, f. 8-29-86, ef. 9-1-86; SSD 4-1989, f. & cert. ef. 4-18-89; SSD 10-1989, f. 6-30-89, cert. ef. 7-1-89; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 10-1992, f. 10-30-92, cert. ef. 11-1-92; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0425

Resident Days

The provider must keep census records on all residents.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; Renumbered from 461-017-0420 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SS 2-1981, f. 12-31-81, ef. 1-1-82; SSD 5-1985, f. & ef. 5-1-85; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06

411-070-0430

Allocation Methods

(1) The provider must use the allocation methods designated on the NFFS: COST -- ALLOCATION METHOD

(a) Property -- Resident Days or Square Footage;

(b) Administrative and General -- Resident Days;

(c) Other Operating Support -- Resident Days;

(d) Food -- Resident Days;

(e) Direct Care Compensation -- Actual Cost or Resident Days;

(f) Direct Care Supplies -- Actual Cost or Resident Days.

(2) Where costs are related to non-nursing facility activities, the provider must use an appropriate allocation method to reasonably and accurately allocate these costs (see OAR 411-070-0415). For residential care facility individuals, the facility must use resident days for all areas except direct care compensation and direct care supplies and property. The direct care compensation and direct care supplies
allocation must be actual costs incurred. The property allocation method may be based on either resident days or on square footage and must be designated on the NFPS.

(3) Square footage must be used to allocate property costs to pediatric units as defined in OAR 411-070-0452.

(4) Actual payroll for the pediatric unit must be used as the basis for allocating direct care compensation to pediatric units.

(5) If SPD determines that for a provider it is more reasonable and accurate to use a different allocation method than specified in sections (1) and (2) of this rule, then such allocation method must be used.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; AFS 29-1978, f. 7-28-78, ef. 8-1-78; Renumbered from 461-017-0425 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SS 2-1981, f. 12-31-81, ef. 1-1-82; SSD 10-1986, f. & ef. 7-1-86; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0435

Appeals

(1) The Department will send letters to a provider that inform the provider of any changes made by the Department from the provider Nursing Facility Financial Statement. A provider is entitled to an informal conference or a contested case hearing pursuant to ORS 183.413 -183.470, as described in sections (2) or (3) of this rule, to protest the change(s).

(2) The provider may request an informal conference, by notifying the Department in writing within 30 days of receipt of the letter from the Department that informs the provider of the change(s). The request for an informal conference must be postmarked within the 30-day limit and must state, specifically, the reason(s) for requesting the conference. At the informal conference, the provider may submit documentation and explain the basis for the provider's protest. Following the informal conference, the Department will notify the provider of its decision by mail. No judicial review is available following a decision from an informal conference. If the provider is not satisfied with the decision, the provider may request a contested case hearing pursuant to ORS 183.413-183.470 by notifying the Department in writing of the request for the hearing within 10 working days of the date of the decision letter from the informal conference. If a provider is not satisfied with the results from the contested case hearing, the provider may petition for judicial review pursuant to ORS 183.480-183.497.

(3) As an alternative to section (2) of this rule, the provider may request a contested case hearing pursuant to ORS 183.413-183.470 by notifying the Department in writing that a contested case hearing is requested within 30 days of receipt of the letter from the Department that informs the provider of the change(s). The request for the contested case hearing must be postmarked within the 30-day limit and must state, specifically, the reason(s) for requesting the hearing. If a provider is not satisfied with the results from the contested case hearing, the provider may petition for judicial review pursuant to ORS 183.480 - 183.497.

(4) If no request for an informal conference or contested case hearing is made within the specified time period, the most recent decision from the Department will automatically become a final order.

(5) A provider may request documentation supporting the change(s) from the Department; however, a request for documentation does not toll the time period within which an informal conference or contested case must be requested. The Department will produce these work papers within 30 days of receipt for a written request.

Stat. Auth.: ORS 414.070
Stats. Implemented: ORS 410.070
Hist.: PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; AFS 29-1978, f. 7-28-78, ef. 8-1-78; Renumbered from 461-017-0430 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SS 2-1981, f. 12-31-81, ef. 1-1-82; SSD 10-1986, f. & ef. 7-1-86; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0442

Per Diem Rate Setting For the Rate Period Beginning July 1, 2003 Calculation of the Basic Rate and Complex Medical Add-on Rate
(1) The rates are determined for the first year of each biennium, the rebasing year, and the second year of each biennium, the non-rebasing year.

(a) The Rebasing Year.

(A) The basic rate is based on the statements received by SPD by September (or postmarked by October 31, if an extension of filing has been approved by SPD) for the fiscal reporting period ending on June 30 of the previous even-numbered year. For example, for the biennium beginning July 1, 2003, statements for the period ending June 30, 2002 are used. SPD desk reviews or field audits these statements and determines the allowable costs for each nursing facility. The costs include both direct and indirect costs. The costs and days relating to pediatric beds are excluded from this calculation. SPD shall only use financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30 of even numbered years for biennial rebasing.

(B) For the 2009 rebasing period only, SPD shall limit the administrative and property cost components as follows:

(i) Administrative and general costs per facility, less provider tax and employee benefits, equals the lesser of the facility’s allowable cost or the 50th percentile over all facilities; and

(ii) Allowable property expenses shall be limited by the Medicaid occupancy percentage when the facility has an occupancy rate of less than 60 percent.

(C) For each facility, its allowable costs after any limitations as set forth in section (1)(a)(B) of this rule are applied, less the costs of its self-contained pediatric unit (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the first year of the biennium, hereafter referred to as the base year (e.g., for the biennium beginning July 1, 2003, the base year is the fiscal period ending June 30, 2004) by the annual change in the DRI Index, or its successor index, as measured in the previous 4th quarter.

(D) For each facility, its allowable costs after any limitations as set forth in section (1)(a)(B) of this rule are applied, per Medicaid day is determined using the allowable costs as inflated and resident days, excluding pediatric days as reported in the statement.

(E) The facilities are ranked from highest to lowest by the facility's allowable costs after any limitations as set forth in section (1)(a)(B) of this rule are applied, per Medicaid day.

(F) The basic rate will be determined by ranking the allowable costs as set forth in section (1)(a)(B) of this rule are applied, per Medicaid day by facility and identifying the allowable cost per day at the applicable percentage. If there is no allowable cost per day at the applicable percentage, the basic rate is determined by interpolating the difference between the allowable costs per day that are just above and just below the applicable percentage to arrive at a basic rate at the applicable percentage.

(i) The applicable percentage for the period beginning July 1, 2003 through June 30, 2005 is at the 63rd percentile.

(ii) The applicable percentage for the period beginning July 1, 2005 through June 30, 2007 is at the 70th percentile.

(iii) The applicable percentage for the period beginning July 1, 2007 is at the 63rd percentile.

(b) The Non-Rebasing Year. On July 1 of each non-rebasing year, the basic flat rate shall be inflated by the annual change in the DRI Index, or its successor index, as measured in the previous 4th quarter.

(2) The complex medical add-on rate is 40 percent of the basic rate for the rebasing year and the non-rebasing year.

(3) SPD shall add a standard payment to fund implementation of certified nursing assistant staffing requirements contained in OAR 411-086-0100 in accordance with the Legislatively Adopted Budget.

Stat. Auth.: ORS 410.070 & 414.065
Hist.: SPD 36-2004, f. 12-23-04, cert. ef. 12-28-04; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

Pediatric Nursing Facilities

(1) PEDIATRIC NURSING FACILITY.
(a) A pediatric nursing facility is a licensed nursing facility at least 50 percent of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

(b) A nursing facility that meets the criteria of section (1)(a) of this rule shall be reimbursed as follows:

(A) The pediatric rate is a prospective rate and is not subject to settlement. SPD shall only use financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30 of even numbered years for biennial rebasing.

(B) The facility specific pediatric cost per resident day shall be inflated by the annual change in the DRI Index as measured in the previous 4th quarter. The Oregon Medicaid pediatric days are multiplied by the inflated facility specific cost per resident day for each pediatric facility. The totals are summed and divided by total Oregon Medicaid days to establish the weighted average cost per pediatric resident day. The rebase relationship percentage (90.18%), determined in the implementation of the flat rate system in 1997, is applied to the weighted average cost to determine the pediatric rate.

(C) On July 1 of each non-rebasing year after 1999, the pediatric rate shall be increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate rebasing shall occur in alternate years. Rebasing of pediatric nursing facility rates shall be calculated using the method described in section (1)(b)(B) of this rule.

(c) Even though pediatric facilities shall be reimbursed in accordance with section (1)(b) of this rule, pediatric facilities must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements.

(2) LICENSED NURSING FACILITY WITH A SELF-CONTAINED PEDIATRIC UNIT.

(a) A nursing facility with a self-contained pediatric unit is a licensed nursing facility that provides services for pediatric residents (individuals under the age of 21) in a separate and distinct unit within or attached to the facility with staffing costs separate and distinct from the rest of the nursing facility. All space within the pediatric unit must be used primarily for purposes related to the services of pediatric residents and alternate uses must not interfere with the primary use.

(b) A nursing facility that meets the criteria of section (2)(a) of this rule shall be reimbursed for its pediatric residents served in the pediatric unit at the per diem rate described in section (1)(b) of this rule commencing on July 1, 1999.

(c) Licensed nursing facilities with a self-contained pediatric unit must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by SPD, related to the costs of the self-contained pediatric unit.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 4-1988, f. & cert. ef. 6-1-88; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 6-1995, f. 6-30-95, cert. ef. 7-1-95; SSD 6-1996, f. & cert. ef. 7-1-96; SDSD 10-1999, f.11-30-99, cert.ef. 12-1-99; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09

411-070-0464

Final Report

(1) FINAL REPORTS. When a provider agreement is terminated for any reason, the provider must submit final reports in accordance with OAR 411-070-0300. Full payment for the month during which the provider agreement is terminated will not be made by the Department until final reports are received and desk reviewed. The Department will initially pay the provider the excess by which the payment for the month in which the provider agreement is terminated exceeds the maximum amount the Department can penalize a provider under OAR 411-070-0300(2)(c). The remainder of the payment must be made by the Department after receipt and desk review of final reports.

(2) Settlement rates based on Nursing Facility Financial Statements submitted for the period that ends June 30, 1997 must be calculated as defined by these rules as they existed on June 30, 1997.

Stat. Auth.: ORS 410.070
Uniform Chart of Accounts

The following account definitions will be used to classify the dollar amounts on the Nursing Facility Financial Statement (NFFS). The account balance is to be reported in whole dollars under the facility gross column on the NFFS and referenced by the providers' chart of accounts number. It is the provider's responsibility to ensure that the balances reported reconcile to their fiscal year statements and general ledger balances with any differences explained on Schedule A to Form SPD 35 or SPD 35A. The provider is responsible for making adjustments to these accounts for non-allowable items and amounts using the adjustment column to arrive at the net allowable balance. Each adjustment is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(1) CURRENT ASSETS -- The following accounts include cash and other assets reasonably expected to be realized in cash or sold, or consumed during the normal nursing facility operating cycle, or within one year when the operating cycle is less than one year.

(a) 101 -- Cash on Hand -- This account balance represents the amount of cash on hand for petty cash funds.
(b) 102 -- Cash in Bank -- This account balance represents the amount in a bank checking account.
(c) 103 -- Cash in Savings -- This account balance represents the amount accumulated in a savings account.
(d) 104 -- Resident Trust Account -- This account balance represents the amount of resident funds entrusted to the provider and held as cash on hand in the bank.
(e) 109 -- Accounts Receivable -- This account balance represents the amounts due from or due on behalf of all residents at the end of the fiscal period being reported.
(f) 110 -- Notes Receivable -- This account balance represents the current balance of amounts owed to the facility (payee) that are covered by a written promise to pay at a specified time, and is signed and dated by the maker.
(g) 111 -- Allowance for Doubtful Accounts -- This account balance represents amounts owed to the facility and estimated to be uncollectible.
(h) 115 -- Employee Advances -- This account balance represents amounts paid in advance to employees for salaries or wages that will be liquidated in the next payroll cycle following the closing date of the financial statement.
(i) 120 -- Inventory -- This account balance represents the cost value of inventory on hand at the end of the reporting period.
(j) 125 -- Prepaid Expenses -- This account balance represents the cost value of paid expenses not yet incurred covering regularly recurring costs of operation like rent, interest, and insurance.
(k) 149 -- Other Current Assets -- This account balance comprises all current assets not identified above. Each item in this account, including short-term savings certificates, must be explained on Schedule A to Form SPD 35 or SPD 35A.

(2) NON-CURRENT ASSETS -- The balances of the following accounts represent assets not recognized as current.

(a) 151 -- Land -- This account balance represents the acquisition cost and other costs, like legal fees and excavation costs that are incurred to put the land in condition for its intended use.
(b) 153 -- Building(s) -- This account balance represents the acquisition cost of permanent structures and property owned by the provider used to house residents. It includes the purchase or contract price of all permanent buildings and fixed equipment attached to and forming a permanent part of the building(s).
(c) 154 -- Accumulated Depreciation -- This account balance represents the accumulation of provisions made to record the expiration in the building(s) life attributable to wear and tear through use, lapse of time, obsolescence, inadequacy or other physical or functional cause. The straight line method is the only recognized depreciation method for cost reimbursement.
1/20/2011

(d) 155 -- Land Improvements -- This account balance represents the acquisition cost of permanent improvements, other than buildings that add value to the land. It includes the purchase or contract price.

(e) 156 -- Accumulated Depreciation -- This account is of the same nature and is used in the same manner as Account 154.

(f) 157 -- Building Improvements -- This account balance represents the acquisition cost of additions or improvements that either add value to or increase the usefulness of the building(s). It includes the purchase or contract price.

(g) 158 -- Accumulated Depreciation -- This account is of the same nature and is used in the same manner as Account 154.

(h) 161 -- Equipment -- This account balance represents the acquisition cost of tangible property of a permanent nature, other than land, building(s) or improvements, used to carry on the nursing facility operations. It includes the purchase or contract price.

(i) 162 -- Accumulated Depreciation -- This account is of the same nature and is used in the same manner as Account 154.

(j) 165 -- Leasehold Improvements -- This account balance represents the acquisition cost of any long-lived improvements or additions to the property being leased that will belong to the owner (lessor) at the expiration of the lease.

(k) 166 -- Accumulated Amortization -- This account is of the same nature and is used in the same manner as Account 154 except the cost of improvements or additions will be amortized over the lesser of the expected benefit life or the remaining life of the lease.

(l) 181 -- Investments -- This account balance represents the value of assets unrelated to the nursing facility operation. The detail of this account must be explained on Schedule A to Form SPD 35 or SPD 35A.

(m) 187 -- Goodwill -- This account balance represents the value of goodwill identified with the purchase of assets.

(n) 199 -- Other -- Non-Current Assets -- This account balance comprises all non-current assets not identified above. Each item in this account, including long-term savings certificates, must be explained on Schedule A to Form SPD 35 or SPD 35A.

3) CURRENT LIABILITIES -- The balances of the following accounts are considered current liabilities.

(a) 201 -- Accounts Payable -- This account balance represents the liabilities for goods and services received but unpaid at the end of the reporting period.

(b) 202 -- Accounts Payable -- Resident Trust Account -- This account balance represents the amount owed to residents for the cash entrusted to the facility in Account 104.

(c) 203 -- Notes Payable -- Other -- This account balance represents the current portion of the amount owed by the facility that is covered by a written promise to pay at a specified time and is signed and dated by the facility (maker).

(d) 204 -- Notes Payable to Owner -- This account balance represents notes payable to the owner(s) and is of the same nature and is used in the same manner as Account 203.

(e) 205 -- Accrued Interest Payable -- This account balance represents the liabilities for interest accrued at the end of the reporting period but not payable until a later date.

(f) 207 -- Other Accrued Payable -- This account is of the same accrual nature and is used in the same manner as Account 205 and is to be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(g) 208 -- Payroll Payable -- This account balance is the accrued payroll, less withheld payroll taxes and other deductions, payable to employees at the end of the reporting period.

(h) 217 -- Payroll Tax Payable -- This account balance is the employer's share of accrued payroll taxes payable at the end of the reporting period.

(i) 218 -- Payroll Deductions Payable -- This account balance is the employee's share of accrued payroll taxes withheld from the employer's gross pay payable at the end of the reporting period.

(j) 219 -- Deferred Income -- This account balance represents the liability for revenue collected in advance.
(k) 229 -- Other Current Liabilities -- This account balance comprises all current liabilities not identified above. The nature and purpose of amounts included in this account must be explained on Schedule A to Form SPD 35 or SPD 35A.

(4) LONG-TERM LIABILITIES -- The balances of the following accounts are considered long-term liabilities.

(a) 231 -- Long-Term Mortgage Payable -- This account balance represents the amount owed by the facility that is secured by a mortgage or other contractual agreement providing for conveyance of property at a future date.

(b) 233 -- Long-Term Notes Payable -- This account is of the same nature and is used in the same manner as Account 203 except the liability extends beyond one year.

(c) 234 -- Long-Term Notes Payable Owner -- This account is of the same nature and is used in the same manner as Account 204 except the liability extends beyond one year.

(d) 249 -- Other Long-Term Liabilities -- This account comprises all long-term liabilities not identified above. The amount and nature of items in this account must be explained on Schedule A to Form SPD 35 or SPD 35A.

(5) NET WORTH -- The balances of the following accounts represent the amount by which the facility's assets exceed its liabilities.

(a) 251 -- Capital Stock -- This account balance represents the amount of cash or property received in exchange for the corporation's capital stock.

(b) 255 -- Retained Earnings -- This account balance represents the amount of capital resulting from retention of corporate earnings.

(c) 261 -- Capital Account -- This account balance represents the book value of the proprietor or partner(s) equity in the facility.

(d) 265 -- Drawing Account -- This account balance represents the owners withdrawals of funds during the reporting period that were not paid as part of the payroll.

(e) 290 -- Net Profit (Loss) -- This account balance is the facility's revenue minus expenses for the reporting period.

(6) RESIDENT REVENUE -- These accounts include room and board revenue and related room and board contractual adjustments including revenue from bed hold days for routine service charges exclusive of ancillary charges. Routine service charges are to be reported in the following accounts:

(a) 301 -- Private Resident -- Complex Medical Needs -- This account includes room and board revenue for complex medical needs routine private resident services including health maintenance organization (HMO) payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid complex medical needs criteria.

(b) 303 -- Private Resident -- Basic Rate -- This account includes room and board revenue for basic rate routine private resident services including HMO payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid basic rate needs criteria.

(c) 304 -- Private Resident -- Assisted Living Facilities/Residential Care Facilities — This account includes room and board revenue for other than private complex medical needs and basic rate, non long-term residents and is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(d) 311 -- Medicaid Resident -- Complex Medical Needs -- This account includes room and board revenue from all sources for complex medical needs Medicaid residents.

(e) 312 -- Medicaid Resident -- Pediatric -- This account includes room and board revenue from all sources for pediatric Medicaid residents.

(f) 313 -- Medicaid Resident -- Basic Rate -- This account includes room and board revenue from all sources for basic rate Medicaid residents.

(g) 314 -- Medicaid -- Assisted Living Facilities/Residential Care Facilities -- This account includes room and board revenue for Medicaid, non long-term resident services from all sources other than NF Payment Categories 1, basic rate, complex medical needs and pediatric and is to be explained on Schedule A to Form SPD 35 or SPD 35A.
(h) 315 -- Medicaid -- HMO -- This account includes room and board revenue from all sources for Medicaid-HMO resident services.

(i) 316 -- Medicaid -- Out of State -- This account includes room and board revenue from all sources for non-Oregon Medicaid resident services.

(j) 318 -- Medicare Resident -- This account includes room and board revenue from all sources for Medicare resident services.

(k) 319 -- Other Governmental Resident -- This account includes room and board revenue from all sources for Veteran Affairs and other governmental program resident services other than Medicaid or Medicare and is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(7) ANCILLARY REVENUE -- These accounts include revenue for professional and non-professional services and supplies not included in section (6) of this rule. Revenue other than that described above must be reported as gross revenue and related expenses to be reported in the appropriate expense accounts. Ancillary service charges and ancillary contractual adjustments are to be reported in the following accounts:

(a) 321 -- Nursing Supplies -- This account includes revenue from the sale of nursing supplies or services.

(b) 322 -- Oxygen -- This account includes revenue from the sale of oxygen (gas) and concentrator supplies.

(c) 323 -- Prescription Drugs -- This account includes revenue from the sale of prescription drugs.

(d) 324 -- Laboratory -- This account includes revenue from laboratory services provided.

(e) 345 -- X-Ray -- This account includes revenue from X-Ray services.

(f) 326 -- Equipment Rental -- This account includes revenue from equipment rental.

(g) 330 -- Physical Therapy -- This account includes revenue from physical therapy services provided.

(h) 331 -- Speech Therapy -- This account includes revenue from speech therapy services.

(i) 332 -- Occupational Therapy -- This account includes revenue from occupational therapy services.

(j) 341 -- Personal Purchases -- This account includes revenue from residents for personal purchases.

(k) 342 -- Barber and Beauty -- This account includes revenue from residents for barber and beautician services.

(l) 349 -- Other Ancillary -- Items and amounts included in this account must be described on Schedule A to Form SPD 35 or SPD 35A.

(m) 398 -- Contractual Adjustments -- This is a revenue offset account and includes all contractual adjustments to resident revenue and ancillary revenue.

(8) OTHER REVENUE -- These accounts include other revenue, exclusive of resident and ancillary revenue. The intent is for revenue to be reported in gross and the related expenses reported in the appropriate expense accounts. Other revenues are classified as follows:

(a) 901 -- Grants -- This account includes revenue amounts received in the reporting period from public and privately funded grants and awards.

(b) 902 -- Donations -- This account includes donations in the form of cash or goods and services received during the reporting period.

(c) 911 -- Interest -- This account includes revenue from any interest bearing note, bank account, or certificate.

(d) 912 -- Staff & Guest Food Sales -- This account includes revenue from facility food sales to individuals other than residents of the facility.

(e) 913 -- Vending Sales -- This account includes revenue from vending machines or for resale items not reported in Accounts 813 and 351.

(f) 914 -- Television and Telephone Revenue -- This account includes revenue from television and telephone sales to residents of the facility.
(g) 915 -- Independent Senior Housing -- This account includes revenue from any other apartment and continuing care retirement community housing.

(h) 916 -- Hospital Revenue -- This account includes revenue from hospital operations not related to the nursing facility.

(i) 918 -- Nursing Aide Training -- This account is for reporting all revenue associated with OAR 411-070-0470, Nursing Assistant Training and Competency.

(j) 919 -- Miscellaneous Other Revenue -- Items and amounts, including revenues for Mental Health revenues received from local governments, and Workers Compensation refunds, included in this account are to be described on Schedule A to Form SPD 35 or SPD 35A.

(9) PROPERTY EXPENSES -- These accounts are for reporting property expenses.

(a) 452 -- Interest -- This account is for reporting all interest expense related to the acquisition of fixed assets, adjusted for historical cost limitations.

(b) 453 -- Rent Building -- This account is for reporting all building rent or lease expenses.

(c) 454 -- Leased Equipment -- This account is for reporting equipment rental and lease expense for all equipment used in the administrative and general and other operating expense categories.

(d) 455 -- Depreciation -- Building -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 153.

(e) 456 -- Depreciation -- Land Improvement -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 155.

(f) 457 -- Depreciation -- Building Improvement -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 157.

(g) 458 -- Depreciation -- Equipment -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 161.

(h) 459 -- Amortization -- Leasehold Improvement -- This account is for reporting amortization, for the reporting period, associated with assets capitalized in Account 165 and Account 166.

(i) 461 -- Miscellaneous -- Property -- This account is for reporting other property costs, such as amortization of organizational costs, and items of equipment less than $1,000 that are for general use, such as privacy curtains and blinds.

(10) ADMINISTRATIVE AND GENERAL EXPENSES -- These accounts report expenses for administration of the facility and the business office, and items not readily associated with other departments.

(a) 411 -- Compensation -- Administrator -- This account is for reporting all the compensation received by the licensed administrator of the facility. Compensation includes salary, bonuses, auto, moving, travel and all other allowances paid directly or indirectly by the facility.

(b) 412 -- Compensation -- Assistant Administrator -- This account is to be used for reporting all compensation of the individual who is identified as, and has the specific duties of, Assistant Administrator.

(c) 413 -- Compensation -- Bookkeeper -- This account is for reporting all the compensation received by the facility bookkeeper, controller and chief financial officer.

(d) 415 -- Compensation -- Other Administrative -- This account is for reporting all of the compensation received by administrative, clerical, secretarial, accounting, central supply, in-service director and personnel.

(e) 418 -- Purchased Services -- Administrative -- This account is for reporting all non-employee services required in the administrative operations of the facility.

(f) 440 -- Payroll Taxes -- Administrative -- This account is for reporting all of the employer’s portion of payroll taxes, including Federal
Insurance Contributions Act (FICA) tax, unemployment and other payroll taxes not withheld from the employee’s pay for administrative employees.

(g) 441 -- Worker’s Compensation -- Administrative -- This account is for reporting the employer’s portion of worker’s compensation insurance not withheld from the employee’s pay for administrative employees.

(h) 442 -- Employee Benefits -- Administrative -- This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners. Established child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account for administrative employees.

(i) 443 -- Employee Paid Time Off -- Administrative -- This account is for reporting established vacation, holiday and sick pay programs for administrative employees.

(j) 420 -- Vending Expense -- This account is for reporting expenses of non-medical, non-resident service items sold to the residents and non-residents including items sold through vending machines.

(k) 423 -- Personal Purchase -- This account is for reporting all expenditures for personal items purchased for individual residents.

(l) 425 -- Office Supplies -- This account is for reporting expenses of all office supplies except those chargeable to Account 863. Materials include stationery, postage, printing, bookkeeping supplies, and office supplies.

(m) 426 -- Communications -- This account is for reporting all telephone, internet access, communication, and paging system charges.

(n) 427 -- Travel -- This account is for reporting all transportation costs and mileage reimbursement associated with vehicles used for resident services or resident recreation, exclusive of insurance and depreciation and for reporting all other travel expenses such as lodging and meals for conferences, conventions, workshops, or training sessions.

(o) 429 -- Advertising -- Help Wanted -- This account is for reporting all help wanted advertising expense.

(p) 430 -- Advertising -- Promotional -- This account is for reporting all expenditures of the facility related to promotional advertising including yellow page advertising.

(q) 431 -- Public Relations -- This account is for reporting all expenditures related to public relations.

(r) 432 -- Licenses, Dues & Subscriptions -- This account is for reporting all fees for facility licenses; dues in professional associations; and costs of subscriptions for newspapers, magazines, and periodicals provided for resident and staff use.

(s) 433 -- Accounting & Related Data Processing -- This account is for reporting all accounting, payroll, and other data and report processing expenses.

(t) 435 -- Legal Fees -- This account is for reporting all legal fees and expenses. Legal fees must be reported in conformance with OAR 411-070-0359(1)(t).

(u) 436 -- Management Fees -- This account is for reporting all management fees charged to the facility, including management salaries and benefits at the home office.

(v) 437 -- Insurance -- Liability -- This account is for reporting all liability insurance expenses, including employee dishonesty, Board of Director, and umbrella coverage.

(w) 439 -- Other Interest Expense -- This account is for reporting interest expense not attributable to the purchase of the facility and equipment.

(x) 444 -- Bad Debts -- This account is for reporting the expense recorded from recognizing a certain portion of accounts receivable as uncollectible.

(y) 445 -- Education & Training -- This account is for reporting registration, tuition, materials, and manual costs for training the staff included in the administrative and general expense category.

(z) 446 -- Contributions -- This account is for reporting the expense of any gift or donation.
(aa) 449 -- Miscellaneous -- This account is for reporting general administrative operating expenses not specifically included in other general administrative operating expense accounts. Entries must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(bb) 450 -- Long Term Care Facility Tax, effective 07/01/2003.

(11) OTHER OPERATING SUPPORT EXPENSES -- The following accounts are included in this category.

(a) 511 -- Compensation -- Other Operating Employees -- This account is for reporting all compensation received by employee(s) responsible for providing facility repair and maintenance, dietary, laundry and housekeeping services.

(b) 540 -- Payroll Taxes -- Other Operating -- This account is for reporting all of the employer’s portion of payroll taxes, including FICA, unemployment and other payroll taxes not withheld from the employee’s pay for other operating employees.

(c) 541 -- Worker’s Compensation -- Other Operating -- This account is for reporting the employer’s portion of worker’s compensation insurance not withheld from the employee’s pay for other operating employees.

(d) 542 -- Employee Benefits -- Other Operating -- This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners. Established child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account for other operating employees.

(e) 543 -- Employee Paid Time Off -- Other Operating -- This account is for reporting established vacation, holiday and sick pay programs for other operating employees.

(f) 551 -- Purchased Services -- Maintenance -- This account is for reporting all non-employee services required in maintenance operations.

(g) 552 -- Purchased Services -- Dietary -- This account is for reporting all non-employee services required in dietary operations including dietary consulting expenses.

(h) 553 -- Purchased Services -- Laundry -- This account is for reporting all non-employee services in laundry operations.

(i) 554 -- Purchased Services -- Housekeeping -- This account is for reporting all non-employee services required in housekeeping operations.

(j) 510 -- Real Estate & Personal Property Taxes -- This account is for reporting real estate and personal property tax expenses for the facility.

(k) 512 -- Insurance -- Property & Auto -- This account is for reporting all insurance expenses other than liability insurance reportable in Account 437, and employee insurance expenses.

(l) 513 -- Cable Television -- This account is for reporting all cable and satellite television expenses.

(m) 514 -- Heat & Electricity -- This account is for reporting all facility heating and lighting expenses.

(n) 515 -- Water, Sewer & Garbage -- This account is for reporting all water, sewer and garbage expenses.

(o) 516 -- Maintenance Supplies & Services -- This account is for reporting all expenses required for building and equipment maintenance and repairs including preventative maintenance and not capitalized.

(p) 526 -- Dietary Supplies -- This account is for reporting the expense of all supplies, dishes and utensils, and non-capitalized equipment utilized within this department, exclusive of food.

(q) 532 -- Linen and Bedding -- This account is for reporting the expense of all linen and bedding utilized within the facility.

(r) 536 -- Laundry Supplies -- This account is for reporting the expense of all supplies utilized by the laundry.

(s) 546 -- Housekeeping Supplies -- This account is for reporting the expense of all supplies utilized to provide housekeeping services.

(t) 549 -- Miscellaneous -- Other Operating -- This account is for reporting other operating support expenses not specifically included in an identified account. Entries must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.
FOOD -- 522 Food -- This account is for reporting all food products and supplements used in food preparations including dietary supplements.

DIRECT CARE COMPENSATION -- These accounts include compensation used in providing direct resident services.

(a) 640 -- Payroll Taxes -- Direct Care -- This account is for reporting the employer’s entire portion of payroll taxes, including FICA, unemployment and other payroll taxes not withheld from the employee’s pay for direct care employees.

(b) 641 -- Worker’s Compensation -- Direct Care -- This account is for reporting the employer’s portion of worker’s compensation insurance not withheld from the employee’s pay for direct care employees.

(c) 642 -- Employee Benefits -- Direct Care -- This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners. Established child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account for direct care employees.

(d) 643 -- Employee Paid Time Off -- Direct Care -- This account is for reporting established vacation, holiday and sick pay programs for direct care employees.

(e) 651 Compensation -- Director of Nursing Services -- This account is for reporting all compensation received by employee(s) responsible for directing the nursing services of the facility.

(f) 652 Compensation -- Registered Nurses -- This account is for reporting all compensation received by Registered Nurse employees of the facility who provide nursing services, other than the Director of Nursing Services, but including Resident Care Managers. If a Registered Nurse provides nursing services part of the time and carries out other duties the rest of the time, this employee's compensation will be allocated to the appropriate account based on time spent on each activity.

(g) 653 Compensation -- Licensed Practical Nurses -- This account is for reporting all compensation received by Licensed Practical or Licensed Vocational Nurse employees of the facility who provide nursing services. If a Licensed Practical Nurse provides nursing services part of the time and carries out other duties the rest of the time, this employee's compensation will be allocated to the appropriate account based on time spent on each activity.

(h) 654 -- Compensation -- Certified Medical Aides -- This account is for reporting all compensation received by certified medical aides.

(i) 655 -- Compensation -- Certified Nursing Aides and Restorative Aides -- This account is for reporting all compensation received by certified nursing aides and restorative aides not part of the physical therapy department.

(j) 656 Compensation -- Other Nursing Employees -- This account is for reporting all compensation received by non-licensed, non-professional employees who provide nursing services. If such employees provide nursing services part of the time and carry out other duties the rest of the time, these employees' compensation will be allocated to the appropriate account based on time spent on each activity.

(k) 661 -- Compensation -- Activities Employees -- This account is for reporting all compensation of employees engaged in the planning and carrying out of resident recreational activities.

(l) 662 -- Compensation -- Social Workers -- This account is for reporting all compensation of social workers and assistants employed to provide social service activities.

(m) 663 -- Compensation -- Medical Records -- This account is for reporting all compensation of medical records employees.

(n) 664 -- Compensation -- Rehabilitation Employees -- This account is for reporting all compensation of occupational and physical therapists, and technicians, and therapy aides employed to provide resident rehabilitation activities or services. This account will be subdivided in accordance with OAR 411-070-0359(3)(g) on Schedule A to Form SPD 35 or SPD 35A.

(o) 671 -- Compensation -- Religious Employees -- This account is for reporting all compensation for individuals employed who provide religious services.

(p) 672 -- Compensation -- Hospital Employees -- This account is for reporting the expense attributable to hospital employees not related to nursing facility long-term care.
(q) 681 -- Compensation -- Other Employees -- This account is for reporting all compensation for dentists, barbers, beauticians, research, and other non-identified personnel employed by the facility and must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(r) 752 -- Purchased Services -- Registered Nurses -- This account is for reporting the expense attributable to employment agencies that provide part-time registered nurse employees on a fee and salary basis.

(s) 753 -- Purchased Services -- Licensed Practical Nurses -- This account is for reporting the expense attributable to employment agencies that provide part-time licensed practical nurse employees on a fee and salary basis.

(t) 754 -- Purchased Services -- Certified Medical Assistants -- This account is for reporting the expense attributable to employment agencies that provide part-time certified medical assistant employees on a fee and salary basis.

(u) 755 -- Purchased Services -- Certified Nursing Assistants & Restorative Aides -- This account is for reporting the expense attributable to employment agencies that provide part-time certified nursing assistant and restorative aide employees on a fee and salary basis.

(v) 756 -- Purchased Services -- Other Nursing -- This account is for reporting the expense attributable to employment agencies that provide part-time other nursing employees on a fee and salary basis, and must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(14) DIRECT CARE SUPPLIES -- These accounts include supplies and services used in providing direct resident services.

(a) 811 -- Education & Training -- This account is for reporting registration, tuition, and book expense associated with education and training of direct care personnel.

(b) 812 -- Nursing Assistant (Aide) Training and Competency Evaluation -- This account is for reporting all expenses associated with OAR 411-070-0470 (which excludes salaries of nurse aide trainees).

(c) 816 -- Nursing Supplies -- This account is for reporting all medical supplies consumed by this department, exclusive of oxygen, used in providing direct care services.

(d) 819 -- Physician Fees -- This account is for reporting all expenditures for physician treatment, services and evaluation of the resident.

(e) 826 -- Oxygen Supplies -- This account is for reporting the expense of all oxygen (gas) and concentrator rentals.

(f) 836 -- Pharmacy Supplies -- This account is for reporting the expense of all materials utilized in the facility pharmacy operation.

(g) 837 -- Drugs and Pharmaceuticals -- Nursing Home -- This account is for reporting all expenditures meeting the criteria of 411-070-0085(2)(j).

(h) 838 -- Drugs & Pharmaceuticals -- Prescriptions -- This account is for reporting all expenditures for legend drugs and biologicals prescribed by a licensed physician and not meeting the criteria of 411-070-0090.

(i) 846 -- Laboratory Supplies & Fees -- This account is for reporting the expense of all materials utilized in the facility laboratory operation and fees paid for non-employee pathologist and laboratory technician services.

(j) 856 -- X-Ray Supplies & Fees -- This account is for reporting the expense of all materials utilized in the facility X-Ray department and fees for non-employee radiologists and X-Ray technician services.

(k) 859 -- Equipment Rental -- Chargeable -- This account is for reporting chargeable equipment rental costs for equipment used in direct care services cost categories.

(l) 861 -- Barber & Beauty -- The cost of non-employee barber and beautician services will be reported in this account.

(m) 863 -- Medical Records Supplies -- This account is restricted to materials and software used in resident charting, including data processing for medical records.

(n) 866 -- Activities & Recreational Supplies -- This account is for reporting the expense of entertainers, and all materials used in providing resident recreational activities. Related transportation is to be reported in Account 427.

(o) 876 -- Rehabilitation Supplies & Fees -- This account is for reporting the expense of all materials used in providing occupational and...
physical therapy including fees for non-employee related services. This account must be subdivided in accordance with OAR 411-070-0359(3)(l) on Schedule A to Form SPD 35 or SPD 35A.

(p) 882 -- Utilization Review -- This account is for reporting the expenses of all non-employee fees associated with utilization review.

(q) 889 -- Consultant Fees -- This account is for reporting all expenditures for consultant fees, including travel and lodging, exclusive of dietary and management consultants and must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(r) 899 -- Miscellaneous -- Expenses reported in this account must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: AFS 19-1978, f. & ef. 5-1-78; AFS 29-1978, f. 7-28-78, ef. 8-1-78; Renumbered from 461-017-0460, AFS 69-1981, f. 9-30-81, ef. 10-1-81; SS 2-1981, f. 12-31-81, ef. 1-1-82; SSD 10-1986, f. & ef. 7-1-86; SSD 10-1989, f. 6-20-89, cert. ef. 7-1-89; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 6-1995, f. 6-30-95, cert. ef. 7-1-95; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 11-2004(Temp), f. & cert. ef. 5-28-04 thru 11-24-04; SPD 36-2004, f. 12-23-04, cert. ef. 12-28-04; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08

411-070-0470

Nursing Assistant Training and Competency Evaluation Programs Cost Reports

(1) COST REPORT REQUIRED. Medicaid certified nursing facilities must file a Nursing Assistant Training and Competency Evaluation Program (NATCEP) cost report (Form SDS 451) quarterly with SPD's Financial Audit Unit that meets the following standards:

(a) A NATCEP cost report is due and must be postmarked by the last day of the calendar quarter subsequent to the quarter that it covers (or postmarked the first business day after the quarter if the last day of the quarter is a Sunday or holiday). The cost report must identify all costs incurred and related revenues (not including NATCEP payments from SPD) received during the reporting period. If a facility fails to file a report postmarked as described, NATCEP reimbursement must be reduced by 3 percent for each business day the report is past due until received.

(b) A cost report must:

(A) Be submitted on a form provided by SPD.

(B) Include actual costs incurred and paid by the facility. SPD may not reimburse a facility prospectively.

(C) Include all revenue (not including NATCEP payments from SPD) received by the facility for conducting nurse aide training. All revenue must be used to offset the costs incurred and paid in the period.

(D) Include appropriate documentation to support each specific area identified for payment by the state. For example, invoices for equipment purchases or to reimburse contract trainers, time sheets for qualified facility training staff, evidence an aide paid for NATCEP and was reimbursed by the facility as specified in section (2) of this rule. Failure to provide required documentation shall result in the form being rejected and returned to the facility.

(E) Include all appropriate NATCEP costs and revenues only. NATCEP costs, including costs disallowed, must not be reimbursed as part of the facility's bundled rate. However, NATCEP costs, revenues, and reimbursement must be included on the facility's annual NFFS.

(F) Include only true and accurate information. If a facility knowingly or with reason to know files a report containing false information, such action must constitute cause for termination of the facility's provider agreement with SPD. Providers filing false reports may be referred for prosecution under applicable statutes.

(2) CHARGING OF FEES PROHIBITED. The nursing facility must not charge a trainee any fee for participation in NATCEP or for any textbooks or other materials required for NATCEP if the trainee is employed by or has an offer of employment from a nursing facility on the date on which the NATCEP begins.

(3) FEES PAID BY EMPLOYER.
(a) All charges and materials required for NATCEP and fees for nursing assistant certification must be paid by the nursing facility if it
offered employment at the facility on the date training began.

(b) If a nursing assistant who is not employed by a Medicaid certified facility and does not have an offer of employment by a Medicaid
nursing facility on the date on which the NATCEP began becomes employed by, or receives an offer for employment from, a nursing
facility within twelve months after completing a NATCEP, the employing facility must reimburse the nursing assistant on a monthly basis for
any NATCEP fees paid (including any fees for textbooks or other required course materials) by the nursing assistant. Evidence the nursing
assistant paid for training must include the graduation certificate from the school and receipt of payment.

(c) Such reimbursement must be calculated on a pro rata basis. The reimbursement must be determined by dividing the cost paid by the
nursing assistant by 12 and multiplying by the number of months during this 12-month period in which the aide worked for the facility. The
facility must claim the appropriate pro rata amount on each report it submits not to exceed the lesser of 12 months or the total number of
months the nursing assistant was employed at that facility. The facility must submit evidence provided by the nursing assistant of the training
costs incurred at an approved training facility.

(4) REIMBURSEMENT BY SPD. SPD shall reimburse the facility for the Medicaid portion of the costs described in this section unless
limited by the application of section (5). This portion is calculated by multiplying the eligible costs paid by the facility by the percentage of
resident days that are attributable to Medicaid residents during the reporting period. SPD's payment to the facility for the NATCEP cost is
in addition to payments based upon the facility's bundled rate.

(a) Employee Compensation. Reimbursement for trainer hours must not exceed 1 1/3 times the number of hours required for certification.
A facility may claim reimbursement for the portion of an employee's compensation attributable to nurse aide training if:

(A) The employee meets the qualifications of 42 CFR 483.152 and OAR chapter 851, division 061;

(B) The employee directly conducts training or testing in a certified program;

(C) The employee's compensation, including benefits, is commensurate with other RN compensation paid by the facility;

(D) The employee's total compensated hours do not exceed 40 in any week during which NATCEP reimbursement is claimed;

(E) No portion of the claimed reimbursement is for providing direct care services while assisting in the training of nurse aides if providing
direct care services is within the normal duties of the employee; and

(F) The facility provides SPD with satisfactory documentation to support the methodology for allocating costs between facility operation
and NATCEP.

(b) Training Space and Utilities. Costs associated with space and utilities are eligible only if the space and utilities are devoted 100 percent
to the NATCEP. The facility must provide documentation satisfactory to SPD to support the need for, and use of, the space and utilities.

(c) Textbooks and Course Materials. A portion of the cost of textbooks and materials is eligible if textbooks and materials are used
primarily for NATCEP. The portion reimbursable is equal to the percentage of use attributable to NATCEP. "Primarily" means more than
50 percent. The facility must provide satisfactory documentation supporting the NATCEP need for and percentage of use of textbooks
and materials.

(d) Equipment. A portion of the cost of equipment is eligible if used primarily for NATCEP. However, equipment purchased for $500 or
more per item must be prior approved by SPD to qualify for reimbursement. The portion reimbursable is equal to the percentage of use
attributable to NATCEP. "Primarily" means more than 50 percent. The facility must provide satisfactory documentation supporting the
NATCEP need for and percentage of use of the equipment. Disposition of equipment and software purchased in whole or in part under
the Title XIX Medicaid Program must meet the requirements of the facility's provider agreement.

(e) Certification Fees. Nursing assistant certification and recertification fees paid to the Oregon State Board of Nursing for facility
employees are eligible.

(f) Reimbursement for CNAs. Reimbursement provided to nursing assistants pursuant to section (3) of this rule is eligible. The training must
have occurred at an approved training center, including nursing facilities in Oregon or other states.

(g) Contract Trainers. Payment for nurse aide certification classes provided under contract by persons who meet the qualifications of 42
CFR 483.152 is eligible for reimbursement. For this purpose, either the facility or the contractor must be certified for NATCEP. Allowable
contract trainer payments shall be limited to the lesser of actual cost or the salary calculation described in section (4)(a) of this rule.

(h) Ineligible Costs -- Trainee Wages. Wages paid to nursing assistants in training are not eligible for NATCEP reimbursement, but may be claimed as part of the daily reimbursement costs.

(i) Reimbursement for Combined Classes. If two or more Medicaid certified facilities cooperate to conduct nurse aide training, SPD shall not reimburse any participating facility for the combined training class until all participating facilities have filed a cost report. For a combined class, SPD shall apportion reimbursement to participating facilities pro rata based on the number of students enrolled at the completion of the first 30 hours of classroom training or in any other equitable manner agreed to by the participating facilities. However, when cooperating facilities file separate NATCEP cost reports, nothing in this section authorizes SPD to deny or limit reimbursement to a facility based on a failure to file or a delay in filing by a cooperating facility.

(5) Notwithstanding section (4) of this rule, SPD shall calculate the 80th percentile of the Medicaid portion of reported NATCEP costs per trainee completing the training. If a facility's Medicaid portion exceeds the 80th percentile of costs, SPD shall evaluate the facility's NATCEP costs to determine whether its costs are necessary due to compelling circumstances including but not limited to:

(a) Rural or isolated location of the training facility;

(b) Critical individual care need;

(c) Shortage of nursing assistants available in the local labor market; or

(d) Absence or inadequacy of other training facilities or alternative training programs, e.g., community college certification programs.

(6) If, under the analysis in section (5) of this rule, SPD finds that a facility's NATCEP costs are justified, SPD shall reimburse the reported costs pursuant to section (4) of this rule. However, if, under the analysis in section (5) of this rule, SPD finds that a facility's NATCEP costs are not justified, SPD shall reimburse the reported costs pursuant to section (4) of this rule but limited by the cost plateau.

(7) RECORDKEEPING, AUDIT, AND APPEAL.

(a) The facility must maintain supportive documentation for a period of not less than three years following the date of submission of the NATCEP cost report. This documentation must include records in sufficient detail to substantiate the data reported. If there are unresolved audit questions at the end of the three-year period, the records must be maintained until the questions are resolved. The records must be maintained in a condition that can be audited.

(b) SPD shall analyze by desk review each timely filed and properly completed NATCEP cost report. All cost reports are also subject to field audit at the discretion of SPD. The facility shall be notified in writing of the amount to be reimbursed and of any adjustments to the cost statement. Settlement of any amounts due to SPD must be made within 30 days of the date of notification to the facility.

(c) A facility is entitled to an informal conference and contested case hearing pursuant to ORS 183.413 through 183.470, as described in OAR 411-070-0435, to protest the reimbursement amount or the adjustment. If no request for an informal conference or contested case hearing is made within 30 days, the decision becomes final.

[Publications: Publications referenced are available from the agency.]
Purpose

(1) The purpose of Private Admission Assessment is to ensure that non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified nursing facility receive information regarding appropriate service and placement alternatives.

(2) These rules establish procedures and requirements for admission assessment of non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified nursing facility as required in ORS 410.505 to 410.545. The admission assessment includes mandatory services necessary to comply with the federal pre-admission screening requirements established by the Health Care Financing Administration. It also provides optional information regarding appropriate care settings and services, including nursing facilities and community-based options such as adult foster care, assisted living, residential care, in-home services, and other community-based services.

(3) These rules establish a certification process for programs henceforth called "certified programs," to perform admission assessments to individuals seeking admission to nursing facilities with a Medicaid contract. These rules establish standards for assessments performed by certified programs, local Area Agencies on Aging and Department personnel. Recommendations made during the admission assessment are not binding. Each individual has the right to choose from any of the long-term care options available.

Stat. Auth.: ORS 410.505 - 410.545
Stats. Implemented: ORS 410.030 & 410.510

Definitions

(1) "Act" means the provisions of ORS 410.505 to 410.545 and ORS 410.890.

(2) "Activities of Daily Living (ADL)" means those personal functional activities required by an individual for continued well being and are essential for health and safety. This includes eating, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder management, and cognition.

(3) "Admission Assessment" means a professional program that provides an assessment of the long-term care needs of an individual applying for or considering admission to a nursing facility who is not or does not appear to be Medicaid eligible. The admission assessment includes mandatory services necessary to comply with the federal pre-admission screening requirements and optional information regarding appropriate care settings and services, including nursing facilities and community-based options.
"Adult Foster Home" means any family home or other facility in which care is provided for compensation to five or fewer elderly or disabled adults who are not related to the provider by blood or marriage.

"Applicant" means a hospital or private agency applying for certification to conduct admission assessments according to the provisions of the Act.

"Application for Certification" means the application form designated and distributed by the Department to applicants.

"Area Agency on Aging (AAA)" means the agency designated by the Department and charged with the responsibility of providing a comprehensive and coordinated system of services to the elderly and people with disabilities in a planning and service area.

"Assessment Fee" means the amount of money charged by a certified program to the Department or to an individual for admission assessment services.

"Assisted Living Facility" means a program approach, within a physical structure that provides or coordinates a range of services, available on a 24-hour basis, for support of an individual's independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions and emphasizes choice, dignity, privacy, individuality, independence and home-like surroundings.

"Certification" means the process of being certified by the Department to conduct admission assessments for non-Medicaid individuals. Hospitals and private agencies wishing to conduct admission assessments must be certified by the Department.

"Certification Fee" means a fee charged to an applicant program to become certified under ORS 410.505 et seq.

"Certified Program" means a hospital, private agency, an Area Agency on Aging, or an individual certified by the Department to conduct admission assessments in accordance with ORS 410.530.

"Continuing Care Retirement Community" means a facility as defined in ORS 101.020.

"Civil Penalty" means a penalty imposed on a nursing facility by the Department in the manner provided in ORS 441. 705 to 745.

"Community-Based Care" means services provided in local communities including, but not limited to, adult foster care, assisted living, residential care, and in-home services.

"Decertify" means to revoke the certification to conduct admission assessments.

"Department" means the Department of Human Services/Seniors and People with Disabilities.

"Exception" means a variance from the provisions of these rules granted by the Department to a certified program.

"Exemption" means an individual who does not have a diagnosis of mental illness or mental retardation/developmental disabilities and is not subject to the requirement for an admission assessment prior to admission to a nursing facility in accordance with ORS 410.520(2).

"Facility" means, unless otherwise indicated, a nursing facility as defined under these Rules.

"Financial Interest" means ownership in any nursing facility or other facility licensed by the Department, or receiving placement fee from a facility. This includes ownership as an individual or as a fiduciary, a relationship in a capacity as a director, or an advisor or any other participant holding legal or equitable interest.

"Hospital" means an acute care facility, as defined in ORS 442.015(13)(a), licensed by the Health Services under ORS 441.020 - 441.097.

"Individual" means the person applying for or considering admission to a nursing facility and who is not or does not appear to be Medicaid eligible.

"Legally Designated Representative" means a legal guardian or a person holding the power of attorney for health care as defined in ORS 127.305(10).

"Level II Evaluation" means a comprehensive assessment implemented by the Department of individuals with mental illness or mental retardation/developmental disabilities to evaluate and determine whether nursing facility services and Specialized Services are needed.
"Long-Term Care" means community-based services and nursing facility care funded by public and/or private money.

"New Admission" for pre-admission screening means an individual admitted to any nursing facility for the first time. With the exception of certain hospital discharges in accordance with OAR 411-071-0015, new admissions are subject to Pre-Admission Screening.

"Nursing Facility" means a facility licensed to provide nursing care. Unless indicated otherwise, "nursing facility" means a Medicaid certified nursing facility.

"Placement" means a nursing facility or community-based care setting where an individual will reside and receive services.

"Program" means a certified program as defined under these rules.

"Recommend Placement" means to communicate to an individual information about a specific facility and/or service(s) that have been determined to be most appropriate to the individual's needs and preferences.

"Referral" means the process by which an individual may receive assessment services from a different assessment source.

"Resident" means any individual who is residing in a hospital or nursing facility.

"Residential Care Facility" means a facility that provides care for six or more persons over the age of 18 on a 24-hour basis in one or more buildings on contiguous property.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.505

411-071-0010

Assessment Requirements

(1) An admission assessment must be provided prior to admission for all non-Medicaid eligible individuals applying as new admissions to a Medicaid certified nursing facility except as provided in OAR 411-071-0015. The admission assessment must occur no more than 90 days prior to the date of admission.

(2) Admission assessments are to be performed by certified programs.

(3) If the assessment is performed by personnel from a certified program, such personnel must make a good faith effort to determine whether the individual receiving the assessment is or appears to be Medicaid eligible based on a review of optional income and asset information provided by the individual. If the individual appears to be Medicaid eligible or may become Medicaid eligible within 60 days, the certified program must contact and coordinate with the local Area Agency on Aging/Seniors and People with Disabilities unit to provide further assessment services.

Stat. Auth.: ORS 410.505 - 410.545
Stats. Implemented: ORS 410.510 & 410.520

411-071-0015

Exemptions

(1) The criteria under which an individual is exempted must be clearly indicated on the form designated by the Department.

(2) An exemption from the full assessment process may be granted for an individual who meets one of the following criteria:

(a) An individual seeking temporary admission to a nursing facility from a hospital and meets all of the following criteria as certified by the attending physician:

(A) Seeks admission directly from a hospital, or within 30 days of discharge from the hospital, after receiving acute inpatient care at the hospital; and
(B) Requires nursing facility services for the condition for which he or she received care in the hospital; and

(C) Requires nursing facility services for 30 days or less.

(b) An individual has a medical prognosis with life expectancy of 30 days or less;

(c) An individual seeking temporary admission for respite services with expected length of stay of 30 days or less;

(d) A resident of a continuing care retirement community who is seeking admission to a Medicaid certified nursing facility that is part of the same continuing care retirement community; or

(e) An individual certified by the attending physician that he/she must be admitted from the community or hospital emergency room without delay due to a serious and immediate threat to the individual's health and safety.

(3) The assessment must be completed and signed by a certified program, the attending physician, or a professional medical staff person working directly under the supervision of the attending physician for individuals admitted under an exemption criteria.

(4) An individual admitted to a nursing facility under an exemption under subsections (2)(a), (b), or (c) of this rule must receive an assessment within 7 days after the 30th day of admission.

(5) An individual temporarily admitted to a nursing facility under subsection (2)(e) of this rule must receive an assessment within seven days from the date of admission.

(6) No assessment or exemption is required for:

(a) An individual returning to a nursing facility after having entered a hospital from the same nursing facility; or

(b) An individual transferring from one Oregon nursing facility to another Oregon nursing facility with or without an intervening hospital stay.

Assessment Process

(1) The Department must develop and provide to certified programs an assessment instrument to be used for all admission assessments.

(2) The admission assessment must consist of:

(a) Information necessary to comply with federal pre-admission screening requirements as established by the Centers for Medicare Services;

(b) Recommendations regarding appropriate care settings and services based on the individual's personal, family, and community support system, discussion of the individual's lifestyle preferences and goals, and other information. An individual or the individual's representative must indicate on the assessment form provided by the Department whether the individual has received information about care options or does not want the information. An individual may not be required to receive this information. Documentation by non-hospital based programs must be on the form designated by the Department. Hospital based programs must document information regarding appropriate care settings and services in their own discharge planning documents for all individuals assessed.

(3) Appropriate information about care settings and services may be made available to individuals choosing to receive such information, including information on community-based care services, nursing facility options, and additional information as may be appropriate to a particular geographic area.

(4) The recommendations of the admission assessment are not binding; an individual has the right to choose any or none of the available options. An individual may designate someone to participate in the assessment process.

(5) As part of the admission assessment process, the individual or the individual's representative, as specified in section (6) of this rule,
must be requested to certify on the assessment instrument whether the individual has received information about care options or does not want the information.

(6) The following descending hierarchy is to be observed when certifying the information required in sections (5) and (6) of this rule and signing the assessment form:

(a) The individual, if the individual is capable at the time the assessment is performed;

(b) The individual's legally designated representative (as defined in OAR 411-071-0005) if the individual is not capable at the time the admission assessment is performed;

(c) The individual's next of kin or, if appropriate, a knowledgeable friend if the individual has no legally designated representative and is not capable at the time the admission assessment is performed;

(d) The person performing the assessment if a good faith effort fails to locate the individual's next of kin or appropriate friend, the individual has no legally designated representative, and is not capable at the time the admission assessment is performed;

(e) The person performing the assessment if the individual is capable at the time the assessment is performed but refuses to sign.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.510, 410.525 & 410.530

411-071-0025

Recommendations for Placement/Prohibition on Conflict of Interest

(1) If the individual chooses to have long-term care information provided by a certified program, the certified program must provide information about appropriate care settings and services.

(2) A certified program must not recommend placement to a specific nursing facility, assisted living facility, residential care facility or adult foster home in which it has a financial interest.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.525 & 410.530

411-071-0027

Confidentiality of Assessment Information

(1) Any records, forms, or information collected during the assessment process that identify an individual by name or address must be confidential and subject to the Department's rules on confidentiality set forth in OAR chapter 411, division 005.

(2) Certified programs must not release information obtained during the assessment process to any person or entity not authorized by law to receive such information without the written consent of the individual or the individual's legal guardian.

Stat. Auth.: ORS 410.535
Stats. Implemented: ORS 410.505 - 410.545
Hist.: SSD 3-1991, f. & cert. ef. 2-1-91; SPD 30-2004, f. 8-27-04, cert. ef. 9-1-04

411-071-0030

Assessment Fees

A certified program must not charge an individual for any portion of the assessment.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.515, 410.525 & 410.530

arcweb.sos.state.or.us/.../411_071.html
Certification Process

(1) Any hospital, agency, program, or Area Agency on Aging must obtain certification from the Department before providing admission assessment services.

(2) The certification issued to a program is not valid for use by any other program.

(3) Certification is valid for the length of the contract unless revoked or suspended by the Department.

Application Process

(1) Application for certification must be submitted in writing on a form provided by the Department. The application must include but not be limited to:

(a) The name, address, phone number and other descriptive information about the applicant;

(b) A statement of the applicant's experience in performing functional assessments and knowledge of long term care resources in the area to be served by the applicant. This statement must demonstrate, to the satisfaction of the Department, the ability of the applicant to perform admission assessments;

(c) Information and supporting documentation regarding qualifications and training of personnel performing assessments, as required by the Department;

(d) Examples of informational materials provided to individuals receiving admission assessments;

(e) Information pertaining to the program's financial interests in nursing facilities, assisted living facilities, residential care facilities and adult foster homes; and

(f) A signed and dated statement from the applicant stating that the applicant will comply with the requirements of ORS 410.505 to 410.545 and these rules.

(2) The application will not be considered complete until all the required information is received by the Department.

(3) After receipt of the completed application materials, the Department will investigate the information submitted and consult with the local Area Agency on Aging/Seniors and People with Disabilities unit and health care providers who have worked with the applicant to determine compliance with these rules.

(4) If the Department determines after review of the completed application that the applicant does not meet the requirements for certification, the Department must issue a written notice to the applicant citing the deficiencies in the application. If the applicant fails to correct the deficiencies within the time frames specified by the Department, the application may be denied. If denied, the applicant is entitled to a hearing as defined in ORS Chapter 183.
Qualifications for Personnel Performing Admission Assessments

(1) Except as provided in section (2) of this rule, all persons performing admission assessments shall meet one of the following criteria:

(a) Be a registered nurse licensed by the State of Oregon;

(b) Have a master of social work degree from an accredited institution of higher education; or

(c) Have a bachelor's degree from an accredited institution of higher education and have experience in gerontology, health care, long-term care, or other relevant human services.

(2) Any applicant or Certified Program may request that the Division allow an employee who meets the following conditions to perform admission assessments:

(a) The employee for whom the exception is being requested works directly under the supervision of someone qualifying under section (1) of this rule; and

(b) One or more of the following apply:

(A) The employee has at least one year of experience performing functions substantially similar to admission assessments;

(B) The employee has other work or educational experiences that provide clear and convincing evidence of the person's ability to perform admission assessments.

Stat. Auth.: ORS 410.535
Stats. Implemented: ORS 410.505 - 410.545
Hist.: SSD 22-1990, f. & cert. ef. 10-15-90; Renumbered from 411071-0065; SPD 30-2004, f. 8-27-04, cert. ef. 9-1-04

411-071-0045

Issuance of the Certificate for Private Admission Assessment

Within 60 days of receipt of a completed application, the Department must issue a Certificate for Private Admission Assessment to the applicant if the applicant meets all the requirements of ORS 410.505 to 410.545 and these rules. The Certificate must indicate the name, address and telephone number of the program and the name of the owner and/or manager of the program.

Stat. Auth.: ORS 410.535
Stats. Implemented: ORS 410.505 - 410.545

411-071-0050

Contracts, Reimbursements, and Certification Fees

(1) Certified programs eligible for reimbursement must enter into a contract with the Department regarding provision of admission assessment services. Certified hospital programs that only provide inpatient admission assessment services and are not eligible for reimbursement must enter into an agreement with the Department regarding provision of assessment services.

(2) The maximum fee a certified program may charge to the Department for the admission assessment will be $140 for all assessments, including those performed on an outpatient basis by hospitals that are certified programs.

(3) Each certified program that has a contract with the Department must pay an annual certification fee to the Department of $200. Fee payments must be received by the Department within 60 days of the date the invoice was issued, unless other specific arrangements have been approved by the Department. Failure to pay fees in a timely fashion may be cause for suspension of reimbursement payments and/or suspension or revocation of a program's certification.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.515, 410.530 & 410.535
Renewal

(1) At least 30 days prior to the expiration of the Certificate for Private Admission Assessment, a reminder notice and renewal application shall be sent by the Division to the certified program. Submittal of a renewal application and the certification fee prior to the expiration date will keep certification in effect until the Division takes action. If the renewal application and fee are not submitted prior to the expiration date, the program shall no longer be considered certified by the Division.

(2) In making its renewal decision, the Division may investigate any information in the renewal application and evaluate past performance upon consultation with area agencies on aging/SPD units. The Division may refuse to renew the certification if the renewal application does not meet the requirements of these rules.

Exceptions

(1) A certified program may make written request to the Department for an exception from the provisions of these rules. An exception may be granted if the certified program proves to the Department by clear and convincing evidence that such an exception is in compliance with ORS 410.505 to 410.545 and the federal criteria for pre-admission assessment, and will not jeopardize the health, safety, and welfare of the individuals receiving the admission assessment.

(2) Exceptions will be granted in writing and reviewed at each renewal period.

Orientation Requirement

(1) Management and supervisory personnel responsible for the admission assessment activities of the program applying for certification must participate in orientation or training sessions conducted by the Department.

(2) All personnel of the certified program, who will be performing admission assessments, must participate in the earliest available orientation or training session conducted by or approved by the Department on the admission assessment process, the forms designated by the Department and the continuum of long term care options available.

Record Keeping

Certified programs must maintain records for three calendar years of the following materials:

(1) Completed assessment forms for each individual assessed;

(2) Personnel records for all employees engaged in performing admission assessments;

(3) Billing and financial records required by the program's contract with the Department; and
(4) Any other information as required by the Department and necessary for the implementation and enforcement of ORS 410.505 to 410.595 and these rules.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.530 & 410.535

411-071-0080

Complaints Against Certified Programs

(1) Any person who believes these rules or the provisions of ORS 410.505 to 410.545 have been violated may file a complaint with the Department or with a local Area Agency on Aging/Seniors and People with Disabilities unit.

(2) The Department or its representative must notify the certified program that a complaint has been filed.

(3) After consultation with the local area agency on aging/Seniors and People with Disabilities unit, the Department or its designee will investigate the complaint. Department investigators may interview employees of the certified program and must have access to pertinent documents and records of the program. The Department will notify the program of the results of the investigation and any proposed action or sanction.

(4) Any complainant, witness or employee of a certified program must not be subject to retaliation by a program for making a report, for being interviewed about a complaint, or for being a witness.

(5) The certified program is responsible for violation of these rules by its employees, subcontractors or agents.

Stat. Auth.: ORS 410.535
Stats. Implemented: ORS 410.505 - 410.545
Hist.: SSD 3-1991, f. & cert. ef. 2-1-91; SPD 30-2004, f. 8-27-04, cert. ef. 9-1-04

411-071-0085

Procedures for Corrections of Violations

(1) After investigation, if the Department has determined that a certified program has violated the Act or these rules, the Department or its authorized representative must so notify the program in writing. The Notice of Violation must include:

(a) A description of the matters asserted or charged;

(b) A reference to the particular section of the statute, rule or order involved;

(c) A specific time frame for correction, that must be no later than 60 days after receipt of the notice;

(d) A statement of the sanctions that may be imposed against the program for failure to correct the violations; and

(e) A statement of the right to request a hearing if a sanction is imposed.

(2) At any time during the time frame for correction specified in the Notice of Violation, the certified program or the Department may request a conference. The conference must be scheduled within ten days of a request by either party.

(3) The purpose of the conference is to discuss the violations stated in the Notice of Violation and to provide information to the certified program to assist the program in complying with the requirements of these rules.

(4) The certified program must notify the Department of correction of violations no later than the date specified in the Notice of Violation.

(5) The Department may reinvestigate the certified program after the date the Department receives the report of compliance or after the date by which the violations must be corrected as specified in the Notice of Violation.

(6) All hearings must be conducted according to the applicable provisions of ORS 183.310 to 183.550.
Complaint Records

(1) A record must be maintained by the Department of all complaints and any action taken on the complaint. Any information regarding the investigation of the complaint must not be filed in the public file until the investigation has been completed.

(2) The name, addresses and other identifying information of the complainant, client and any witnesses are confidential and must not be placed in the public record.

(3) Any person has the right to inspect and photocopy the public complaint file maintained by the Department. Disclosure of information of the public complaint file must be governed by relevant statutes concerning public records and confidentiality.

Sanctions

(1) The Department may suspend, revoke or refuse to renew the certification to provide admission assessment if the Department finds that the program has violated any provision of the Act or these rules, including:

(a) Substantial failure to comply with these rules or with the Act;

(b) Refusal by a program or employee to allow access and inspection of records by an authorized representative of the Department;

(c) Fraudulent information or material misrepresentations in the application or renewal for a Certificate for Private Admission Assessment; or

(d) Failure to comply with a final order of the Department imposing an administrative sanction.

(2) The Department may require a certified program to be involved in a process of corrective action and may provide the program a specified amount of time to meet the standards of the Act and these rules before suspension or revocation of their certification.

(3) If the Department imposes an administrative sanction, it must serve notice of administrative sanction upon the program personally or by certified mail.

(4) The Notice of Administrative Sanction must include:

(a) Each sanction imposed;

(b) A description of each violation;

(c) A reference to the particular section of the statute, rule or order involved;

(d) A statement of the certified program's right to a contested case hearing;

(e) A statement that the Department's files on the subject of the contested case automatically become part of the contested case record upon default for the purpose of proving a prima facie case; and

(f) A statement that the notice becomes a final order upon default if the program fails to request a hearing within the specified time.

(5) If an administrative sanction is imposed it must be preceded by a hearing if the program requests the hearing in writing within 60 days after receipt of the notice. All hearings must be conducted according to the applicable provisions of ORS 183.310 to 183.550.
(6) If a program fails to request the hearing within the 60 days, the notice of administrative sanction will become a final order of the Department in accordance with ORS 183.310.

Stat. Auth.: ORS 410.535
Stats. Implemented: ORS 410.505 - 410.545
Hist.: SSD 3-1991, f. & cert. ef. 2-1-91; SPD 30-2004, f. 8-27-04, cert. ef. 9-1-04

411-071-0100

Responsibilities of Nursing Facilities

(1) A Medicaid eligible individual must have an AAA/Seniors and People with Disabilities Pre-Admission Screening and prior authorization of payment prior to admission to a nursing facility. A nursing facility must not admit a Medicaid eligible individual based on a Private Admission Assessment.

(2) A nursing facility receiving an application for admission from an individual who is subject to the admission assessment requirement but has not had an assessment performed within the preceding 90 days must provide the individual with information on the admission assessment process and a list of certified programs provided by the Department or the area agency on aging/Seniors and People with Disabilities office.

(3) Except as provided in section (4) of this rule, nursing facilities must not admit an individual without a completed and signed assessment form in the client record. Such forms are to be maintained as a permanent part of the client record.

(4) A nursing facility may admit an individual without a completed and signed assessment form in the client record provided the facility has received verbal confirmation from a certified program that an assessment has been completed for the individual within the preceding 90 days and a copy of the assessment form will be sent to the facility as soon as is reasonably possible. The facility must note in the client record the name of the certified program, the name and title of the person providing the verbal confirmation, and the date and time confirmation was provided.

(5) If a nursing facility admits an individual under an exempted hospital discharge set forth in OAR 411-071-0015(3)(a) for the purpose of rehabilitative and/or nursing services for 30 days or less, the nursing facility must contact a certified program to ensure a Private Admission Assessment is completed within seven days after the 30th day of admission.

(6) If a nursing facility admits an individual under an emergency exemption set forth in OAR 411-071-0015(3)(e), the nursing facility must contact a certified program and must ensure a Private Admission Assessment is completed within seven days of admission.

(7) A nursing facility receiving an application from an individual who is not an Oregon resident, or from an individual who is being discharged from a hospital that is not a certified program, or from an individual currently residing in a nursing facility outside the state of Oregon must immediately notify the local Area Agency on Aging/Seniors and People with Disabilities unit of the need for the individual to receive an admission assessment. The nursing facility must contact a certified program to ensure a Private Admission Assessment is completed within seven days of admission.

(8) The nursing facility is responsible for assuring that an individual subject to the Level II pre-admission screening evaluation required by the federal pre-admission screening requirements has been referred to the Seniors and People with Disabilities of the Department of Human Services.

(9) The Department may disallow payment for nursing services provided to an individual who has not been screened in compliance with the federal pre-admission screening requirements or an individual who is subject to the Level II evaluation and determination but who has not received such a determination within the time limits established in the federal pre-admission requirements.

(10) A nursing facility failing to comply with these rules may be subject to administrative sanctions as provided in ORS 410.540 and/or civil penalties as provided in OAR 411-071-0105.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.515 & 410.540

411-071-0105

arcweb.sos.state.or.us/.../411_071.html

11/13
Civil Penalties

(1) Civil penalties, not to exceed $5,000, may be assessed to nursing facilities for violation of the Act or these rules, and must be imposed in the manner provided in ORS 441.705 to 441.745.

(2) Any civil penalty imposed must become due and payable when the nursing facility incurring the penalty receives a notice in writing from the Department. The notice must be sent by registered or certified mail and shall include:

(a) A reference to the particular sections of the Act involved;

(b) A short and plain statement of the matters asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the right to request a hearing.

(3) The facility to which the notice is addressed will have ten days from the date of mailing in which to make written application for a hearing.

(4) All hearings must be conducted according to the applicable provisions of ORS 183.310 to 183.550.

(5) If the nursing facility fails to request a hearing within the time specified, or if the facility is found to be in violation of ORS 410.540 or these rules, an order may be entered assessing a civil penalty.

(6) Unless the penalty is paid within ten days after the date the order becomes final, the order constitutes a judgement and may be filed in accordance with ORS 183.413 to 183.470. Execution may be issued upon the order in the same manner as upon a judgement of a court of record.

(7) Judicial review of civil penalties imposed must be as provided in ORS 183.480, except that the court may, in its discretion, reduce the amount of the penalty.

(8) All penalties recovered under ORS 410.505 to 410.545 must be paid into the State Treasury and credited to the General Fund.

Stat. Auth.: ORS 410.535
Stats. Implemented: ORS 410.505 - 410.545
Hist.: SSD 3-1991, f. & cert. ef. 2-1-91; SPD 30-2004, f. 8-27-04, cert. ef. 9-1-04

411-071-0110

Responsibility of Certified Programs

A certified program performing an admission assessment must:

(1) Transmit a copy of the assessment form to the nursing facility upon admission of the individual;

(2) Send a copy of the completed assessment form to the Department;

(3) Provide a copy of the assessment form to the individual who receives the assessment or exemption; and

(4) Refer to either Seniors and People with Disabilities of the Department of Human Services, or Mental Health and Addiction Services of Health Services, for an individual subject to the Level II pre-admission screening evaluation required by the federal pre-admission screening requirements.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.530 & 410.535

411-071-0115
Responsibility of Adult Foster Homes, Residential Care Facilities and Non-Medicaid Nursing Facilities

(1) On or after February 1, 1991, except as provided in section (2) of this rule, prior to admission to an adult foster home, a residential care facility, or a non-Medicaid certified nursing facility, the facility must advise the individual seeking admission of the availability of admission assessment services at their own expense.

(2) An individual who is entering a non-Medicaid certified nursing facility that is part of a closed system continuing care retirement community shall be exempt from this requirement.

(3) The facility must certify on a form provided by the Department that the individual has been so advised. The facility shall maintain a copy of the form in the individual's client record and make a copy available to the Area Agency on Aging/Seniors and People with Disabilities unit upon request.

(4) Adult foster homes, residential care facilities and non-Medicaid nursing facilities who fail to comply with these rules will be subject to sanctions against their license as specified in: ORS 443.705 to 443.820 and OAR chapter 411, division 50, for adult foster homes; ORS 443.400 to 443.455 and chapter OAR 411, division 54, for residential care facilities; and ORS Chapter 441 and OAR chapter 411, divisions 85 through 89, for non-Medicaid nursing facilities.

Stat. Auth.: ORS 410.505 - ORS 410.545
Stats. Implemented: ORS 410.515 & ORS 410.540
Purpose

The purpose of these rules is to define the process through which the Seniors and People with Disabilities Division may impose remedies against Medicaid-only certified nursing facilities when such facilities fail to comply with the federal statute or Code of Federal Regulations (CFR). These rules are issued pursuant to 42 CFR 488.400 et. seq. and apply to all surveys performed on or after September 1, 1995. The remedies are designed to correct nonconforming conditions and to ensure prompt facility compliance with the CFR and consistency in facility performance. The federal Health Care Financing Administration (HCFA) is responsible for implementing similar remedies for Medicare and Medicare/Medicaid (dually-certified) facilities.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. ef. 10-1-95

Definitions

As used in these rules (OAR Chapter 411, Division 73) unless the context requires otherwise, the definitions in OAR 411-070-0005, OAR 411-085-0005, and following definitions apply:

(1) "Deficiency" means a facility's failure to meet a requirement of participation as specified in 42 CFR Part 483 et.seq. (Subpart B).

(2) "Directed Plan of Correction" means a course of action specified by the federal Health Care Financing Administration (HCFA), the Division or person designated by the Division which requires a facility to take specific actions to correct deficiencies within specified timeframes.

(3) "Facility" means a nursing facility licensed by the Division pursuant to OAR 411-085-0010 and certified for Medicaid, Medicare or both, or, if the context suggests, an owner, employee or other party acting (or failing to act) in behalf of the facility.

(4) "HCFA" means the federal Health Care Financing Administration.

(5) "Immediate Family" means a husband or wife; natural or adopted parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild.

(6) "Immediate Jeopardy" means a situation in which a facility's non-compliance with one or more requirements of participation or
conditions of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual receiving care in the facility.

(7) "New Admission" means a person admitted on or after the effective date of a denial of payment remedy. A resident temporarily absent from the facility to go to a general hospital, other health care setting, or home, etc. and was not discharged from the facility, shall not be considered to be a new admission.

(8) "Noncompliance" means any deficiency that causes a facility to not be in substantial compliance.

(9) "Plan of Correction" means a written description of the actions to be taken by a facility in order to correct deficiencies, and which has been approved by the Division or HCFA. The Plan shall include the dates by which the deficiencies will be corrected. Unless otherwise provided by these rules, the Plan of Correction is prepared by the facility.

(10) "Requirement of Participation" means a provision under the Code of Federal Regulations, Title 42, Part 483 or 488, or provision of the Social Security Act.

(11) "Standard Survey" means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

(12) "Statement of Deficiencies" means a written description of deficiencies prepared by HCFA or the Division.

(13) "Substandard Quality of Care" means one or more deficiencies in 42 CFR §483.13 Resident Behavior and Facility Practices, 42 CFR §483.15 Quality of Life, or in 42 CFR §483.25 Quality of Care, that constitutes either immediate jeopardy to resident health and safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy and with no actual harm.

NOTE: See Exhibit 1 (OAR 411-073-0040).

(14) "Survey Exit Date" means the last day of a standard survey by the Division or HCFA.

(15) "Work Day" means Monday, Tuesday, Wednesday, Thursday or Friday, excluding State holidays.

[ED NOTE: The Exhibit referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. ef. 10-1-95

411-073-0020

Statement of Deficiencies/Plan of Correction

(1) Statement of Deficiencies. When the Division identifies a facility's failure to comply with federal regulations, the Division shall document such failure(s) on a federal Statement of Deficiencies form HCFA 2567. The Statement of Deficiencies shall be accompanied by a notification of the informal dispute resolution process.

(2) Plan of Correction.

(a) When Required. Except as otherwise provided by this rule, the facility receiving a Statement of Deficiencies shall develop, submit to the Division, and begin implementing a Plan of Correction (POC) within 10 days of receiving the Statement of Deficiencies. A Plan of Correction is required regardless of whether remedies are imposed. A Plan of Correction is not an enforcement remedy.

(b) Form. The Plan shall be documented on the federal Statement of Deficiencies form HCFA 2567.

(c) Isolated Deficiencies. A Plan of Correction is not required if the Division declares on the Statement of Deficiencies that "the deficiencies are isolated, no harm has resulted, and there is no potential for anything more than minimal harm."

(d) Approval. All Plans of Correction submitted by a facility are subject to approval by the Division. A facility shall not delay implementation of its Plan of Correction because it has not yet received approval from the Division. If approval is denied, the facility shall have five days to submit an acceptable revised Plan of Correction.
411-073-0030

**Remedies Generally**

(1) Remedied Available. In addition to the remedies which may be provided pursuant to OAR Chapter 411, Division 89, one or more of the remedies listed in these rules (OAR Chapter 411, Division 73) may be imposed by the Division when a facility fails to comply with federal statute or regulations. The remedy(s) issued by the Division may be based upon findings of noncompliance with one or more requirements of participation.

(2) Factors To Be Considered. In order to determine the seriousness of the deficiency, and the appropriate remedy to pursue, if any, the Division:

(a) Shall consider whether a facility's noncompliance resulted in harm, whether there was a potential for harm, the degree of actual and/or potential harm, and/or whether there was immediate jeopardy;

(b) Shall consider whether the deficiencies are isolated, constitute a pattern, or are widespread; and

(c) May consider the relationship of the deficiency to other deficiencies and the facility's history of noncompliance.

(3) Appeal. When the Division issues a remedy, the facility may dispute the findings of noncompliance upon which the remedy is based. Except as otherwise provided by these rules, the Division's choice of remedy, including the factors considered by the Division in selecting the remedy, is not subject to appeal. The process for disputing a Division finding is found in OAR 411-073-0120 and 411-073-0140.

411-073-0040

**Categories of Remedies**

(1) Category 1 Remedies. Category 1 remedies include one or more of the following:

(a) Directed Plan of Correction (including directed inservice training);

(b) Directed inservice training; or

(c) Division monitoring (state monitoring).

(2) Category 2 Remedies. Category 2 remedies include one or more of the following:

(a) Denial of Medicaid payment for new admissions;

(b) Denial of Medicaid payment for all residents if imposed on the state by HCFA; or

(c) Civil money penalties of $50 to $3,000 per day.

(3) Category 3 Remedies. Category 3 remedies include one or more of the following:

(a) Temporary management;

(b) Civil money penalties of $3,050 to $10,000 per day;

(c) Closure of the facility in emergency situations and/or transfer of residents; or

(d) Termination of the Division's Provider Agreement.
Medicaid Remedies Matrix. Exhibit 1, "Medicaid Remedies Matrix," defines the circumstances under which the different categories of remedies shall or may be issued. Exhibit 1 is incorporated and made a part of these rules.

(a) Once a particular level of noncompliance is determined by the Division, the matrix indicates which category of remedies are required and optional.

(b) Required Remedies. When a category or remedy is "required", the Division shall impose one or more of the remedies in that category and/or initiate termination of certification.

(c) Optional Remedies. When a category is optional, the Division may impose one or more of the remedies under that category in addition to the required remedies.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f 9-29-95, cert. ef. 10-1-95

Specific Remedies

411-073-0050

Directed Plan of Correction

(1) When Imposed. The Division may require a Directed Plan of Correction:

(a) When isolated deficiencies or a pattern of deficiencies result in actual harm or a potential for more than minimal harm, including immediate jeopardy; or

(b) In any other situation under which a category 1 remedy is required or optional in Exhibit 1.

(2) Required Action. Facilities shall adopt and implement a Directed Plan of Correction prescribed in part or in whole by the Division when required by the Division. The Directed Plan of Correction may include, but is not limited to, outside consultation, training for facility staff and employment of additional staff.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f 9-29-95, cert. ef. 10-1-95

411-073-0060

Directed Inservice Training

(1) When Imposed. The Division may require Directed Inservice Training:

(a) When isolated deficiencies or a pattern of deficiencies result in actual harm or a potential for more than minimal harm, including immediate jeopardy; or

(b) In any other situation under which a category 1 remedy is required or optional in Exhibit 1.

(2) Required Action. Facilities shall implement a Directed Inservice Training prescribed by the Division when required by the Division.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f 9-29-95, cert. ef. 10-1-95

411-073-0070

Monitoring by the State

(1) When Imposed. The Division may initiate state monitoring under these rules:

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(a) When a facility is not in substantial compliance with one or more requirements of participation and is in the process of correcting deficiencies;

(b) When a facility has corrected deficiencies and verification of continued substantial compliance is needed;

(c) When the Division has reason to question the substantial compliance of the facility with one or more requirements of participation;

(d) When a facility has been cited with substandard quality of care deficiencies on the last three consecutive standard surveys; or

(e) In any other situation under which a category 1 remedy is required or optional in Exhibit 73-1.

(2) Required Action.

(a) Reports. Monitors shall prepare written reports at the request of the Division describing facility progress toward correcting deficiencies. Monitors may request written information on facility progress to be prepared and submitted by facility staff.

(b) Access to facility. Monitors shall have the same access to residents, staff and documentation as inspectors/surveyors under OAR 411-089-0010.

(c) Monitors. The monitor(s) shall not:

(A) Be an employee of the facility;

(B) Serve as a consultant to the facility; or

(C) Have an immediate family member be a resident of the facility.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f 9-29-95, cert. ef. 10-1-95

411-073-0080
Denial of Payment for New Admissions

(1) When Imposed. The Division may deny payment for new Medicaid admissions:

(a) When there are widespread deficiencies constituting no actual harm, but with a potential for more than minimal harm;

(b) When there is at least one deficiency constituting actual harm to a resident;

(c) When the Division finds that the facility is not in substantial compliance three months after the last day of a survey in which the facility was found to not be in substantial compliance;

(d) When the Division finds substandard quality of care on the last three consecutive standard surveys;

(e) When there is immediate jeopardy; or

(f) In any other situation under which a category 2 remedy is required or optional in Exhibit 1.

(2) Required Action. When the Division determines that there is cause pursuant to section (1) of this rule, the Division shall deny payment for new Medicaid admissions.

(3) Resumption of Payment. The Division may resume payment for new admissions when the facility achieves substantial compliance and is capable of remaining in substantial compliance as determined by HCFA or the Division.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f 9-29-95, cert. ef. 10-1-95

411-073-0090
Civil Money Penalties

(1) When Imposed. The Division may impose a civil money penalty for each day a facility is or was not in substantial compliance with one or more requirements of participation. The penalty may be imposed in any situation under which a category 2 or 3 remedy is required or optional in Exhibit 1.

(2) Required Action.

(a) Amount.

(A) Except as otherwise provided by this rule, if deficiencies do not constitute immediate jeopardy but cause actual harm or have potential of causing more than minimal harm, the penalty shall be an amount not less than $50 nor more than $3,000 per day of violation (amounts set in $50 increments).

(B) If deficiencies constitute immediate jeopardy, the penalty shall be an amount not less than $3,050 nor more than $10,000 per day of violation (amounts set in $50 increments).

(C) Except as otherwise provided by this rule, if deficiencies constituting immediate jeopardy are resolved and immediate jeopardy is removed but noncompliance continues, the daily penalty shall be reduced to an amount not less than $50 nor more than $3,000, as determined by the Division.

(D) If deficiencies not constituting immediate jeopardy become more serious and immediate jeopardy exists, the daily penalty shall be increased to an amount not less than $3,050 nor more than $10,000, as determined by the Division.

(E) If the Division determines a facility is not complying with a requirement of participation and a civil money penalty was imposed during or subsequent to the previous standard survey for deficiencies within the same requirement of participation, the Division shall issue another civil money penalty for a higher amount. Penalties for such repeat deficiencies may exceed the range established by paragraphs (2)(a)(A) and (C) of this rule.

(F) The Division shall discontinue accrual of the civil money penalty on the day the Provider Agreement is terminated or on the day the Division determines substantial compliance was achieved, whichever is sooner.

(b) Factors to Consider. In setting the amount of the civil money penalty within the ranges established by subsection (2)(a) of this rule, the Division shall consider:

(A) The facility's noncompliance history;

(B) The facility's financial condition (the facility shall be responsible for supplying the Division with financial information if the facility believes its financial condition should be a mitigating factor);

(C) The factors described in section (2) of OAR 411-073-0030; and

(D) The facility's degree of culpability including, but not limited to, neglect, indifference, or disregard to resident care, comfort, health and safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the civil money penalty.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. ef. 10-1-95

411-073-0100

Temporary Management

(1) When Imposed. The Division may appoint a temporary manager to oversee facility operation:

(a) When there is one or more deficiencies constituting an immediate jeopardy or when there are widespread deficiencies constituting actual harm; or

(b) In any other situation under which a category 3 remedy is required or optional in Exhibit 1.
(2) Required Action.

(a) Manager Authority/Responsibility. A temporary manager shall have authority to hire, terminate or reassign staff; obligate facility funds; alter facility procedures; and manage the facility in a manner to correct deficiencies identified.

(b) Manager Qualifications. A temporary manager shall:

(A) Have experience and education needed to oversee the correction of deficiencies, as determined by the Division;

(B) Not have been found guilty of misconduct by the Board of Examiners of Nursing Home Administrators or any other professional society or licensing board;

(C) Not, nor a member of his/her immediate family, have any financial ownership interest in the facility; and

(D) Not be or have been an employee of the facility within the past two years.

(c) Payment of Salary. The temporary manager's salary:

(A) Is paid directly by the facility while the manager is assigned to the facility;

(B) Must be at least equivalent to the sum of the following:

(i) Prevailing salary paid by facilities for positions of this type in what the Division considers to be the facility's geographic area;

(ii) Additional costs that would have reasonably been incurred by the facility if such a person had been in an employment relationship; and

(iii) Any other costs incurred by such a person in furnishing services under such an arrangement or as otherwise set by the Division; and

(C) May exceed the amount provided for in paragraph (2)(c)(B) of this rule if the Division is otherwise not able to find a qualified temporary manager.

(d) Failure to Relinquish Control or Pay Manager. If the facility fails to relinquish control to a temporary manager or make timely payment of a manager's salary as determined by the Division, the Division shall terminate its Provider Agreement within 23 calendar days from the survey exit date or within seven days of the determination of failure to relinquish control, whichever is earlier. If immediate jeopardy is removed prior to termination of the Provider Agreement, as determined by the Division, the Division may withdraw termination action.

(e) Failure to Correct. If the temporary manager does not correct immediate jeopardy within 23 days of the survey exit date, the Provider Agreement shall be terminated.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. ef. 10-1-95

411-073-0110

Termination of Provider Agreement/Resident Transfer

(1) When Imposed. The Division may terminate the Provider Agreement and/or transfer residents:

(a) When there is immediate jeopardy, when the facility closes, or during an emergency;

(b) When the facility is not in substantial compliance with requirements of participation, regardless of whether or not immediate jeopardy is present;

(c) When the facility fails to submit an acceptable Plan of Correction within the time frame specified by the Division;

(d) When the facility fails to relinquish control to a temporary manager appointed by the Division;

(e) When the facility fails to provide a timely and adequate allegation of compliance required by federal rules governing the survey process; or
In any other situation under which a category 1, 2 or 3 remedy is allowed in Exhibit 1.

(2) Required Action.

(a) Transfer. The Division may transfer Medicaid and Medicare residents when required to protect resident health and safety. The Division shall attempt to minimize stress related to such a transfer by involving the resident and, if appropriate, the resident's family and friends to the greatest extent feasible.

(b) Provider Agreement.

(A) The Division shall terminate the Provider Agreement if it determines no feasible alternative to termination exists.

(B) When a Provider Agreement is terminated the Division shall provide for the safe and orderly transfer of residents.

(C) The Division shall terminate the Provider Agreement within 23 days of the survey exit date unless immediate jeopardy is removed, regardless of any other remedies imposed.

(D) If there is no immediate jeopardy, the Division may allow the facility to continue to participate for up to 6 months from the survey exit date if:

(i) The Division concludes it is more appropriate to impose alternative remedies than to terminate the Provider Agreement;

(ii) The facility's Plan of Correction is approved by HCFA; and

(iii) The facility agrees to repay the Division (or the federal government, as appropriate) all payments made to the facility following the survey which identified the deficiencies. Such repayment shall be requested by the Division if the Division determines that the facility failed to implement their Plan of Correction.

(E) The Division may deny payment for new Medicaid admissions if the facility is not in substantial compliance three months after the last day of the survey.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. f. 10-1-95

Selection of Remedies

411-073-0120

Notice of Remedy, Excluding Civil Money Penalties

(1) Notice Time Frame. This rule sets forth the notice requirements for remedies other than civil money penalties. The notice requirements for civil money penalties are set forth in OAR 411-073-0140.

(a) No Notice Required. Prior notice is not required when state monitoring is imposed pursuant to OAR 411-073-0070.

(b) Two Day Notice/Immediate Jeopardy.

(A) Provider Agreement. If there is immediate jeopardy, the facility and the public shall receive at least 2 calendar days prior written notice of Termination of Provider Agreement. This remedy shall be effective within 23 days of the survey exit date unless the immediate jeopardy is removed.

(B) Other Remedies. The Division may issue any other remedy(s) provided for under these rules with two calendar days prior written notice if there is immediate jeopardy. The remedy(s) shall be effective no later than 20 days after the mailing of the notice, unless otherwise provided by OAR 411-073-0130.

(c) Fifteen Day Notice. If remedies are proposed but there is no immediate jeopardy, at least 15 calendar days prior written notice shall be provided.

(2) Contents. When the Division issues a notice of remedy(s), the notice shall include:
(a) The nature of the noncompliance;
(b) Which remedy(s) is imposed;
(c) The effective date of the remedy(s); and
(d) The right to appeal the finding(s) of noncompliance upon which the remedy is based.

(3) Distribution. In addition to the facility, the Division shall notify:
(a) HCFA, if there is immediate jeopardy;
(b) The Long Term Care Ombudsman;
(c) The Board of Examiners of Nursing Home Administrators if the immediate jeopardy involves substandard care;
(d) Attending physicians if the immediate jeopardy involves substandard care; and
(e) The Department of Justice.

(4) Facility Response. Within ten work days of receiving a notice of remedy(s), the facility shall provide the following information:
(a) The name of each resident of the facility with respect to which the findings of deficiency were made; and
(b) The name and address of the attending physician for each such resident.

(5) Failure To Disclose Information. If a facility fails to provide information required under section (4) of this rule, the Division may terminate the facility's Provider Agreement or impose other remedies as appropriate.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, ef. 9-29-95, cert. ef. 10-1-95

411-073-0130

Notice of Civil Money Penalty/Hearing/Order for Payment

(1) Contents of Notice. The notice of intent to impose a civil money penalty under these rules shall include:
(a) Nature of the noncompliance;
(b) Statutory basis for the penalty;
(c) Amount of penalty per day of noncompliance;
(d) Any factors specified in OAR 411-073-0090(3)(b) that were considered when the amount of the penalty was determined;
(e) Date upon which the penalty begins to accrue;
(f) Date the penalty stopped accruing or circumstances under which the penalty will stop accruing; and
(g) Instructions for responding to the notice, a statement of the facility's right to a hearing, and the implication of waiving the hearing.

(2) Waiver of Hearing.
(a) The facility may waive, in writing, the right to a hearing within 60 days from the date of the Division's notice of intent to impose the civil money penalty.
(b) If the facility waives the right to a hearing in accordance with subsection (2)(a) of this rule, the amount of the civil money penalty shall be reduced by 35 percent.
(3) Hearing.

(a) Reduction of Penalty. If the hearings officer finds the basis for imposing a civil money penalty exists, (s)he may not reduce the amount of the civil money penalty below the level required by the scope and severity of noncompliance found pursuant to OAR 411-073-0040, OAR 411-073-0090 and Exhibit 1.

(b) Issues Considered. The only issues the hearings officer may consider in reviewing the amount of the civil money penalty are:

(A) The facility's history of noncompliance, including repeated deficiencies;

(B) The facility's financial condition;

(C) The factors listed in OAR 411-073-0030(2); and

(D) The facility's degree of culpability. The absence of culpability is not a mitigating circumstance in reducing the amount of the civil money penalty.

(c) Standard of Review. The Division's determination as to a facility's level of noncompliance pursuant to OAR 411-073-0030(2) shall be upheld by the hearings officer unless (s)he determines it is clearly erroneous.

(4) Order Of Payment.

(a) The Division shall issue a "Final Order for Payment of Civil Money Penalty" when

(A) The facility did not request a hearing; or

(B) The facility waived the right to a hearing; or

(C) The civil money penalty was upheld after a hearing; and

(D) The facility has been determined to be in substantial compliance; or

(E) The facility has been terminated from participation.

(b) The final order for payment shall include:

(A) The nature of the noncompliance;

(B) The statutory basis of the penalty;

(C) The amount of the penalty per day of noncompliance;

(D) Any factors specified in OAR 411-073-0090(2)(b) that were considered when determining the amount of the penalty;

(E) The dates for which the penalty was charged;

(F) The total amount due;

(G) The due date the penalty must be paid; and

(H) The rate of interest assessed on any unpaid balance after the due date.

(c) The Division may deduct the amount of the penalty from any sum then or later owed to the facility by the Division or HCFA.

(d) The civil money penalty is due 15 days after the Final Order for Payment of Civil Money Penalty is mailed.

(5) Interest. The Division shall assess interest on any unpaid balance of the penalty, beginning on the date the penalty is due. The interest rate is the rate established by ORS 82.010.

(6) Use Of Civil Penalty Monies. Civil money penalties collected by the Division pursuant to these rules (OAR Chapter 411, Division 73) shall be applied to the protection of the health and property of residents in facilities found to be deficient by the Division or HCFA.
may include but not be limited to:

(a) Relocation costs;

(b) Division costs related to temporary management; or

(c) Reimbursement of resident funds or property lost at the facility as a result of actions by the facility or by employees of the facility.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. ef. 10-1-95

411-073-0140

Dispute Resolution

(1) Informal Dispute Resolution. Upon receipt of a Statement of Deficiencies, the facility shall be provided an opportunity to dispute the Division's survey findings.

(a) If a facility wishes an informal conference to dispute the Division's survey findings, the facility shall advise the Division in writing within ten calendar days after receipt of the Statement of Deficiencies.

(b) The facility may not seek a delay of any enforcement action against it on the grounds the informal dispute resolution has not been completed.

(c) If a facility is successful in demonstrating the deficiencies should not have been cited, the Division shall reissue the Statement of Deficiencies, removing such deficiencies and rescinding or modifying any remedies issued for such deficiencies. The reissued Statement of Deficiencies shall state that it supersedes the previous Statement of Deficiencies, and shall clearly identify the date of the superseded Statement of Deficiencies.

(2) Formal Hearing.

(a) A facility subjected to a remedy pursuant to OAR Chapter 411, Division 73, excluding OAR 411-073-0070 (state monitoring), shall be entitled to a contested case hearing in accordance with ORS Chapter 183 and OAR Chapter 137.

(b) If a facility wishes a formal hearing, a written request must be received by the Division within 10 calendar days of the informal dispute resolution decision (if applicable) or within 60 days of the notice of remedy or notice of intent to impose a civil money penalty, whichever is later.

(c) The facility may not seek a delay of any enforcement action against it on the grounds the formal hearing has not been completed. If a facility is successful in demonstrating the deficiencies should not have been cited, the Division shall reissue the Statement of Deficiencies, removing such deficiencies and rescinding or modifying any remedies for such deficiencies.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. f. 10-1-95

411-073-0150

Change of Ownership

(1) A facility may not avoid a remedy on the basis it underwent a change of ownership.

(2) If a facility has undergone a change of ownership the Division will not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the satisfaction of the Division that the poor past performance is no longer a factor.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1995, f. 9-29-95, cert. ef. 10-1-95

arcweb.sos.state.or.us/.../411_073.html
The Oregon Administrative Rules contain OARs filed through December 15, 2010

DEPARTMENT OF HUMAN SERVICES,
SENIORS AND PEOPLE WITH DISABILITIES DIVISION

DIVISION 85

NURSING FACILITIES/LICENSING -- GENERALLY

411-085-0000

Statement of Purpose

The purpose of these rules (OAR 411, divisions 85-89) is to establish requirements for nursing facilities that promote quality care and maximization of personal choice and independence for residents. Whenever possible, care shall be directed toward returning the resident to his/her own residence or to the least restrictive alternative environment within the shortest time possible.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert.ef. 8-1-04

411-085-0005

Definitions

As used in OAR chapter 411, divisions 70 and 85 to 89, unless the rule requires otherwise, the following definitions apply:

(1) "Abuse" means:

(a) Any physical injury to a resident that has been caused by other than accidental means. This includes injuries that a reasonable and prudent individual would have been able to prevent, such as hitting, pinching or striking, or injury resulting from rough handling.

(b) Failure to provide basic care or services to a resident that results in physical harm, unreasonable discomfort, or serious loss of human dignity.

(c) Sexual contact with a resident, including fondling, caused by an employee, agent, or other resident of a long-term care facility by force, threat, duress or coercion, or sexual contact where the resident has no ability to consent.

(d) Illegal or improper use of a resident's resources for the personal profit or gain of another individual, borrowing resident funds, spending resident funds without the resident's consent or, if the resident is not capable of consenting, spending resident funds for items or services from which the resident cannot benefit or appreciate, or spending resident funds to acquire items for use in common areas when such purchase is not initiated by the resident.

(e) Verbal abuse as prohibited by federal law, including the use of oral, written, or gestured communication to a resident or visitor that describes a resident in disparaging or derogatory terms.
(f) Mental abuse as prohibited by law including humiliation, harassment, threats of punishment, or deprivation, directed toward the resident.

(g) Corporal punishment.

(h) Involuntary seclusion for convenience or discipline.

(2) "Abuse Complaint" means any oral or written communication to the Department, one of the Department's agents, or a law enforcement agency alleging abuse.

(3) "Activities Program" means services offered to each resident that encourage the resident to participate in physical and mental exercises that are designed to maintain or improve physical and mental well-being and social skills.

(4) "Applicant" means the individual required to complete a nursing facility application for a license. Applicant includes a sole proprietor, each partner in a partnership, or the corporation that owns the nursing facility business. Applicant also includes the sole proprietor, each partner in a partnership, or the corporation that operates the nursing facility on behalf of the nursing facility business owner.

(5) "Area Agency on Aging (AAA)" means a Type B Area Agency on Aging that is an established public agency within a planning and service area designated under the Older Americans Act, 42 U.S.C. 3025, that has responsibility for local administration of Division programs.

(6) "Assessment" means a written evaluation of the resident's abilities, condition, and needs based upon resident interview, observation, clinical and social records, and other available sources of information.

(7) "Care" means services required to maximize resident independence, personal choice, participation, health, self-care, and psychosocial functioning, as well as to provide reasonable safety, all consistent with the preferences of the resident.

(8) "Certified Medication Assistant" or "Certified Medication Aide" means a certified nursing assistant who has been certified as a medication assistant or medication aide pursuant to ORS chapter 678 and the rules adopted thereunder.

(9) "Certified Nursing Assistant" means an individual who has been certified as a nursing assistant pursuant to ORS chapter 678 and the rules adopted thereunder.

(10) "Change of Ownership" and "Change of Operator" means a change in the individual or entity that owns the facility business, a change in the individual or entity responsible for the provision of services at the facility, or both. Events that change ownership include but are not limited to:

(a) A change in the form of legal organization of the licensee;

(b) Transfer of the title to the nursing facility enterprise by the owner to another party;

(c) If the licensee is a corporation, dissolution of the corporation, merger of the corporation with another corporation, or consolidation of one or more corporations to form a new corporation;

(d) If the licensee is a partnership, any event that dissolves the partnership;

(e) Any lease, management agreement, or other contract or agreement that results in a change in the legal entity responsible for the provision of services at the facility; or

(f) Any other event that results in a change of the operating entity.

(11) "Day Care Resident" means an individual who is not bedfast who receives services and care in a nursing facility for not more than 16 hours per day.

(12) "Department" means the Department of Human Services.

(13) "Division" means the Department of Human Services, Seniors and People with Disabilities Division.

(14) "Drug" has the same meaning set forth in ORS chapter 689.005.

(15) "Entity" means "Individual" as defined by these rules.
(16) "Establish a Nursing Facility" or "Maintain a Nursing Facility" means to possess or hold an incident of ownership in a nursing facility business.

(17) "Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Division as a nursing facility.

(18) "Facility Fund" means a fund created under ORS 441.303 to meet expenses relating to the appointment of a trustee under ORS 441.277 to 441.323 or the appointment of a temporary manager under ORS 441.333 for a nursing facility or a residential care facility.

(19) "Health Care Facility" means a health care facility as defined in ORS 442.015, but also includes a residential care facility as defined in ORS 443.400 and an adult foster home as defined in ORS 443.705.

(20) "Hearing" means a contested case hearing according to the Administrative Procedures Act and the rules of the Department.

(21) "Incident of Ownership" means:
(a) An ownership interest;
(b) An indirect ownership interest; or
(c) A combination of direct and indirect ownership interest.

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

(23) "Individual" means an entity including an individual, a trust, an estate, a partnership, a corporation, or a state or governmental unit as defined in ORS 442.015 including associations, joint stock companies, insurance companies, the state, or a political subdivision or instrumentality including a municipal corporation.

(24) "Inpatient Beds" means a bed in a facility available for occupancy by a resident who is cared for and treated on an overnight basis.

(25) "Inspection" means any on-site visit to the facility by anyone designated by the Secretary of the U.S. Department of Health and Human Services, the Department, or a "Type B" Area Agency on Aging and includes but is not limited to a licensing inspection, certification inspection, financial audit, Medicaid Fraud Unit review, monitoring, or complaint investigation.

(26) "Legal Representative" means an attorney at law, the individual holding a general power of attorney or special power of attorney for health care, a guardian, a conservator, or any individual appointed by a court to manage the personal or financial affairs of a resident, or individual, or agency legally responsible for the welfare or support of a resident, other than the facility.

(27) "Licensed Nurse" means a registered nurse or a licensed practical nurse.

(28) "Licensed Practical Nurse (LPN)" means an individual licensed under ORS chapter 678 to practice practical nursing.

(29) "Licensee" means the applicant to whom a nursing facility license has been issued.

(30) "Local Designee of the Division" means the local unit of the Division or the Type B Area Agency on Aging.

(31) "Long Term Care Facility" means nursing facility.

(32) "Major Alteration" means change other than repair or replacement of building materials or equipment with materials and equipment of a similar type.

(33) "Management" or "Control Interest" means:
(a) Possessing the right to exercise operational or management control over, or to directly or indirectly conduct the day-to-day operation of, an institution, organization, or agency; or
(b) An interest as an officer or director of an institution, organization, or agency organized as a corporation.

(34) "New Construction" means:
(a) A new building.
(b) An existing building or part of a building that is not currently licensed as a nursing facility;

(c) A part of an existing building that is not currently licensed for the purpose for which such part is proposed to be licensed (e.g., rooms that are proposed to be licensed as nursing facility resident rooms but are not currently licensed as nursing facility resident rooms);

(d) A major alteration to an existing building, additions, or conversions in use; or

(e) Renovation or remodeling of existing buildings.


(36) "Nurse Practitioner" means an individual certified under ORS chapter 678 as a nurse practitioner.

(37) "Nursing Assessment" means evaluation of fluids, nutrition, bowel/bladder elimination, respiration, circulation, skin, vision, hearing, musculoskeletal systems, allergies, personal hygiene, mental status, communicative skills, safety needs, rest, sleep, comfort, pain, other appropriate measures of physical status, and medication and treatment regimes. Nursing assessment includes data collection, comparison with previous data, analysis or evaluation of that data, and utilization of available resource information.

(38) "Nursing Assistant" or "Nurse Aide" means an individual who assists licensed nurses in the provision of nursing care services. "Nursing Assistant" includes but is not limited to a certified nursing assistant, a certified medication assistant, and individuals who have successfully completed a state approved nurse assistant training course.

(39) "Nursing Care" means direct and indirect care provided by a registered nurse, licensed practical nurse, or nursing assistant.

(40) "Nursing Facility" means an establishment with permanent facilities including inpatient beds, that provide medical services, including nursing services, but excluding surgical procedures, and that provide care and treatment for two or more unrelated residents. In this definition, "treatment" means complex nursing tasks that cannot be delegated to an unlicensed individual. "Nursing Facility" shall only include facilities licensed and operated pursuant to ORS 441.020(2).

(41) "Nursing Facility Administrator" means an individual licensed under ORS chapter 678 who is responsible to the licensee and is responsible for planning, organizing, directing, and controlling the operation of a nursing facility.

(42) "Nursing Facility Law" means ORS chapter 441 and the rules for nursing facilities adopted pursuant thereto.

(43) "Nursing Home" means nursing facility.

(44) "Nursing Staff" means registered nurses, licensed practical nurses, and nursing assistants providing direct resident care in the facility.

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

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

(47) "Pharmacist" has the same meaning as set forth in ORS 689.005.

(48) "Pharmacy" has the same meaning as set forth in ORS 689.005.

(49) "Physician" means an individual licensed under ORS chapter 677 as a physician.

(50) "Physician's Assistant" means an individual registered under ORS chapter 677 as a physician's assistant.

(51) "Podiatrist" means an individual licensed under ORS chapter 677 to practice podiatry.

(52) "Prescription" has the same meaning as set forth in ORS 689.005.

(53) "Public or Private Official" means:

(a) Physician, naturopathic physician, osteopathic physician, chiropractor, podiatric physician, physician assistant, or surgeon including any intern or resident;

(b) Licensed practical nurse, registered nurse, nurse practitioner, nurse’s aide, home health aide, or employee of an in-home health agency;
(c) Employee of the Department, Area Agency on Aging, county health department, community mental health program, community
developmental disabilities program, or nursing facility;

(d) Individual who contracts to provide services to a nursing facility;

(e) Peace officer;

(f) Clergy;

(g) Licensed clinical social worker, psychologist, licensed professional counselor, or licensed marriage and family therapist;

(h) Physical, speech, or occupational therapist, respiratory therapist, audiologist, or speech language pathologist;

(i) Senior center employee;

(j) Information and referral or outreach worker;

(k) Any public official who comes in contact with elderly individuals in the performance of the official’s official duties;

(l) Firefighter or emergency medical technician;

(m) Legal counsel for the resident; or

(n) Guardian for, or family member of, the resident.

(54) "Registered Nurse (RN)" means an individual licensed under ORS chapter 678.

(55) "Rehabilitative Services" means specialized services by a therapist or a therapist’s assistant to a resident to attain optimal functioning including but not limited to physical therapy, occupational therapy, speech and language therapy, and audiology.

(56) "Relevant Evidence" means factual information that tends to either prove or disprove the following:

(a) Whether abuse or other rule violation occurred;

(b) How abuse or other rule violation occurred; or

(c) Who was involved in the abuse or other rule violation.

(57) "Resident" means an individual who has been admitted, but not discharged, from the facility.

(58) "Restorative Aide" means a certified nursing assistant primarily assigned to perform therapeutic exercises and activities to maintain or re-establish a resident's optimum physical function and abilities according to the resident's restorative plan of care and pursuant to OAR 411-086-0150.

(59) "Restorative Services" or "Restorative Nursing" means those measures provided by nursing staff and directed toward re-establishing and maintaining the residents’ fullest potential.

(60) "Safety" means the condition of being protected from environmental hazards without compromise to a resident's or legal guardian's choice, or undue sacrifice of the resident’s independence.

(61) "Significant Other" means an individual designated by the resident or by the court to act on behalf of the resident. If the resident is not capable of such designation, and there is no court-appointed individual, then a significant other shall mean a family member or friend who has demonstrated consistent concern for the resident. No rule using this term is intended to allow release of, or access to, confidential information to individuals who are not otherwise entitled to such information, or to allow such individuals to make decisions that they are not entitled to make on behalf of a resident.

(62) "Suspected Abuse" means reasonable cause to believe that abuse may have occurred.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070, 441.055, 441.615 & 441.637
Issuance of License

(1) License Required. No person acting individually or jointly with any other person shall establish, conduct, maintain, manage, or operate a nursing facility without a license from The Department.

(2) Not Transferable. Each nursing facility license issued by The Department applies only to person or persons named on the license. The license is not transferable or assignable. The license is valid only for the specific premises designated on the license and for the time period specified on the license.

(3) Certificate of Need. A license will not be issued for a new facility, an expanded facility or a facility offering new services unless the State Office of Health Policy has issued a certificate of need for said facility or service, or has determined that a certificate of need is not required.

(4) Application for Initial Licensure and License Renewal.

(a) The application(s) shall be on a form or forms provided by The Department and shall include all information requested by The Department including, but not limited to, identity and financial interest of any person, including stockholders who have an incident of ownership in the applicant representing an interest of ten percent or more or ten percent of a lease agreement for the facility.

NOTE: Facilities applying for Medicaid and/or Medicare certification are required by federal law to identify applicants representing a five percent or more interest.

(b) If the owner of the nursing facility business is a different entity from the operator of the nursing facility, an application for licensure will be required from both the operator and the owner. Only one license fee is required. Each application must be signed and dated by a legally authorized representative of the entity submitting the application. Name(s) of owner(s)/operator(s) will appear on the license.

(c) The application will require the identification of any person who has ten percent incident of ownership, direct or indirect, in a pharmacy or in any business that provides services or supplies to nursing facilities. If any such person(s) exist(s), the application must identify the person, the name and address of the pharmacy or business.

(d) The application will identify the number of beds the facility is then presently capable of operating considering existing equipment, ancillary service capability and the physical requirements as specified within these rules (OAR 411, divisions 85-89). The number of beds requested to be licensed must not exceed the number identified on the license to be renewed unless prior approval has been issued by The Department or a certificate of need has been issued when required pursuant to ORS Chapter 442.

(e) The application will include a floor plan showing the location of each bed and the dimensions and room number of each room in which a bed is located. The plan will also show the location of dining and activities areas, shower and tub rooms, toilet rooms, clean and dirty utility rooms, therapy services areas, and dietary service areas. After the first filing, plans need only be submitted when changes in the information required in this subsection occur and when requested by The Department.

(f) The application must include a copy of all leases, management and ownership of the facility.

(g) The application must list all states in which the licensee or persons having a ten percent or more incident of ownership in the facility currently or previously is/has been licensed to provide long-term care.

(h) If a renewal is desired, the licensee must make application at least 45 days prior to the expiration date of the existing license.

(i) The license fee must accompany the application.

(j) If the applicant fails to provide complete and accurate information on the application, The Department may deny or revoke the license if it determines the missing or corrected information is needed to determine if a license should be granted.
An application will not be considered to be complete until all requested information and signatures have been provided.

Each application for a new license (excludes license renewal) must include a completed and signed credit and criminal record check authorization form for the applicant(s), and for each person with ten percent incident of ownership in the applicant.

Applicants for license renewal must provide The Department with a completed and signed credit and criminal record check authorization form for the applicant(s), and for each person with incident of ownership in the applicant, when required by The Department.

Applications must state whether or not the applicant(s), and persons with incident of ownership in the applicant, have ever been convicted of a crime associated with operation of a health care facility or agency under federal law or the laws of any state.

Applicants must provide such other information and documentation as The Department may reasonably require for proper administration of these rules, including, but not limited to, information about ownership interest in other business enterprises, if relevant.

The Department will issue the license or issue a denial of licensure within 60 days of receipt of the completed application.

Demonstrated Capability:

Prior to issuance of a license or a license renewal, the applicant must demonstrate to the satisfaction of The Department that the applicant is capable of providing care in a manner consistent with the requirements of these rules (OAR 411, divisions 85-89);

The Department may consider the background and qualifications of any person owning ten percent or more interest in the nursing facility operation when determining whether an applicant may be licensed;

The Department may consider the applicant's history of compliance with Division rules and orders, including the history of compliance of each person with a ten percent or more incident of ownership in the applicant;

Any person with a past or present interest of ten percent or more incident of ownership in any nursing facility operation will be considered responsible for acts occurring during and relating to the operation of the nursing facility for the purpose of licensing.

Separate Buildings. Separate licenses are not required for separate buildings located contiguously and operated as an integrated unit by the same ownership or management.

New Applicant Qualifications

For the purpose of this rule, "applicant" means each person, as defined in ORS 442.015, who holds ten percent or greater incident of ownership in the facility. Applicants for licensure (excluding license renewal, but including all changes of ownership) must meet the following criteria:

1) CRIMINAL HISTORY. Each applicant must complete a Criminal History Clearance conducted by The Department in accordance with OAR chapter 407, division 007. The Department conducts the fitness determination. If determined "unfit," applicants may appeal as described in OAR 407-007-0330.

2) PERFORMANCE HISTORY. Each applicant must:

(a) Be free of incident of ownership history in any facility in Oregon that provides or provided (at the time of ownership) care to children, elderly, ill or disabled persons and was involuntarily terminated from licensure or certification, or voluntarily terminated during any state or federal termination process, during the past five years;

(b) Be free of incident of ownership history in any nursing facility in any state that was involuntarily terminated from licensure or certification, or voluntarily terminated during any state or federal termination process, during the past five years;

(c) Be free of history of termination of licensure as a nursing facility administrator or health care provider during the past five years;
(d) Failure to demonstrate required performance history may result in The Department’s denial of a license.

(3) FINANCIAL HISTORY. Each applicant must:

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

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

(c) Have a record of good credit as evidenced by a Division credit check;

(d) Submit proof of fiscal responsibility, including an auditor’s certified financial statement and other verifiable documentary evidence of fiscal solvency, documenting that the prospective licensee has sufficient resources to operate the facility for 60 days. Proof of fiscal responsibility must include liquid assets sufficient to operate the facility for 45 days. Anticipated Medicaid income is not be considered to be "liquid assets," but may be considered to be "financial resources." Liquid assets may be demonstrated by:

(A) An unencumbered line of credit;

(B) A joint escrow account with SPD;

(C) A performance bond; or

(D) Any other method satisfactory to SPD.

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

(4) EXPERIENCE. If an applicant does not have experience in the provision of nursing facility care, the applicant must employ the services of a consultant with experience in the provision of nursing facility care for a period of at least six months. The consultant and the terms and length of employment are subject to the approval of The Department. Costs incurred for such consulting services are not an allowable cost for Medicaid reimbursement.

(5) DEMONSTRATION OF RIGHT TO PROPERTY/BUSINESS. The applicant must demonstrate that they have the legal right to possess the nursing facility property and operate the nursing facility business.

EXAMPLE: If purchasing the property, the applicant must include documentation demonstrating clear title and current right to possess the property. If leasing the facility property, or planning to operate it under a management agreement, the applicant must provide all legal documents needed to demonstrate the right to possess the property and operate the business.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.025, 441.055 & 441.615
Hist.: SSD 8-1993, f. & cert. ef. 10-1-93; SDSD 13-1999, f. 12-30-99, cert. ef. 1-1-00; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0015

License Expiration, Termination of Operation, License Return

(1) EXPIRATION. Unless revoked or terminated earlier, or issued for a shorter specified period, each license to operate a nursing facility expires on December 31 following the date of issue.

(2) TERMINATION OF OPERATION. Except as otherwise provided in this rule, if facility operation is discontinued for any reason, the license is expired. The licensee has appeal rights under ORS Chapter 183.

(3) INACTIVE LICENSE. When the licensee proposes to replace an existing (original) licensed nursing facility with a new building, The Department may grant the licensee an inactive license for up to 24 months after closure of the original facility (departure of the last resident) under the following conditions:

(a) The existing facility must not meet the physical environment requirements for new construction (division 87 of OAR 411);
(b) The licensee must comply with the Health Division's Certificate of Need process, including the physical environment requirements for new construction;

(c) The licensee must submit to The Department a written request for an extension to continue the license, and must submit an application for license renewal and the license fee prior to the beginning of each calendar year;

(d) The licensee must comply with plan review (OAR 411-087-0010(3)) and all other applicable requirements; and

(e) The licensee's written request must include information that assures The Department that the new facility will provide an improved quality of care that is needed in the community and that is determined by The Department to be in the public's interest.

(f) The licensee must provide written notice of intent to apply for an inactive license at least 30 days prior to closure of the original building. This notice must be provided to The Department and every licensed nursing facility, assisted living facility and residential care facility within 20 miles of the proposed new building site.

(g) The licensee must provide a minimum of two written progress reports to The Department regarding the status of the new building.

(A) The first report must be received by The Department between six months and nine months after the original facility is closed.

(B) The second report must be received by The Department between 18 months and 21 months after the original facility is closed.

(4) EXTENSION. If the licensee fails to open the new building within 24 months of the closure of the original facility, The Department may extend the inactive license for an additional 18 months. The licensee must submit written request to The Department for an extension prior to expiration of the inactive license. The following must be included in the request for extension:

(a) Notice to Nearby Facilities. A statement certifying that the licensee has made reasonable attempt to provide written notice to each nursing, assisted living and residential care facility within 20 miles of the site of the proposed facility of the intent to request an extension. Upon request, The Department will provide a list of the names and addresses of all nursing, assisted living and residential care facilities in the state.

(b) Site Plan. A completed site plan that has been submitted to the local jurisdiction (city or county planning agency).

(c) Architectural Drawings. Working architectural drawings that have been stamped or prepared by a licensed architect.

(d) Building Site. Evidence that the land proposed for the new building is under control of the licensee.

(e) Local Jurisdiction Communication. Evidence of continued contact with the local jurisdiction.

(f) Financial Commitment. Evidence of financial commitments towards completion of the project, including proof of lender commitments and cash on hand sufficient to complete the construction.

(g) Construction Contracts. Construction contracts or other evidence showing that the project will be completed prior to the expiration of the extended inactive license.

(5) RETURN OF LICENSE. Each license certificate must be returned to The Department immediately upon issuance of a final order revoking or suspending the license. If a license is terminated voluntarily or involuntarily because operation has been discontinued, the license certificate must be immediately returned to The Department.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.025, 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SDSD 13-1999, f. 12-30-99, cert. ef. 1-1-00; SDSD 3-2001, f. 2-14-01, cert. ef. 2-15-01; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0020

License Fees, Special Assessment

(1) LICENSE APPLICATION FEES.

(a) License application fees may not be prorated for a partial year. The annual license fee is:
(A) For 1 to 15 beds: $180
(B) For 16 to 49 beds: $260
(C) For 50 to 99 beds: $520
(D) For 100 to 150 beds: $670
(E) For more than 150 beds: $750

(b) All monies received shall be deposited in the Quality Care Fund.

(2) SPECIAL TRUST FUND ASSESSMENT.

(a) Whenever the Department determines that the balance in the Facility Fund created by Oregon statute is less than the amount established by the statute, a special assessment is levied against all licensees. The special assessment shall be pro-rated (based upon the annual fee of the licensee) in order to result in collection of an amount that shall result in a Facility Fund balance of no more than the amount set by the statute. In no event may the special assessment be greater than the annual license fee. The special assessment may be levied only once each calendar year.

(b) Monies are disbursed from the Facility Fund in accordance with ORS 441.277 to 441.323.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.020, 441.055, 441.303 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SDSD 13-1999, f. 12-30-99, cert. ef. 1-1-00; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04; SPD 19-2009, f. 12-23-09, cert. ef. 1-1-10; SPD 24-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 11-2010, f. 6-30-10, cert. ef. 7-1-10

411-085-0025

Change of Ownership or Operator/Cessation of Business

(1) PENDING CHANGE OF OWNERSHIP/MANAGEMENT. When a change of ownership or a change of operator is contemplated, the licensee and the prospective licensee must each notify The Department in writing of the contemplated change. The change of ownership/operator must be received by The Department at least 45 days prior to the proposed date of transfer. A shorter timeframe may be allowed at the sole discretion of The Department. The notification must be in writing and must include the following:

(a) Name and signature of the current licensee;
(b) The name of the prospective licensee;
(c) The proposed date of the transfer;
(d) Type of transfer (e.g., sale, lease, rental, etc.).
(e) A complete, signed nursing facility application from the prospective licensee.

(2) EFFECTIVE DATE OF CHANGE. The prospective licensee will not assume possession or control of the facility until after the prospective licensee has been notified by The Department that its license application has been approved.

(3) LICENSEE RESPONSIBLE. The licensee(s) is/are responsible for operation of the facility and resident care provided therein until a new license is issued to a new owner or manager or the facility operation is closed.

(4) Before a licensee ceases operation of and closes a facility, the licensee must notify The Department of the impending closure in writing at least 90 days prior to the proposed date of closure. The licensee is responsible for operation of the facility and for the resident care provided therein until all residents are transferred and the facility is closed.

EXCEPTION: When the closure date is established by The Department.

Stat. Auth.: ORS 410.070 & 441.055
411-085-0030

Required Postings

(1) PUBLIC NOTICES:

(a) Content. Public notices required to be posted include:

(A) The most recent licensing and, if applicable, certification survey report(s);

(B) The placard provided by The Department that includes information on reporting of abuse and summarizes the nursing facility rules. In addition to the location specified in subsection (1)(b) of this rule, this placard must also be prominently and conspicuously posted in close proximity to each nursing station and in the area(s) where residents are admitted;

(C) The current week's menu and activities schedule;

(D) The facility license and the administrator's license. (It is recommended the titles and names of the administrator, the DNS, the Social Services Director, the Activities Director, the Dietary Services Supervisor and the RN Care Manager(s) are also posted);

(E) Waivers received from The Department pursuant to OAR 411-085-0040 and 411-087-0030, and waivers of any federal regulations; and

(F) Any other notice relevant to residents or visitors required by state or federal law.

(b) Location. The facility will designate a specific area where notices listed in subsection (1)(a) of this rule will be posted and that:

(A) Is routinely accessible and conspicuous to residents and visitors, including those in wheelchairs; and

(B) Provides sufficient space for prominent, conspicuous display of each notice.

(2) NOTICES FOR STAFF. The facility must post the names of registered nurses as required by OAR 411-086-0020 and the physician(s) available for emergencies as required by OAR 411-086-0200 at each nursing station.

411-085-0040

Alternative Methods, Waivers

(1) APPLICATION. While all nursing facilities are required to maintain compliance with The Department's rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications, or the conducting of pilot projects or research. Requests for waivers to the rules must:

(a) Be submitted to The Department in writing;

(b) Identify the specific rule for which a waiver is requested;

(c) Describe the special circumstances relied upon to justify the waiver;

(d) Describe what alternatives were considered, if any, and why alternatives (including compliance) were not selected;

(e) Demonstrate that the proposed waiver is desirable to maintain or improve the quality of care for the residents, will maintain or improve resident potential for self-direction and self-care, and will not jeopardize resident health and safety; and

(f) Identify the proposed duration of the waiver.
(2) APPROVAL PERIOD. Upon finding that the licensee has satisfied the conditions of this rule, The Department may grant a waiver for a specified period of time, not to exceed a period of three years.

(3) REVOCATION. The Department may revoke any waiver or variance issued by The Department immediately upon finding that the facility's operation under the waiver or variance has endangered, or if continued would endanger, the health or safety of one or more residents.

(4) IMPLEMENTATION. The facility may implement a waiver only after written approval from The Department.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0050

Hospital-Based Nursing Facilities

Facilities that are physically connected to and operated by a licensed general hospital will be considered to be in compliance with the following Oregon nursing facility requirements:

(1) Requirements for policies, procedures and quality assurance programs if such policies, procedures and programs exist for both hospital and nursing facility.

(2) Requirements for full-time staff positions, departments and committees if the hospital has similar positions/departments/committees that address needs in the nursing facility.

(3) Requirements for a drug room or pharmacy if the hospital has a pharmacy or drug room available to the nursing facility 24 hours per day.

(4) Rules requiring specific training for the DNS and the RN Care Manager until January 1, 1990.

(5) Requirements that the administrator be full-time in the nursing facility if the nursing facility has 40 or fewer licensed beds. The administrator, however, must work full-time, based on time spent on both the hospital and nursing facility responsibilities, and must be available to nursing facility staff on a full-time basis.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 14-1988, f. 12-30-88, cert. ef. 1-1-89; SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0060

Specialty Nursing Facilities

(1) APPLICATION. Facilities that have successfully obtained from the State Office of Health Policy a certificate of need for "specialty long-term care beds" pursuant to OAR 333-610 must make application to The Department for licensure as "Special Nursing Facility" in accordance with OAR 411-085-0010.

(2) ISSUANCE OF LICENSE. Licenses will only be issued to a Specialty Nursing Facility after written notification from the State Office of Health Policy that the facility is eligible for such licensure. The license issued will state "Specialty Nursing Facility" and will identify the type of residents and specialized services the facility is authorized to admit and retain.

(3) COMPLIANCE WITH RULES. Specialty Nursing Facilities will be required to meet all Oregon Administrative Rules that apply to Nursing Facilities.

(4) ADMISSIONS. Facilities and distinct parts of facilities licensed as Specialty Nursing Facilities must only admit and provide services for residents consistent with the Certificate of Need issued by the Office of Health Policy.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Licensee, Employees, Consultants

(1) LICENSEE. The licensee will be responsible for the operation of the facility and the quality of care rendered in the facility.

(2) EMPLOYEES.

(a) Licensure, Registration, Certification Required. All health care personnel working in the facility must be licensed, registered, or certified as required. Documentation thereof is required for all such employees.

(b) Reference Check. The licensee must check and document references for all prospective employees prior to employment.

(c) Job Description. All employees' duties must be defined in writing and maintained in the facility. All employees must be instructed in and perform the duties assigned.

(d) Nursing Personnel. Before employing a registered nurse, licensed practical nurse or nursing assistant, the licensee must contact the Oregon State Board of Nursing and inquire whether the person is licensed or certified by the Board and whether there has been any disciplinary action by the Board against the person or any substantiated abuse findings against a nursing assistant.

(e) The licensee must assure a criminal history check is completed on all employees, in accordance with OAR chapter 407, division 007, (Criminal History Checks). A licensee must not employ any individual who is determined to be ineligible to provide services as outlined in OAR chapter 407, division 007.

(3) PROHIBITION OF EMPLOYMENT. The facility must not employ or retain in employment any of the following:

(a) Any person found responsible for abusing, neglecting or mistreating a person receiving long-term care services in a final administrative action that is not under appeal or in a court of law;

(b) Any nursing assistant against whom a finding of resident abuse has been entered into the registry maintained under ORS 678.150; or

(c) Any person who is known or reasonably should be known to the facility to be abusive or to have been abusive.

(4) CONSULTANTS. When consultants are required, a facility will require consultants to file written reports at least quarterly. These reports must include date(s) of visit(s), length of time spent on premises, action taken on previous reports, problems identified, recommendations, staff members contacted, services performed, distribution of reports, and date mailed or delivered. The facility must maintain these quarterly reports in the facility.

Facility Policies

(1) POLICIES REQUIRED. A Quality Assessment and Assurance Committee must develop and adopt facility policies. The policies must be followed by the facility staff and evaluated annually by the Quality Assessment and Assurance Committee and rewritten as needed. Policies must be adopted regarding:

(a) Admission, fees and services;

(b) Transfer and discharge, including discharge planning;

(c) Physician services;

(d) Nursing services;
(e) Dietary services;

(f) Rehabilitative services and restorative services;

(g) Pharmaceutical services, including self administration;

(h) Care of residents in an emergency;

(i) Activities;

(j) Social services;

(k) Clinical records;

(l) Infection control;

(m) Diagnostic services;

(n) Oral care and dental services;

(o) Accident prevention and reporting of incidents;

(p) Housekeeping services and preventive maintenance;

(q) Employee orientation and inservice;

(r) Laundry services;

(s) Possession of firearms and ammunition;

(t) Consultant services; and

(u) Resident grievances.

(2) DOCUMENTATION. Each policy must be in writing and must specify the last date at which such policy was reviewed by the Quality Assessment and Assurance Committee.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0220

Quality Assurance

(1) QUALITY ASSESSMENT AND ASSURANCE COMMITTEE. Each facility must have a Quality Assessment and Assurance Committee. The committee must include the administrator, medical director, Director of Nursing Services (DNS), consulting pharmacist and at least one other facility staff person. The committee must:

(a) Ensure a quality assurance program is conducted as required in this rule;

(b) Adopt facility policies as identified in OAR 411-085-0210;

(c) Ensure a pharmaceutical services review is completed as required by OAR 411-086-0260(2);

(d) Ensure that an infection control program as identified in OAR 411-086-0330 is conducted; and

(e) Meet no less often than quarterly.

(2) QUALITY ASSURANCE. The Quality Assessment and Assurance Committee must conduct an annual review of care practices to ensure quality. The review must include:
(a) Evaluation of resident audits (biannual physical examination of a representative sample of facility residents). The sample must include a minimum of 20 percent of the residents or ten residents, whichever is greater;

(b) Clinical records, including medication administration and treatments;

(c) Resident nutritional status, including weights, intake, and output;

(d) Care plans to ensure that care needs have been identified and addressed;

(e) The services and functions required by the policies listed in OAR 411-085-0210; and

(f) Actions taken to resolve identified problems and to prevent their recurrence.

(3) DOCUMENTATION. All meetings of the Quality Assessment and Assurance Committee must be documented. Documentation must include a listing of those in attendance, length of the meeting, issues discussed, findings, actions, recommendations made and assessment of previous actions and recommendations.

Stat. Auth.: ORS 410.070 & 441.055
Stat. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0300

Civil Rights

(1) The facility must not make any distinction, discrimination or restriction based on a resident's, potential resident's or visitor's sex, marital status, race, color, national origin or disability.

(2) The facility must make reasonable accommodations in order to provide services needed by applicants who are disabled.

Stat. Auth.: ORS 410.070 & 441.055
Stat. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0310

Residents' Rights: Generally

The facility must protect, encourage and assist the resident in exercising the rights identified in OAR 411-085-0300 – 411-085-0350. Each resident and the resident's legal representative, as appropriate, have the right to:

(1) Be encouraged and assisted while in the facility to exercise rights as a citizen or resident of Oregon and of the United States.

(2) Be fully informed, orally and in writing in a language the resident understands of these rights, and of all facility guidelines for resident conduct and responsibilities. This must be documented by the resident's written acknowledgment, prior to or at the time of admission.

(3) Be fully informed, prior to or at the time of admission and during stay, of services available in the facility, including Medicaid and Medicare certification status and the potential consequences thereof to the resident. The facility must assist the resident to apply for Medicaid and Medicare benefits, by ensuring that the resident is able to contact the local Medicaid agency, whenever a resident may be eligible.

(4) Be fully informed of his/her total health status, including but not limited to medical status. The resident must be informed of the right to choose his/her own physician and to be fully informed in advance of any changes in care or treatment. The facility staff must encourage the resident to exercise the right to make his/her own decisions and fully participate in care and care planning unless the resident has been found legally incapable of doing so.

(5) Refuse any medication, treatment, care or any participation in experimental research unless the resident has been found legally incapable of doing so.

(6) Be encouraged, but not required, to perform activities for therapeutic purposes when identified in the resident's care plan.
(7) Be free from verbal, sexual, mental and physical abuse, corporal punishment and involuntary seclusion. Chemical and physical restraints may only be used to ensure the physical safety of the residents and may not be used for discipline or convenience. Except as provided in OAR 411-086-0140, restraints may only be used on order of a physician.

(8) Be transferred or discharged only in accordance with the Seniors and People with Disabilities Division transfer and discharge rules in OAR chapter 411, division 088.

(9) Not be reassigned to a new room within the facility without cause and without adequate preparation for the move in order to avoid harmful effects.

(a) Involuntary reassignment of rooms may only be made after reasonable advance notification (oral or written) and preparation. Unless there is clear and adequate written justification for a shorter time frame, "reasonable advance notification" means no less than 14 days.

(b) Residents must not be involuntarily reassigned rooms within the facility if such reassignment would have a significant adverse impact on the resident's medical or psychological status.

(c) Moving residents on the basis of source of payment is not just cause for intrafacility transfers.

(d) Residents and significant others must receive prior notice of any move and any change in roommate assignment.

(10) Voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of restraint, interference, coercion, discrimination, or reprisal. The facility staff must listen to and act promptly upon grievances and recommendations received from residents and family groups.

(11) Be treated with consideration, respect and dignity and assured complete privacy during treatment and when receiving personal care.

(12) Associate and communicate privately with persons of the resident's choice, to send and receive personal mail unopened and to have regular access to the private use of a telephone.

(13) Be provided privacy for visits when requested, including meetings with other residents and family groups.

(14) Have clinical and personal records kept confidential. Copies of the records must not be transferred outside the facility unless the resident is transferred, or examination of the records is required by the attending physician, the third party payment contractor, the Seniors and People with Disabilities Division, Type B Area Agency on Aging, or the Long Term Care Ombudsman. Nothing in this rule is intended to prevent a resident from authorizing access to the resident's clinical and personal records by another person.

(15) Promptly inspect all records pertaining to the resident.

(16) Purchase photocopies of records pertaining to the resident. Photocopies requested by the resident must be promptly provided, but in no case require more than two business days (days excluding Saturdays, Sundays and state holidays).

(17) Participate in social, religious, and community activities at the discretion of the resident.

(18) Keep and use personal clothing and possessions as space permits unless to do so infringes on other residents' rights. The resident must be permitted to have a lockable storage space for personal property. Both the resident and facility management may have keys.

(19) Be free of retaliation. After the resident, or the resident's legal representative, has exercised rights provided by law or rule, neither the facility nor any person subject to the supervision, direction, or control of the facility may retaliate by:

(a) Increasing charges or decreasing services, rights or privileges;

(b) Threatening to increase charges or decrease services, rights or privileges;

(c) Taking or threatening any action to coerce or compel the resident to leave the facility; or

(d) Abusing, harassing, or threatening to abuse or harass a resident.

(20) Not be required to sign any contract or agreement that purports to waive any resident's right, including the right to collect payment for lost or stolen articles.
(21) Be fully informed of the facility policy on possession of firearms and ammunition within the facility.

(22) Receive care from facility staff trained to provide care that is specific to the resident’s disease or medical condition.

(23) Receive a modified or special diet that meets the specific requirements of the resident’s disease or medical condition.

Residents' Rights: Charges and Rates

(1) ADMISSION. The facility must provide written and oral notice before or at the time of admission to each resident specifying:

(a) The base daily rate, or Medicaid rate and, as soon as known, amount of resident liability, as applicable; services provided for that rate, and other charges that might reasonably be expected, including but not limited to medical supplies, pharmaceuticals, incontinence care, feeding, bedhold daily rate, and laundry;

(b) Whether the facility accepts Medicaid reimbursement:

(A) If the facility accepts Medicaid reimbursement, the notice must include a description of the Medicaid eligibility requirements and who to contact to apply for Medicaid assistance;

(B) If the facility does not accept Medicaid, the notice must include the facility’s policy regarding residents who exhaust their private resources and become eligible for Medicaid;

(C) Nothing in this section will be construed to permit discrimination based on payment source; and

(c) Alternative forms of transportation available to the resident for routine and emergency transportation, including information on possible cost and how to access such service(s).

(2) RATE CHANGES. The facility must give 30 days' written notice to all residents of changes in base rates and any other charge.

Residents' Rights: Visitor Access

(1) DEFINITION. As used in this rule, "full and free access" means access to the fullest extent possible without undue adverse interference on the operation of the facility.

(2) FULL ACCESS. The facility must permit individuals and groups full and free access to:

(a) Visit, talk with and make personal, social and legal services available to all residents;

(b) Inform residents of their rights and entitlements, and their corresponding obligations, under federal and state laws by means of distribution of educational materials and discussion in groups and with individual residents;

(c) Assist, advise and represent residents in obtaining public assistance, medical assistance, social security benefits and in asserting resident rights. Assistance may be provided to residents individually or in groups.

(3) RIGHT TO REFUSE. The resident has the right to refuse contact with any individual or group who otherwise has access to the facility under this rule. The refusal to communicate with any individual or group must be made directly by the resident unless the resident's medical record clearly documents the reasons for not doing so.
(4) SOLICITATION. This rule is not intended to allow access to persons or organizations whose primary purpose is to solicit purchase of services or products, or solicit contributions, from the residents or staff.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055, 441.605 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0340

Residents' Rights: Pharmaceutical Services, Charges for Drugs

(1) CHOICE OF SUPPLIERS:

(a) The resident must have a choice from among prescription/nonprescription drug delivery systems so long as the system selected:

(A) Provides for timely delivery of drugs;

(B) Provides adequate protection to prevent tampering with drugs;

(C) Provides that drugs are delivered in a unit of use compatible with the established system of the facility for dispensing drugs, whether that system is provided by a facility pharmacy or by a contract with a pharmacy; and

(D) Provides a 24-hour emergency service procedure either directly or by contract with another pharmacy.

(b) The resident must have a choice from among suppliers of nonprescription medication, but no facility is required to accept any opened container of such medication;

(c) If the established system of the facility, whether provided by facility pharmacy or a pharmacy under contract, provides resident profile information (diagnosis, medications and allergies), the pharmacy chosen by the resident under subsection (1)(a) of this rule must also provide that information for any resident it serves at the facility;

(d) The resident must have a choice from among suppliers of nonprescriptive sickroom supplies so long as any items supplied can be maintained in a clean manner with equipment available at the facility;

(e) For purposes of subsections (1)(b) and (c) of this rule, "supplier" includes an authorized representative of the resident who purchases nonprescriptive medication or nonprescriptive sickroom supplies at retail.

(2) CHARGES FOR DRUGS:

(a) If a facility charges residents for drugs, the following must be made available to the resident on request:

(A) Name of the drug;

(B) Amount paid by the facility for the drug;

(C) Amount charged by the facility for the drug; and

(D) Amount of repackaging costs, if any.

(b) If a pharmacy charges any resident's insurance company or other party for a drug administered to a resident in a nursing facility, the pharmacy must provide on request a written bill listing the:

(A) Name of the drug; and

(B) Amount charged by the pharmacy for the drug.
Residents' Rights: Personal Funds

(1) RESIDENT HELD FUNDS. The resident has the right to manage his/her financial affairs and the facility may not require residents to deposit personal funds with the facility.

(2) FACILITY HELD FUNDS.

(a) Resident Request. The facility must hold, safeguard, manage and account for the personal funds of the resident when requested in writing. The resident must be fully informed of the facility's system for protecting personal funds. When the resident requests that the facility hold such funds, the facility must ensure that such request is in writing;

(b) Accounting System. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility. The system may allow resident funds to be pooled together, however it must preclude any commingling of resident funds with facility funds;

(c) Report to Resident. The facility must provide a copy of the individual financial record to the resident no less often than quarterly and upon request of the resident. The statement must include the following information:

(A) Identification number and location of the account in which the resident's personal funds have been deposited.

(B) The resident's account balance at the beginning of the statement period.

(C) A listing of each deposit, and each withdrawal, to and from the resident's account. Each withdrawal must include an explanation of the reason for the withdrawal (Example: If money is requested by the resident, facility may document "resident request").

(D) The interest earned, if any, and the current interest rate.

(E) The ending balance.

(d) Resident Control of Funds. The facility must take all reasonable precautions to ensure the resident's funds are handled according to the resident's wishes. If resident's wishes cannot be determined, funds must be handled in accordance with the best interest of the resident;

(e) Resident Access to Funds. The facility must allow residents access to funds on weekdays (Monday through Friday, excluding holidays) during business office hours (no less than six hours per day) and at least two hours per day on all other days;

(f) Funds Under $50. The facility may hold up to $50 for each resident in a non-interest-bearing, petty cash fund. All resident funds held by the facility that are not in the petty cash fund must be deposited in an interest-bearing account as described in subsection (g) of this rule;

(g) Funds $50 and over.

(A) Whenever money held by the facility for a resident exceeds $50, the excess above $50 must, within 7 days of receipt, be deposited in the resident's interest-bearing account, unless the money is managed in a Trust and Agency Account held by The Department.

(B) If the interest-bearing account for residents is pooled, the facility must have a system that accurately and promptly allocates earned interest to the appropriate resident.

(h) SSI Resource Limit Exceeded. The facility must notify any resident receiving Medicaid benefits whenever his/her account reaches within $200 of the SSI resource limit for one person; and that, if the amount in the account and the value of the resident's non-exempt resources reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI;

(i) Death of Resident. Upon the death of a Medicaid or General Assistance resident with no known surviving spouse, any personal incidental funds held by the facility for the resident must be forwarded to the Department of Human Services, Estate Administration Unit, P.O. Box 14021, Salem, OR 97309, within ten (10) business days of the death of the resident. The facility must maintain documentation of the action taken and the amount of funds conveyed;

(j) Surety Bond. The licensee must purchase a surety bond, or provide self-insurance to assure the security of all personal funds of residents deposited with the facility. The amount of the bond must be sufficient to cover the highest amount of the account with resident funds, plus the petty cash funds, during the previous 12 months.
(3) CHANGE OF OWNERSHIP OR LICENSEE. At the time of a change of ownership or licensee, the new owner or licensee must ensure:

(a) Written Accounting of Funds. Each resident or delegate receives a written accounting of his/her funds held by the facility at the time of the change. A copy of the written accounting for each resident must be provided to the local SPD or Type B AAA.

(b) Resident Wishes Respected. That the wishes of each resident regarding management of facility held funds is determined and documented (see OAR 411-070-0095 for Medicaid clients), and that funds held by the prior owner or licensee are transferred to the new owner or licensee or to another party, designated by the resident.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SDSD 13-1999, f. 12-30-99, cert. ef. 1-1-00; SDSD 9-2001, f. 11-30-01, cert. ef. 12-1-01; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0360

Abuse

(1) ABUSE IS PROHIBITED. The facility employees, agents and licensee must not permit, aid, or engage in abuse of residents under their care.

(2) REPORTERS AND MANDATORY REPORTERS. All persons are encouraged to report abuse and suspected abuse. The following persons are required to immediately report abuse and suspected abuse to The Department or law enforcement agency;

(a) Physicians, including any resident physician or intern;

(b) Licensed practical nurse or registered nurse;

(c) Employee of the Oregon Department of Human Services, Area Agency on Aging, county health department or community mental health program;

(d) Nursing facility employee or any individual who contracts to provide services in a nursing facility;

(e) Peace officer;

(f) Clergy;

(g) Licensed social worker;

(h) Physical, speech or occupational therapist; and

(i) Family member of a resident or guardian or legal counsel for a resident.

(3) FACILITY REPORTING OF ABUSE OR SUSPECTED ABUSE.

(a) The nursing facility administration must immediately notify The Department, local designee of The Department, or local law enforcement agency of any incident of abuse or suspected abuse. Physical injury of an unknown cause must be reported to The Department as suspected abuse, unless an immediate facility investigation reasonably concludes the physical injury is not the result of abuse.

(b) The local law enforcement agency must be called first when the suspected abuse is believed to be a crime (for example; rape; murder, assault, burglary, kidnapping, theft of controlled substances).

(c) The local law enforcement agency must be called if the offices of The Department or designee are closed and there are no arrangements for after hours investigation.

(4) ABUSE COMPLAINT. The oral or written abuse complaint must include the following information when available;

(a) Names, addresses and phone numbers of alleged perpetrator(s), resident(s) and witness(es);
(b) The nature and extent of the abuse or suspected abuse (including any evidence of previous abuse);

(c) Any explanation given for the abuse or suspected abuse; and

(d) Any other information that the person making the report believes might be helpful in establishing the circumstances surrounding the abuse and the identity of the perpetrator.

(5) PRIVILEGE. In the case of abuse of a resident, the physician-patient privilege, the husband-wife privilege, and the privileges extended under ORS 40.225 to 40.295 will not be a ground for excluding evidence regarding the abuse, or the cause thereof, in any judicial proceeding resulting from an abuse complaint made pursuant to this section.

(6) IMMUNITY AND PROHIBITION OF RETALIATION.

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

(b) The facility licensee, employee and agents must not retaliate against any resident who is alleged to be a victim of abuse.

(c) Anyone who, in good faith, reports abuse or suspected abuse will have immunity from any liability that might otherwise be incurred or imposed with respect to the making or content of an abuse complaint. Any such person will have the same immunity with respect to participating in judicial or administrative proceedings relating to the complaint.

(7) INVESTIGATION BY FACILITY. In addition to immediately reporting abuse or suspected abuse to The Department or law enforcement agency, the facility must promptly investigate all reports of abuse and suspected abuse and must take measures necessary to protect residents from abuse and prevent recurrence of abuse.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055, 441.615, 441.630, 441.637, 441.640, 441.645 & 441.655
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

411-085-0370

Confidentiality

This rule applies to facility licensees, employees and agents, to Division staff and the staff of all Area Agencies on Aging.

(1) RESIDENTS. The names of residents and all documentation that would allow the identification of a resident must be kept confidential and are not accessible for public inspection.

(2) COMPLAINANTS, WITNESSES. The names and identity of complainants and witnesses referred to in Division complaint investigations must be kept confidential and are not accessible for public inspection.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.637 & 441.671
Hist.: SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95; SPD 26-2004, f. 7-30-04, cert. ef. 8-1-04

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DEPARTMENT OF HUMAN SERVICES,
SENIORS AND PEOPLE WITH DISABILITIES DIVISION

DIVISION 86

NURSING FACILITIES/LICENSING -- ADMINISTRATION AND SERVICES

411-086-0010

Administrator

(1) Full-Time. Each licensed nursing facility shall be under the supervision of a full-time Oregon licensed nursing home administrator:

(a) In facilities physically connected with an Oregon licensed general hospital, the nursing home administrator shall be considered "full-time" if the administrator works full-time based on time worked in both nursing facility and hospital, and if the administrator is available to the nursing facility staff on a full-time basis;

(b) In facilities with 40 or fewer beds and which admit only residents requiring intermediate care, a person who meets the requirements for both administrator and director of nursing services (DNS) may function simultaneously in both capacities.

(2) Responsibility:

(a) The administrator shall ensure that the facility uses its resources effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident;

(b) The administrator shall comply with the rules of the Board of Examiners of Nursing Home Administrators;

(c) The administrator shall provide a comprehensive review of Division survey reports and inspections to the licensee.

(3) Temporary Absence of Administrator:

(a) The licensee shall designate, by written policy, an individual who is familiar with the operation of the facility to assume administration in the temporary absence of the administrator. If the designee is the DNS, another RN shall assume the DNS' responsibilities for this period;

(b) If the absence of the administrator is to exceed 30 days, the facility must notify the Division and obtain approval for the arrangements prior to the absence. The Division shall determine whether a licensed administrator shall serve in the administrator's absence.

(4) Change of Administrator:

(a) Upon termination of the administrator, the licensee shall immediately replace the administrator with a full-time administrator;

(b) The licensee shall notify the Division and the Board of Examiners of Nursing Home Administrators within seven days from the date the administrator leaves employment of the facility.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Director of Nursing Services (DNS)

(1) Full-Time. Each facility shall have a director of nursing services who shall be full-time (40-hours per week) in a single nursing facility. Time spent in professional association workshops, seminars and continuing education may be counted in considering whether or not the DNS is full-time.

(2) Qualifications. The DNS shall be a registered nurse who has specific knowledge about nursing administration in a nursing facility:

(a) The DNS shall have at least six months experience in a nursing facility, hospital, or inpatient rehabilitation facility;

(b) Within nine months of employment the DNS shall have:

(A) Successfully completed six credit hours in management or supervision, pertinent to long-term care, from an accredited college or university; or

(B) A baccalaureate or master's degree in nursing and documentation of course work which includes management or supervision.

(c) The DNS shall successfully complete every two years at least 30 continuing education hours pertinent to nursing administration in a nursing facility.

(3) Responsibility:

(a) The DNS shall have written administrative authority, responsibility, and accountability for assuring functions and activities of the nursing services department. The DNS shall participate in the development of any facility policies that affect the nursing services department (OAR 411-085-0210). The DNS shall organize and direct the nursing service department to include as a minimum:

(A) Develop and maintain a nursing service philosophy, objectives, standards of practice, policy and procedure manuals, and job descriptions for each level of nursing service personnel;

(B) Develop and maintain personnel policies of recruitment, orientation, in-service education, supervision, evaluation and termination of nursing service staff;

(C) Develop and maintain policies and procedure for determination of nursing staff's capacity for providing nursing care for any person seeking admission to the facility;

(D) Develop and maintain a quality assurance program for nursing services;

(E) Coordinate nursing service departmental functions and activities with the functions and activities of other departments;

(F) Develop nursing service department budget recommendations and participate with the facility administrator and other department directors in the allocation of funds for the facility;

(G) Participate with the facility administrator and other department directors in development and maintenance of practices and procedures that promote infection control, fire safety, and hazard reduction;

(H) Ensure that all medications and treatments are given promptly as ordered;

(I) Ensure that only licensed nurses or physicians administer injectable medications;

(J) Ensure adequate nursing services staffing (see OAR 411-086-0100), including development of a written staffing plan; and

(K) Ensure that all nursing staff perform their respective duties in a timely, efficient and professional manner.

(b) The DNS shall designate, in writing, a specific registered nurse, licensed to practice in Oregon, to be available immediately in person or by telephone to direct the functions and activities of the nursing services department when the DNS is not available in person or by
telephone. This information shall be posted at each nursing station;

(c) The DNS shall be informed regarding residents' conditions, including when a significant change in a resident's condition warrants nursing or medical intervention;

(d) Effective October 1, 1990, or in the event of delay of the actual federal requirement, effective the actual implementation date, the DNS may serve as the charge nurse only if the facility has a licensed bed capacity of 60 or less and does not provide care for residents requiring skilled nursing care.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90

411-086-0030

RN Care Manager

The RN care manager is a registered nurse who is responsible and accountable for managing the nursing care of his/her assigned residents. Each resident shall have an RN care manager responsible for his/her care:

(1) Training:

(a) Within nine months of hire each RN care manager shall have successfully completed three credit hours from an accredited school, or 30 continuing education hours, pertinent to gerontology, rehabilitation, or long-term care;

(b) Within nine months of hire each RN care manager shall have successfully completed three credit hours from an accredited college or university, or 15 continuing education hours, pertinent to management or supervision.

(2) Responsibility:

(a) The RN care manager shall be responsible and accountable for managing the nursing care of his/her assigned residents. The RN care manager shall ensure maximum independence and self-direction for residents;

(b) The RN care manager shall coordinate the nursing functions and tasks for those residents with physicians and other health care providers. The responsible RN care manager shall ensure the nursing plan and resident care plan are developed and documented, and that residents' care needs are met;

(c) Delegated authority:

(A) The RN care manager shall delegate to other licensed personnel only those nursing functions and tasks that the licensee is competent and qualified to perform and that are permitted by ORS Chapter 678;

(B) The RN care manager, or an RN or LPN with delegated authority from the RN care manager, shall ensure that the nursing assistant is assigned and performs only those tasks for which he/she is competent and qualified to perform and that are permitted by ORS Chapter 678.

(3) Documentation. The name of the responsible RN care manager shall be documented in each resident's clinical record.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90

411-086-0040

Admission of Residents

(1) Admission Conditions:

(a) The facility shall not accept or retain residents whose care needs cannot be met by the facility;
(b) No person shall be admitted to the facility except on the order of a physician;

(c) Admission medical information shall include a statement concerning the diagnosis and general condition of the resident, a medical history and physical, or a medical summary. Other pertinent medical information, orders for medication, diet, and treatments shall also be provided;

(d) No resident shall be admitted to a bed in any location other than those locations shown in the most recent floor plan filed with the Division and under which the license was issued;

(e) No facility shall admit an individual who is mentally ill or mentally retarded unless the Division or local representative thereof has determined that such placement is appropriate.

(2) Admission Status, Preliminary Care Plan, Preliminary Nursing Assessment:

(a) A licensed nurse shall document the admission status of the resident within eight hours, including but not limited to skin condition, nutritional status, hydration status, mental status, vital signs, mobility, and ability to perform ADLs. This review of resident status shall be sufficient to ensure that the immediate needs of the resident are met;

(b) A licensed nurse shall develop a preliminary resident care plan within 24 hours of admission. Staff providing care for the resident shall have access to, be familiar with, and follow this plan;

(c) Social services shall be provided to the resident in accordance with the preliminary resident care plan not later than three days after admission;

(d) A registered nurse shall complete and document a comprehensive nursing assessment within 14 days of admission;

(e) A resident care plan shall be completed pursuant to OAR 411-086-0060.

(3) Directives for Medical Treatment. Each resident shall be provided the following information and materials in written form within five days of admission, but in any event before discharge:

(a) A copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1991, by the Oregon State Bar Health Law Section, which summarizes the rights of individuals to make health care decisions, including the right to accept or refuse any treatment or medication and the right to execute directives and powers of attorney for health care;

(b) Information on the facility's policies with respect to implementation of those rights;

(c) A copy of the Advance Directive form set forth in ORS 127.531 and a copy of the Power of Attorney for Health Care form set forth in ORS 127.610, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form"; and

(d) The name and location of a person who can provide additional information concerning the forms for directives and powers of attorney for health care.

(4) Contracts, Agreements. Contracts, agreements and all other documents provided to, or required to be signed by, the resident shall not misrepresent or be inconsistent with the requirements of Oregon law. See OAR 411-085-0300 - 411-085-0350.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-086-0050

Admission of Day Care Residents

Day care residents may be admitted to the facility only if the facility has written approval from the Division to admit day care residents, the facility is in compliance with OAR 411, divisions 85-89, and provided admittance does not interfere with care needs of other residents.
care residents are considered "residents" for the purpose of OAR 411, divisions 85-89, unless specifically stated otherwise:

(1) Application. Application for permission to accept day care residents shall be made to the Division on a form provided by the Division.

(2) Physical Environment:

(a) The number of day care residents shall not exceed one for every 40 square feet of floor space available for use by day care residents;

(b) Provision shall be made for dining, such as tray service or dining area. Day care residents shall be served meals at the same times as other residents;

(c) Each day care resident shall have either an unassigned bed or a folding cot in an area where rest and privacy can be provided;

(d) There shall be one toilet and one lavatory available to every 15 day care residents. Such facilities shall be in close proximity to the area used by day care residents;

(e) All space required for day care residents shall be in addition to space required for other residents.

(3) Physician. Day care residents shall be under the care of a licensed physician. The physician shall provide the facility with a statement on admission concerning the diagnosis and general condition of the resident and with orders for prescribed care.

(4) Medications. Day care residents taking medication prescribed by their physicians may bring such medication in the original containers to the facility.

(5) Activities. The day care resident shall be encouraged to participate in a program of activities which are suitable to the needs and interests of the day care resident, and which promote learning by and independence of the resident.

(6) Care Plan. Each day care resident shall have a preliminary care plan which includes a nursing assessment and addresses dietary needs/restictions and activities.

(7) Documentation:

(a) There shall be available for each day care resident an admission summary sheet including resident's name, address, telephone number, sex, social security number; name, address, and telephone number of nearest relative or personal representative and attending physician;

(b) There shall be available for each day resident a medication sheet including date, time, dosage, method of administration, and any reaction to a medication. Such medication sheet shall be signed by the nursing personnel administering the medication.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90

411-086-0060

Comprehensive Assessment and Care Plan

(1) Comprehensive Assessment:

(a) An RN shall ensure completion and documentation of a comprehensive assessment of the resident's capabilities and needs for nursing services within 14 days of admission. Comprehensive assessments shall be updated promptly after any significant change of condition and reviewed no less often than quarterly. This assessment shall be on a form specified by the Division. The assessment shall include the following:

(A) Medically defined conditions and medical history;

(B) Medical status measurement;

(C) Functional status;

(D) Sensory and physical impairments;
Nutritional status and requirements;

Treatments and procedures;

Psychosocial status (see OAR 411-086-0240);

Discharge potential (see OAR 411-086-0160);

Dental condition;

Activities potential (see OAR 411-086-0230);

Rehabilitation and restorative potential (see OAR 411-086-0150 and 411-086-0220);

Cognitive status; and

Drug therapy.

Social services, activities and dietary personnel shall complete an assessment within 14 days of admission.

Care Plan Preparation and Implementation. The facility, through the nursing services department and the interdisciplinary staff, shall provide services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written, dated, care plan:

The plan shall be completed within seven days after completion of the comprehensive assessment. The care plan shall be reviewed and updated whenever the resident's needs change, but no less often than quarterly;

The care plan shall describe the medical, nursing, and psychosocial needs of the resident and how the facility will actively meet those needs. This description of needs shall include measurable objectives and time frames in which the objectives will be met;

The plan shall provide for and promote personal choice and independence of the resident;

The plan shall be reviewed and completed at an interdisciplinary care planning conference with participation from the resident's RN care manager and personnel from dietary, activities and social services. The resident's attending physician will participate in the development and any revision of the care plan. Physician participation may be in person, through communication with the DNS or RN Care Manager, or via telephone conference;

The resident, the resident's legal representative, and anyone designated by the resident shall be requested to participate. The request shall be documented in the resident's clinical record;

The plan shall be prepared and implemented with participation of the resident and in accordance with the resident's wishes;

The plan shall include an assessment of the resident's potential for discharge and the facility's efforts to work toward discharge;

The plan shall be available to and followed by all staff involved with care of the resident.

Documentation:

The care plan shall be written in ink and made a part of the resident's clinical record;

Participation in development of the care plan by interdisciplinary staff will be clearly documented.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 24-1990(Temp), f. 12-31-90, cert. ef. 1-1-91; SSD 10-1991, f. & cert. ef. 5-1-91; SSD 8-1993, f. & cert. ef. 10-1-93
(1) STAFFING PLAN.

(a) The facility must have and implement a written plan that:

(A) Ensures staffing sufficient to meet the minimum staffing requirements described in sections (3), (4) and (5) of this rule;

(B) Ensures staffing sufficient to meet the needs of each resident; and

(C) Identifies procedures to obtain required staff when absences occur.

(b) The facility must maintain a written, weekly staffing schedule showing the number and category of staff assigned to each shift and the person to be called in the event of any absence.

(2) DAILY STAFF PUBLIC POSTING.

(a) The facility must have the number of on-duty nursing staff publicly posted 24 hours each day using form SDS 0717.

(A) The posted report must be prominently displayed in a public area, readily accessible to residents and visitors, as described in OAR 411-085-0030(1)(b).

(B) The posted report must be at least 8.5 x 14 inches and printed in a minimum font size of 16.

(C) The staffing information must be an accurate reflection of the actual staff working each shift.

(b) The posted staffing report must include:

(A) Facility name;

(B) Current date;

(C) Current resident census per shift;

(D) The total number and actual hours worked by registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (CNAs and NAs) directly responsible for resident services per shift; and

(E) The minimum staffing standard, nursing assistant to resident ratio, referenced at section (5)(c) of this rule.

(c) The facility must, upon oral or written request, make direct care staffing data available to the public for review at a cost not to exceed the community standard.

(d) The facility must maintain the posted nurse staffing data for a minimum of 18 months.

(3) MINIMUM STAFFING, GENERALLY. Resident service needs must be the primary consideration in determining the number and categories of nursing personnel needed. Nursing staff must be sufficient in quantity and quality to provide nursing services for each resident as needed, including restorative services that enable each resident to achieve and maintain the highest practicable degree of function, self-care and independence, as determined by the resident’s care plan. Such staffing must be provided even though it exceeds other requirements specified by this rule or specified in any waiver.

(4) MINIMUM LICENSED NURSE STAFFING.

(a) Licensed nurse hours must include no less than one RN hour per resident per week.

(b) When a RN serves as the administrator in the temporary absence of the administrator, the RN’s hours must not be used to meet minimum nursing hours.

(c) In facilities with 41 or more beds, the hours of a licensed nurse who serves as facility administrator must not be included in any licensed nurse coverage required by this rule.

(d) The licensed nurse serving as a charge nurse must not be counted toward the minimum staffing requirement under section (5)(c) of this rule.
(e) The facility must have a licensed charge nurse on each shift, 24 hours per day.

(A) A RN must serve as the licensed charge nurse for no less than eight consecutive hours between the start of day shift and the end of evening shift, seven days a week.

(B) The Director of Nursing Services may serve as the charge nurse only when the facility has 60 or fewer residents.

(C) Section (4)(e) of this rule may be waived by the Seniors and People with Disabilities Division (SPD). The request for waiver must comply with OAR 411-085-0040 and must be reviewed annually. This waiver shall be considered by SPD if the facility certifies that:

(i) It has been unable to recruit appropriate personnel despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities);

(ii) The waiver must not endanger the health or safety of residents; and

(iii) A RN or physician is available and obligated to immediately respond to telephone calls from the facility.

(5) MINIMUM CERTIFIED NURSING ASSISTANT STAFFING.

(a) The facility must determine the specific time frame for beginning and ending each consecutive eight-hour shift using one of the following options:

(A) Option 1.

(i) Day shift from 5:30 a.m. to 1:30 p.m.

(ii) Swing shift from 1:30 p.m. to 9:30 p.m.

(iii) Night shift from 9:30 p.m. to 5:30 a.m.

(B) Option 2.

(i) Day shift from 6 a.m. to 2 p.m.

(ii) Swing shift from 2 p.m. to 10 p.m.

(iii) Night shift from 10 p.m. to 6 a.m.

(C) Option 3.

(i) Day shift from 6:30 a.m. to 2:30 p.m.

(ii) Swing shift from 2:30 p.m. to 10:30 p.m.

(iii) Night shift from 10:30 p.m. to 6:30 a.m.

(D) Option 4.

(i) Day shift from 7 a.m. to 3 p.m.

(ii) Swing shift from 3 p.m. to 11 p.m.

(iii) Night shift from 11 p.m. to 7 a.m.

(b) Each resident must have assigned and be informed of the nursing assistant responsible for his or her care and services on each shift. The numbers listed in this rule represent the minimum staffing requirement. The numbers do not represent sufficient nursing staff. The number of staff necessary to meet the needs of each resident determines sufficient nursing staff.

(c) The number of residents per nursing assistant must not exceed the ratios:

(A) Beginning March 1, 2008:
(i) DAY SHIFT: 1 nursing assistant per 8 residents.
(ii) SWING SHIFT: 1 nursing assistant per 12 residents.
(iii) NIGHT SHIFT: 1 nursing assistant per 20 residents.

(B) Beginning April 1, 2009:
(i) DAY SHIFT: 1 nursing assistant per 7 residents.
(ii) SWING SHIFT: 1 nursing assistant per 11 residents.
(iii) NIGHT SHIFT: 1 nursing assistant per 18 residents.

(d) Each facility must submit a quarterly staffing report to SPD, using a SPD approved method and format. The report must provide an accurate daily account of resident census and nursing assistant staffing levels for each shift.

(A) The facility must submit the report to SPD no later than the end of the month immediately following the end of each calendar quarter. (Example: For the calendar quarter ending March 31, the report must be received no later than April 30.)

(B) The report must specify the shifts in which the minimum staffing standards, as set forth in section (5)(c) of this rule, were not met.

(C) The facility must provide documents to support the quarterly staffing report, including payroll records, upon request of SPD.

(e) This rule does not prohibit nursing assistants from providing services to a resident to whom they are not assigned.

(f) The facility must ensure that nursing assistants only perform those tasks for which they are competent and qualified to perform and that are permitted by ORS Chapter 678 and OAR 851-063-0030.

(g) Nursing assistants with a restricted duty status may be counted toward meeting the minimum staffing ratio, as set forth in section (5)(c) of this rule, if the nursing assistant is able to perform 90 percent of the authorized duties and responsibilities, with or without accommodation, required by a certified nursing assistant as determined by the Oregon State Board of Nursing (OAR 851-063-0030(1)(a)(A) through OAR 851-063-0030(1)(g)(H)).

(h) The facility must ensure that nursing assistants are not assigned more residents than the number for which they can meet the individual service needs.

(i) The facility must have a minimum of two nursing staff on duty within the facility at all times.

(j) Nursing staff must be present at all times, in each detached building, distinct and segregated area, including those separated by closed doors, and on each level or floor where residents are housed.

(k) Nursing assistants do not include dining assistants.

(l) Effective September 1, 2008, nursing assistants serving as restorative aides must not be counted toward the minimum staffing requirement under section (5)(c) of this rule.

(m) A facility cannot employ any person as a nursing assistant for longer than four months from the date of hire, without an Oregon State Board of Nursing issued CNA 1 certification.

(n) The facility must ensure no more than 25 percent of the nursing assistants assigned to residents per shift, pursuant to section (5)(c) of this rule, are uncertified nursing assistants.

(6) CERTIFIED MEDICATION AIDES.

(a) The facility must ensure that all nursing assistants administering non-injectable medications are certified as nursing assistants and as medication aides. Documentation of these two certifications must be maintained in the facility.

(b) The certified medication aide assigned to administer medications must not be counted toward meeting the minimum staffing requirements for direct service of residents, referenced at section (5)(c) of this rule.
Nursing Services: Resident Care

(1) Nursing Services Generally. Nursing services staff shall provide and document nursing services for each resident. Nursing staff shall provide services to attain and maintain the highest practicable physical, mental and psychosocial well-being, independence, self-direction, and self-care of each resident, including:

(a) Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including removal or shaving of hair in accordance with resident wishes, and prompt assistance with toileting needs and care for incontinence;

(b) Good body alignment and adequate exercise or range-of-motion, including, when practicable, ambulation;

(c) Adequate fluid and nutritional intake:

(A) Assistance or supervision with eating and drinking shall be provided as required;

(B) Fluids shall be offered at least three times a day (in addition to meal times) to residents who are unable to help themselves; and

(C) Weigh each resident on admission and quarterly thereafter or more often if resident's condition warrants it.

(d) Adequate sleep and rest;

(e) Oral hygiene;

(f) Bowel and bladder evacuation and continence;

(g) Optimal freedom from pain; and

(h) Resident ability to:

(A) Dress, bathe and groom;

(B) Transfer and ambulate;

(C) Appropriately interact with others; and

(D) Effective October 1, 1990, or in the event of delay of the federal requirement, effective the actual federal implementation date, self-medicate based on nursing and physician assessment and provision of instruction to the resident if necessary.

(2) Coordination of Services. The DNS and RN care manager shall coordinate the provision of nursing services for the resident with other disciplines and providers. The DNS and RN care manager shall ensure provision and documentation of resident care interventions prescribed by other health care professionals, including timely medications and treatments ordered by the resident's physician.

(3) Questionable Care. When any RN questions the efficacy, need or safety of medications or treatments, the RN shall report that question to the attending physician or nurse practitioner. The RN shall seek and document instructions received and all actions taken to ensure problem resolution.

(4) Standards of Practice. Nursing care staff shall provide nursing services in accordance with the Oregon Nurse Practice Act (ORS Chapter 678).

(5) Documentation. Licensed nursing staff shall evaluate and accurately document in the clinical record the effectiveness of services provided to the resident, including required preventive care, at least quarterly.
Nursing Services: Changes of Condition

(1) Change of Condition (Generally). Nursing staff shall observe, assess, document, and report to the DNS and the resident's physician any significant change in resident condition that warrants medical or nursing intervention, including any significant change in:

(a) Vital signs;
(b) Skin integrity (i.e., decubitus ulcer);
(c) Hydration;
(d) Ability to take or retain food or fluids;
(e) Weight gain/loss;
(f) Bowel or bladder function;
(g) Behavior;
(h) Level of comfort (i.e., pain, injury); or
(i) Level of consciousness.

(2) Acute Condition Change. The nursing staff shall ensure that any significant and acute condition change is promptly assessed and documented by a registered nurse and that appropriate measures are immediately instituted.

(3) Documentation. Documentation shall include assessment, appropriate interventions, monitoring and outcome until point of resolution.

Nursing Services: Notification

(1) Notification of Significant Other(s). The nursing care staff or other designated staff shall notify the resident's significant others as soon as possible whenever:

(a) The resident has had a change of physical, mental or psychosocial status, including death or accident resulting in injury, or change in type of care needed;
(b) The resident has wandered from the facility.

(2) Notification of Division. The nursing care staff shall notify the Division of any situation in which the health or safety of the resident(s) was/is endangered such as:

(a) Suspected abuse;
(b) Fire;
(c) Lost resident;
(d) Accidental or unusual death.

(3) Notification of Physician. The nursing care staff shall notify the resident's physician of possible changes in the type of care the resident
needs and document such notification in the resident's clinical record. Such notification shall be timely. The physician's determination shall be documented in the resident's clinical record.

NOTE: See requirements for physician visits under OAR 411-086-0200.

(4) Documentation. The nursing care staff, except as provided by section (3) of this rule, shall document all notification/consultation required by this rule in the resident's clinical record.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, § 8-29-90, cert. ef. 10-1-90

411-086-0140

Nursing Services: Problem Resolution and Preventive Care

(1) Problem Resolution and Prevention:

(a) Conditions to be Prevented. The licensee shall take all reasonable measures consistent with resident choice to resolve and to prevent undesirable conditions such as:

(A) Decubitus ulcers and other skin breakdowns;

(B) Loss of mobility, or development of contractures or foot drop;

(C) Dehydration;

(D) Impaction;

(E) Infections;

(F) Weight loss/gain;

(G) Loss of range of motion;

(H) Loss of bowel and bladder control; and

(I) Loss of self-esteem or dignity.

(b) Reasonable Measures. Reasonable measures which are required to be taken include, but are not limited to:

(A) Assessment of residents who are at risk;

(B) Implementation of preventive measures; and

(C) Reassessment and modification of treatment program when the program implemented is not effective.

(2) Safe Environment. The licensee shall ensure the provision of a safe environment to protect residents from injury. Actions taken by the facility staff shall be consistent with each resident's right to fully participate in his or her own care planning and shall not limit any resident's ability to care for himself/herself:

(a) Dangerous Conditions. The licensee shall take all reasonable precautions to protect a resident from possible injury from dangerous conditions;

(b) Falling, Wandering, Negligence. The licensee shall take all reasonable precautions to protect a resident from possible injury from falling, wandering, other resident(s), staff and staff negligence;

(c) Reasonable Precautions. Reasonable precautions include, but are not limited to, provision and documentation of an assessment and evaluation of resident's condition, medications, and treatments, and completion of a care plan, consistent with OAR 411-086-0060; and, when appropriate:
(A) Physician notification;

(B) Provision of additional inservice training; and/or

(C) Evaluation/adjustment of staffing patterns and supervision.

(d) The licensee shall take all reasonable precautions to protect a resident from dangerous conditions relating to remodeling or construction.

(3) Restraints. The licensee shall ensure that, except when required in an emergency, physical and chemical restraints are only applied in accordance with the resident's care plan. Restraints may be used only to ensure the physical safety of the resident or other residents:

(a) Freedom of Choice. When restraints are considered in the interdisciplinary care planning conference to reduce the risk of injury related to falls, the resident or his/her legal guardian or person acting under the resident's power of attorney for health care must be informed of the potential risks of falling and the risks associated with restraints;

(b) Physician Orders Required. Except as provided in subsection (3)(c) of this rule, physical and chemical restraints may be applied only when a physician orders restraints. An order for restraints must clearly identify the reason for the restraints and the duration and circumstances under which they are to be applied;

(c) Emergencies. In an emergency situation, a registered nurse may use physical restraints without physician orders if necessary to prevent injury to the resident or to other residents and when alternative measures do not work. If restraints are used in an emergency situation, the registered nurse shall document in the resident's clinical record the use of restraints and what alternative measures did not work. A licensed nurse shall contact the physician for restraint orders within 12 hours of application;

(d) Re-evaluation. Whenever restraints are used, circumstances requiring the restraints and the need must be continually re-evaluated and documented in the clinical record;

(e) Staff Convenience/Discipline. Restraints shall not be used for discipline or staff convenience;

(f) Periodic Release. Residents who are physically restrained must have the restraints released at least every two hours for a minimum of ten minutes and be repositioned, exercised or provided range of motion during this period;

(g) Toileting. Toileting and incontinence care shall be provided when necessary;

(h) Quick Release. All physical restraints must allow for quick release. Locked restraints may not be used;

(i) Fixed Objects. Residents shall not be physically restrained to a fixed object.

(4) Documentation. All preventive measures taken by the facility staff shall be clearly documented. Such documentation shall include assessment of resident(s) at risk, preventive measures taken, results and evaluation of measures taken, and revision of measures as appropriate.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93

411-086-0150

Nursing Services: Restorative Care

(1) Restorative Program. Nursing services staff shall provide a restorative program which re-establishes and maintains to the greatest extent practical the functional abilities of residents. Such functional abilities shall include but not be limited by the abilities identified in OAR 411-086-0110(1). The facility shall have written policies governing the provision and documentation of restorative services pursuant to OAR 411-085-0210.

(2) Director. The Director of Nursing Services or his/her designee shall ensure the development and implementation of an effective restorative services program.

(3) Staffing. Restorative services shall be provided by facility nursing staff in accordance with the resident's care plan.
411-086-0160

Nursing Services: Discharge Summary

(1) Discharge Summary Required. A discharge summary shall be completed for each resident before discharge.

(2) Contents. The discharge summary shall include:

(a) A recapitulation of the resident's stay;

(b) A final summary of the resident's status, including the most recent nursing assessment as defined in OAR 411-086-0060; and

(c) A post-discharge plan of care developed in accordance with OAR 411-086-0060 which will assist the resident to adjust to his/her new living environment. A post-discharge plan is not required when the resident is discharged to acute care or to the morgue.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93

411-086-0200

Physician Services

(1) MEDICAL DIRECTOR. Each nursing facility shall have a physician medical director designated in writing. The medical director shall:

(a) Serve on the Quality Assessment and Assurance Committee;

(b) Assist the facility to assure that adequate medical care is provided on a timely basis in accordance with OAR 411-085-0210 (Facility Policies); and

(c) Serve as attending physician for those residents who are not able to obtain services of another physician or ensure another physician is available to serve as attending physician.

(2) ATTENDING PHYSICIAN. Each resident shall be under the care of a physician who is responsible for the resident's medical care.

(a) Physician Assistant. The physician may delegate tasks to a physician assistant pursuant to ORS chapter 677 and rules adopted by the Board of Medical Examiners. The physician assistant must be under the direction and supervision of the resident's physician.

(b) Nurse Practitioner. The physician may delegate tasks to a nurse practitioner pursuant to ORS Chapter 678 and the rules adopted by the Oregon State Board of Nursing.

(c) Clinical Nurse Specialist in Gerontological Nursing. The physician may delegate responsibilities identified in section (4)(a) of this rule to a registered nurse who is certified by the American Nurses Association's Credentialing Center as a "Clinical Specialist in Gerontological...
Nursing." The specific tasks which may be delegated to the clinical nurse specialist are governed by the scope of practice as specified by the Oregon State Board of Nursing.

(d) Delegation.

(A) Except as provided in section (4) of this rule, a physician may delegate tasks to a physician assistant, nurse practitioner or clinical nurse specialist who is acting within the scope of practice as defined by Oregon law and who is under the supervision of a physician.

EXCEPTION: A physician may not delegate a task in a Medicare-certified facility when federal regulations specify the physician must perform it personally.

(B) The physician assistant, nurse practitioner or clinical nurse specialist substituting for physician visits as described in section (4)(a) of this rule may not be an employee of the nursing facility.

(3) MEDICATIONS AND TREATMENTS.

(a) Authorization. Physician's orders shall either be initially written and signed by the physician, nurse practitioner (NP) or physician assistant (PA), or given verbally or by telephone. If given verbally or by telephone, the orders shall be accepted only by a licensed nurse and must be written and mailed to the physician, NP or PA within 72 hours to be signed and returned to the facility for filing in the resident's chart.

(b) Promptly Carried Out. All physician orders shall be promptly carried out unless inconsistent with the resident's expressed wishes.

(c) Orders Required. Medications and treatments shall be administered only on the order of a physician or a designee pursuant to ORS Chapters 677, 678, and 679.

(d) Standing Orders. Therapies and drugs not requiring prescription under ORS Chapter 689 may be ordered from standing orders of the attending physician, NP or PA. Therapies and drugs so ordered shall be reviewed and signed at least annually by the attending physician. Use of standing orders shall be authorized by licensed personnel and transcribed to the physician order form.

(4) PHYSICIAN VISITS.

(a) Frequency. Physician visits shall be according to resident's needs. The physician shall comply with Medicare or Medicaid requirements when applicable. Physician visits shall conform to the following schedule.

(A) Medicare Covered Stay. When Medicare is the primary payor source for a resident's stay, the resident must be seen by the physician at least every 30 days for the first 90 days after admission, then every 60 days thereafter. If authorized by the physician, every other visit after the first visit may be conducted by a physician's assistant, a clinical nurse specialist as specified in section (2) of this rule, or nurse practitioner.

(B) Medicare and/or Medicaid Certified Facilities. For residents in facilities which are certified for Medicare and/or Medicaid, and Medicare is not the primary payor source, each resident must be seen by the physician at least every 30 days for the first 90 days after admission, then every 60 days thereafter. If authorized by the physician, all visits may be conducted by a physician's assistant, a clinical nurse specialist as specified in section (2) of this rule, or nurse practitioner.

(C) Licensed Only Facilities. For residents in all facilities which are not certified for either Medicaid or Medicare, each resident shall be visited by the physician every 30 days for the first 90 days, then every 180 days thereafter. If authorized by the physician, all visits may be conducted by a physician's assistant, a clinical nurse specialist as specified in section (2) of this rule, or nurse practitioner.

(D) Timely Visit. A visit required pursuant to sections (4)(a)(A), (B), or (C) of this rule will be considered "timely" if it occurs not later than ten days after the date the visit was required.

(b) Assessments, Observation. The facility shall ensure a physician's assessment and determination of type of care needed is performed for each resident. The results and observations shall be recorded in the physician's progress notes at time of admission and at least annually thereafter.

(c) Policies. The facility shall establish policies to assure physician services are provided in all cases when the attending physician or the attending physician's alternate cannot or does not respond to the resident's needs.
(d) Failure to Visit. If the physician or physician designee fails to visit the resident according to resident's need, fails to respond to requests for assistance in resident's care, or fails to return verbal or telephone orders reduced to writing and forwarded to the physician by the facility, then the facility administrator shall ensure:

(A) Reasonable and repeated attempts are made and documented in the clinical record to get the physician or physician designee to visit resident or return signed orders;

(B) The medical director is notified and the Quality Assessment and Assurance Committee reviews the situation;

(C) The County Medical Society, State Medical Society, and the Board of Medical Examiners are notified in writing of the problem;

(D) The Seniors and People with Disabilities Division is notified in writing of the physician's failure to visit resident(s) or complete progress notes or signed orders; and

(E) The resident and the resident's significant other(s) are notified.

(e) Emergency Backup. Each facility shall provide for one or more physicians to be called in the event of a medical emergency. The names and telephone numbers of such physicians shall be posted at each nurses' station.

(5) DOCUMENTATION. All physician orders, physician visits, and responses thereto shall be promptly documented in the resident's clinical record.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 11-1992, f. 10-30-92, cert. ef. 11-1-92; SPD 3-2008, f. & cert. ef. 3-6-08

411-086-0210

Dental Services

(1) Consulting Dentist. The facility shall have an consulting dentist who shall:

(a) Participate in the development of written policies and procedures for routine dental care, dental emergencies, and oral hygiene (OAR 411-085-0210);

(b) Be available in case of a dental emergency or arrange for another dentist to be available;

(c) Recommend procedures for oral health inservice training. This training shall be provided to appropriate staff at least annually; and

(d) Instruct or arrange for a dental hygienist to instruct registered nurses on the facility staff in how to perform oral screenings.

(2) Physician Participation. The dentist's written treatment orders shall be followed upon documented verbal approval of the attending physician.

(3) Dentures Marked. The facility shall cause the resident's dentures to be marked for identification.

(4) Documentation. Oral and dental care services shall be documented in the resident's clinical record.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90

411-086-0220

Rehabilitative Services

(1) Rehabilitation Program. The facility shall provide rehabilitative services, when applicable, which re-establishes and maintains to the greatest extent practical the functional abilities of residents. The facility shall have written policies governing the provision and documentation of rehabilitative services pursuant to OAR 411-085-0210.
(2) Director. The Director of Nursing Services or his/her designee shall ensure the development and implementation of an effective rehabilitation services program when applicable.

(3) Staffing. When a resident requires rehabilitative services, the services shall be ordered by the attending physician and provided or supervised by personnel qualified under state law to provide that service.

(4) Rehabilitation Plan. Each resident shall have a rehabilitation plan based on an assessment of resident's needs and delivered in accordance with the resident care plan:

(a) The rehabilitation plan shall be implemented within seven days of admission;

(b) The rehabilitation plan shall be reviewed and updated as frequently as the resident's condition changes, but no less often than quarterly.

(5) Documentation. All rehabilitative services provided and results of those services shall be clearly documented in the resident's clinical record. Progress notes relevant to the plan shall be documented in the resident's clinical record as frequently as the resident's condition or ability changes, but no less often than quarterly.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f 8-29-90, cert. ef. 10-1-90

411-086-0230

Activity Services

(1) Activity Program. The facility shall have an activity program available to all residents which encourages each resident to maintain normal activity and to return to self-care. The program shall address the intellectual, social, spiritual, creative, and physical need(s), capabilities, and interests of each resident, and shall encourage resident self-direction:

(a) The program shall encourage involvement and allow each resident to attain and maintain function at his/her highest practical level, and shall include both group and individual activities;

(b) Residents and staff will be informed of scheduled activities;

(c) The program shall include activities meaningful to the residents at least six days per week including:

(A) Gross motor activities (e.g., exercise, dancing, gardening, crafts);

(B) Individual self-care activities designed to enhance personal responsibility and choice (e.g., dressing, personal hygiene);

(C) Social activities (e.g., games, outside activities, field trips); and

(D) Sensory enhancement activities (e.g., pictures, music, olfactory and tactile stimulation, reminiscing, pet therapy).

(d) The facility shall provide equipment, supplies and space to meet individual and group activity needs.

(2) Activity Director. The facility shall employ an Activity Director. He/she shall have a written job description which identifies the duties and responsibilities of the position, including the requirements set forth by this rule:

(a) Qualifications. The Director shall meet one of the following:

(A) Have two years experience in a social or recreational program within the past five years, one of which was full-time in a patient activities program in a health care setting; or

(B) Be eligible for certification as a therapeutic recreation specialist by a recognized accrediting body; or

(C) Be a qualified occupational therapist or occupational therapy assistant; or

(D) Have completed a 36-hour activities workshop. The workshop must be conducted by an individual with a master's or bachelor's degree in recreation therapy or a closely related field, or by a registered occupational therapist. Such individual must have at least one year
of experience in long-term care services. The course must cover the subject matters identified in Exhibit 1, which is attached to and made a part of these rules.

(b) Responsibilities. The Director shall:

(A) Ensure the provision of an activities program as required by this rule and adherence to facility policy (OAR 411-085-0210);

(B) Plan and participate in activities inservice required by OAR 411-086-0310.

(3) Staffing. The facility shall have adequate staffing to carry out the activity program.

(4) Activities Plan. Each resident shall have an activities plan for independent and group activities which is incorporated into the comprehensive care plan. The plan shall include, but not be limited to, past and current interests and activities, skills, medical limitations, and cognitive and emotional functioning:

(a) Activity services shall be available to the resident in accordance with the preliminary resident care plan not later than 24 hours after admission;

(b) The activities plan shall be reviewed and updated as frequently as the resident's condition or needs change, but no less often than quarterly;

(c) The clinical record shall contain written instructions or orders from the resident's attending physician stating the level of activity allowed and any activity restrictions.

(5) Documentation:

(a) The involvement of each resident shall be documented in the resident's clinical record, including the type of activity and the degree of participation;

(b) Progress notes relevant to the activities plan shall be documented in the resident's clinical record as frequently as the resident's condition changes, but no less often than quarterly.

[ED NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93

411-086-0240

Social Services

(1) Social Services Program. A social services program shall be provided which identifies, attains and maintains the highest practicable physical, mental and psychosocial well-being of each resident:

(a) The program shall assist facility staff, family and friends of the resident to help meet the resident's personal and emotional needs;

(b) The facility shall provide space and furnishings for social services which are readily accessible and assure privacy for interviewing, counseling and telephone conversations.

(2) Social Services Director. The facility shall employ a Social Services Director. The Director shall have a written job description which identifies the duties and responsibilities of the position and includes the requirements to be met by this rule:

(a) Qualifications. The Social Services Director shall:

(A) Have a bachelor's or master's degree in behavioral sciences (e.g., human development, psychology, sociology or counseling) with at least one year's experience in a health care setting; or

(B) An associate degree in behavioral sciences with two years' experience in a health care setting; or


(C) Receive regular on-site consultation, no less often than quarterly, from an individual who has a bachelor's or master's degree in social work or a related behavioral science, and one year's experience in a long-term care setting working directly with individual residents, and have written procedures for referring residents in need of social services to appropriate resources;

(D) The Social Services Director of a facility with more than 120 beds shall be full-time and shall meet the requirements in either paragraph (2)(a)(A) or (B) of this rule.

(b) Responsibilities. The Social Services Director shall:

(A) Interview residents and family;

(B) Assess the psychosocial and emotional needs of the residents;

(C) Participate in resident care planning conferences and social service inservices for facility staff;

(D) Identify and document changes in affect, behavior and personality;

(E) Maintain liaison with community agencies and ensure needed ancillary services are available and provided when requested;

(F) Help ensure that the resident's rights are provided and protected;

(G) Make referrals as needed and document outcomes;

(H) Plan and participate in facility inservice required by OAR 411-086-0310; and

(I) Prepare for resident's discharge as appropriate:

(i) The social services program staff shall educate the resident and the resident's significant others regarding the resident's rights, the resident's potential for discharge and the availability of alternate living services;

(ii) The social services staff shall assess the resident's potential for discharge and the availability of alternate living services no less often than quarterly;

(iii) The social services staff shall assist with the development and coordination of services required to effect the resident's discharge.

(J) Assist the resident in obtaining appropriate prosthetics that will allow for resident's optimal functioning and quality of life.

(3) Staffing. The facility shall have adequate staffing to carry out the social services program in accordance with facility policy (OAR 411-085-0210).

(4) Social Services Plan. Each resident shall have a social services plan incorporated into the comprehensive care plan based on the psychosocial and comprehensive assessments. The social services plan shall be reviewed and updated as frequently as the resident's condition changes, but no less often than quarterly.

(5) Documentation. Progress notes relevant to the plan shall be documented in the clinical record as frequently as the resident's condition changes, but no less often than quarterly.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93

411-086-0250

Dietary Services

(1) DIETARY SERVICES DEPARTMENT. The facility shall have a dietary services department which complies with the Food Sanitation Rules, OAR chapter 333, division 150.

(a) Admittance to the kitchen shall be restricted to those who must enter to perform their duties, to government inspectors, or for peer review.
(b) Written procedures for cleaning equipment and work areas shall be prepared and enforced.

(c) Foods shall be protected from contamination during transportation.

(d) There shall be a minimum of one week supply of staple foods and two-day supply of perishable foods on the premises.

(2) DIETARY SERVICES DIRECTOR.

(a) Qualifications. Overall supervision of the dietary service shall be assigned to a full-time dietary service director who is a registered dietician, or:

(A) Is a graduate of a dietetic technician training program (correspondence or classroom) approved by the American Dietetic Association or dietary management training approved by the American Dietary Manager Association; and

(B) Has on-site consultation provided at least monthly.

(i) The consultant shall be a registered dietician or a person with a baccalaureate degree or higher with major studies in food, nutrition, diet therapy, or food service management.

(ii) The consultant shall have at least one year of supervisory experience in an institutional dietary service and shall participate in continuing education annually.

(iii) The visits of the consultant shall be of sufficient duration to review dietary systems and assure quality food to the resident.

(b) Responsibilities. The dietary services director has responsibility, with guidance from the consultant if the director is not a registered dietician, for:

(A) Orientation, work assignments, supervision of work, and food handling technique for dietary service staff. The director shall assure that employees who have or exhibit signs of a communicable disease do not remain on duty;

(B) Participation in regularly scheduled conferences with the administrator and department heads and in the development of dietary policy (OAR 411-085-0210), procedures, and staff development programs; and

(C) Menu planning, recommending and/or ordering food and supplies to be purchased, and record-keeping.

(3) STAFFING. The facility shall employ supportive personnel to carry out functions of the dietary service. There shall be food service personnel on duty at least 12 consecutive hours each day.

(4) DIETS AND MENUS.

(a) Diets shall be prescribed by the attending physician. Therapeutic menus shall be prepared and served as ordered.

(b) A diet manual, approved by a dietitian, shall be readily available to the attending physician, nursing and dietary service personnel. The manual shall be reviewed at least annually by the dietician.

(A) Menus for regular and routine therapeutic diets shall be planned in writing at least three weeks in advance.

(B) The current week's menu shall be posted in the dietary department and in a location accessible and conspicuous to residents.

(C) A different menu shall be followed for each day for a minimum of twenty-one days (this does not apply to facilities using selective menus).

(D) Menus shall include fresh fruits and vegetables in season.

(E) Records of menus, as served, shall be retained for sixty days (this does not apply to facilities using selective menus).

(c) Menus shall be planned and followed to meet nutritional needs of the resident in accordance with physician orders and, to the extent medically possible, in accordance with the recommended dietary allowances in the facility diet manual (see subsection (4)(b) of this rule).

(5) FOOD PREPARATION AND SERVICE.
(a) Foods shall be prepared by methods which conserve nutritive value, flavor, and appearance. A file of recipes adjusted to appropriate yield shall be maintained.

(b) Foods shall be attractively served in a form cut, chopped, ground, or pureed to meet individual needs and delivered to residents at customarily acceptable temperatures.

(c) Residents requiring assistance with feeding shall receive timely assistance while food is at customarily acceptable temperatures.

(d) An identification system shall be established to ensure that each resident receives diet as ordered.

(e) At least three meals or their equivalent shall be served daily at regular hours with not more than a 14 hour span between the beginning of the substantial evening meal and the beginning of breakfast. A substantial evening meal is an offering of three or more menu items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. The meal represents no less than 25 percent of the day's total nutritional requirements.

(f) Bedtime snacks of nourishing quality shall be offered routinely to residents who desire one and for whom it is not medically prohibited. Snacks of nourishing quality are those which provide substantive nutrients in addition to carbohydrates and calories, e.g., milk and milk drinks and fruit juice.

(g) If a resident refuses a food served, substitute foods of necessary nutritional food elements shall be offered.

(6) DOCUMENTATION. Resident's response to diet shall be recorded in the clinical record when there are significant dietary problems.

(7) DINING ASSISTANT. Facilities may use dining assistants to assist residents with feeding and hydration. "Dining Assistant" means a person 16 years of age or older who has successfully completed a Department-approved Dining Assistant training course and competency evaluation. Dining assistants include volunteers participating in facility volunteer programs who feed residents.

(a) Resident selection criteria:

(A) The facility must ensure that a dining assistant feeds and hydrates only residents who have no complicated feeding problems including, but not limited to, difficulty swallowing, recurrent lung aspirations and tube or parenteral/IV feedings.

(B) The facility Director of Nursing Services, RN Care Manager or RN Charge Nurse must assess and document resident selection for dining assistance. The resident assessment must be based on, but is not limited to:

(i) The resident's appropriateness for dining assistance;

(ii) The resident's feeding and hydration needs;

(iii) The resident's communication, behavior and interpersonal skills;

(iv) Risk factors including nausea (acute and ongoing), difficulty swallowing, seizure disorders, acute gastrointestinal issues, vomiting; and

(v) The resident's latest MDS assessment and plan of care.

(C) The documented assessment must be updated promptly after any significant change of condition and reviewed quarterly.

(b) Scope of Duties:

(A) Permitted Duties:

(i) Assist residents with eating and drinking;

(ii) Transport residents to and from dining area;

(iii) Distribute meal trays;

(iv) Ensure accurate meal delivery by verification with accompanying meal card;

(v) Provide assistance in preparing residents for meals including, but not limited to, placement of eye glasses, washing hands and face and placement of clothing protector;
(vi) Assist with insertion of dentures for residents that can self direct care;

(vii) Set up meal tray for residents including, but not limited to, opening food packets, positioning and cutting the food;

(viii) Provide minimal assistance with positioning, as needed, for feeding and hydration and;

(ix) Measure and record food and fluid intake.

(B) Prohibited Duties:

(i) Transfer residents;

(ii) Assist with tube feeding or IV nutrition;

(iii) Assist with insertion of dentures for residents unable to self direct care;

(iv) Provide standby assistance with ambulation or activities requiring gait belt;

(v) Assist with food containing medication;

(vi) Turn, lift or extensively reposition residents; and

(vii) Other CNA tasks including oral care.

(c) Training. A Department-approved facility Dining Assistant training course must include, at a minimum, 16 hours of training and evaluation in the following topics and subject matters and as identified in Exhibit 86-2, which is attached to and made a part of these rules

(A) Training Topics:

(i) Scope of authorized duties and prohibited tasks.

(ii) Feeding and hydration techniques.

(iii) Skills for assisting with feeding and hydration.

(iv) Communication and interpersonal skills.

(v) Appropriate responses to resident behavior.

(vi) Recognizing changes in residents that are inconsistent with their normal behavior and the reporting of those changes to the registered nurse (RN) or licensed practical nurse (LPN).

(vii) Safety and emergency procedures including the abdominal thrust.

(viii) Infection control.

(ix) Assisting residents with dementia.

(x) Resident rights.

(xi) Abuse prevention and reporting.

(B) Instructors of the Department-approved facility Dining Assistant training course must be licensed/certified in one of the following disciplines: registered nurse, registered dietician, occupational therapist or speech language pathologist.

(C) "Successful completion" means a passing score on a written exam for a Department-approved facility Dining Assistant training course and satisfactory completion of competency evaluation as determined by the instructor. A Department-approved certificate will be issued to each dining assistant upon successful completion.

(D) The Department will evaluate, select and approve at least one Dining Assistant training course curriculum which includes the topic and
subject matters contained in Exhibit 86-2. The Department will periodically re-evaluate its selection and approval.

(d) Supervision of dining assistants

(A) Dining assistants must work under the supervision of a registered nurse or licensed practical nurse. A registered nurse or licensed practical nurse must be readily available to respond to urgent or emergent resident needs.

(B) In an emergency, dining assistants must immediately obtain appropriate staff assistance including the use of the resident call system.

(e) Facilities must ensure that dining assistants perform only those tasks for which they are trained and permitted to perform.

(f) It is the responsibility of the facility Director of Nursing Services, RN Care Manager or licensed Charge Nurse to ensure that dining assistants are oriented to the specific residents to whom they are assigned prior to providing dining assistance.

(g) Maintenance of records. Facilities must maintain a record of all facility dining assistants. The record must contain a copy of each dining assistant's certificate for successful completion of a Department-approved Dining Assistant training course. Upon request, a facility will share copies of dining assistant training certificates with other facilities.

[ED. NOTE: Exhibit referenced are available from the agency.]

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f 8-29-90, cert. ef. 10-1-90; SPD 23-2004, f 7-30-04, cert, ef, 8-1-04

411-086-0260

Pharmaceutical Services

(1) Consulting Pharmacist. Each facility shall have a consulting pharmacist who shall ensure compliance with ORS Chapter 689, facility policy (OAR 411-085-0210) and this rule.

(2) Pharmaceutical Services Review. The Quality Assessment and Assurance Committee shall:

(a) Develop written policies and procedures for safe and effective drug therapy, distribution and use;

(b) Oversee pharmaceutical services in the facility, monitor the service to ensure accuracy and adequacy and make recommendations for improvement; and

(c) Meet at least quarterly and document its activities, findings and recommendations.

(3) Drug Supply, Storage and Labeling:

(a) Drug Room. Facilities without a pharmacy shall have a drug room as defined in ORS Chapter 689, supervised by the consulting pharmacist. Drug rooms shall contain only prescribed (legend and non-legend) drugs, non-prescription (non-legend) stock drug supply and the emergency medication kit authorized pursuant to this rule. Locked carts or locked cupboards shall be used to prevent pilferage;

(b) Labels:

(A) All medications purchased or designated for specific residents shall be labeled as prescribed for such resident;

(B) If facility policy allows medications accompanying the resident on admission to be used, the medication must be identified as to the resident and medication and shall be authorized for use only on the written order of the attending physician.

(c) Storage. Except as provided in subsection (4)(b) of this rule, all medications shall be stored in the facility pharmacy, a drug room, or in a locked medication cart;

(d) Stock Supply:

(A) Except as provided in section (6) of this rule, a stock supply of prescription (legend) drugs may be maintained only within a licensed pharmacy;
(B) A stock supply of non-prescription drugs may be maintained in a drug room or locked medication cart, but there must be a doctor's order for administering such drugs. A stock supply of non-prescription drugs means those non-legend medications supplied in the manufacturer's original package or repackaged by a registered pharmacist and labeled in accordance with ORS Chapter 689.

(e) Resident Discharge. Medication to accompany the resident upon discharge must be on the written order of the physician;

(f) References. References regarding use, dosage, contraindications, drug interactions, and adverse reactions shall be available on drug products used in the facility.

(4) Drug Administration:

(a) Medications prescribed to one resident shall not be administered to another;

(b) Self-administration. Facilities shall have written policies and procedures allowing self-administration of medication:

(A) All bedside medications, except nitro-glycerine, shall be stored in closed, locked cupboards or drawers;

(B) The consulting pharmacist shall specify maximum quantities of medications to be stored at bedside to ensure prevention of poisoning by confused or suicidal residents.

(c) Stop Order Policy. An automatic stop order policy shall be adopted and enforced. This policy shall provide guidance when medications ordered are not specifically limited as to time or number of doses. The policy shall be developed by the Quality Assessment and Assurance Committee.

(5) Medication Review. Medications shall be reviewed monthly by the consulting pharmacist and reordered by the physician as necessary, but no less often than quarterly. The pharmacist shall alert the DNS when drugs designated "less-than effective" ("DESI" drugs) by the Federal Food and Drug Administration have been ordered and what alternative medications may be available. The DNS shall notify the physician.

(6) Emergency Medication Kit:

(a) An emergency medication kit shall be prepared and authorized by a registered pharmacist for use in the facility in accordance with written facility policy. The contents shall be selected by the Quality Assessment and Assurance Committee;

(b) The kit shall be sealed and stored in a manner to prevent loss of drugs, but available to authorized personnel. The vendor pharmacist shall be notified when the seal is broken. A record shall be made that identifies each use of an emergency drug. The contents shall be plainly indicated on the outside of the container;

(c) Any drug removed from the kit shall be covered by a prescription and signed by the physician within 72 hours.

(7) Charges for Drugs; Choice of Supplier. See OAR 411-085-0340.

(8) Documentation. The nursing staff shall clearly and accurately document administration of pharmaceuticals and the response thereto.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90

Clinical Records

(1) Clinical Records Department. The facility shall ensure the preparation, completeness, accuracy, preservation, and filing of a clinical record for each resident in accordance with facility policy (OAR 411-085-0210). This rule does not apply to nonmedical records.

(2) Director. The facility shall designate in writing a staff person to function as clinical records coordinator who shall ensure compliance with this rule. Services of a qualified medical record consultant (RRA or ART) shall be provided as needed.

(3) Staffing, Equipment. There shall be personnel, space, and equipment to provide efficient, systematic processing of clinical records including but not limited to reviewing, indexing, filing, and prompt retrieval.
(4) Filing. A system of identification and filing to ensure the rapid location of resident clinical records shall be maintained. A resident master index containing at least the full name of each resident, date of birth, clinical record number as applicable, date of admission, date of discharge, legal representative and physician of record shall be maintained.

(5) Content of Clinical Record. A clinical record shall be maintained for each resident. Each record shall contain supporting data, written in sequence of events to justify the diagnosis and warrant the treatment and results. All entries shall be kept current, accurate, dated and signed. All clinical records shall be either typewritten or recorded legibly in ink and shall include but not be limited to the following information:

(a) Admitting diagnosis and identification data including the resident's name, previous address, date and time of admission, sex, date of birth, marital status, religious preference and social security number; name, address, and telephone number of nearest relative or personal agent; place admitted from; attending physician; alternate physician (clinic or service); dentist; legal representative and RN care manager;

(b) A medical history and physical exam or medical summary as to the resident's condition which is signed by a physician. If a resident is re-admitted within 30 days for the same condition, the previous history and physical or medical summary, with an interval note signed by a physician, will suffice. If an ongoing clinical record is maintained in a comprehensive care facility, it may be used if accompanied by a physical exam report completed within the previous 30 days;

(c) Clinical reports, current, dated, and signed. Such reports include, but are not limited to, laboratory, x-ray, and results of tests/exams including those for communicable diseases;

(d) Physician's orders, current, dated and signed;

(e) Physician's progress notes dated and signed;

(f) Timely, written, dated, pertinent, complete and signed clinical observations. Clinical observations shall include changes in condition, results of treatments and medications, and unusual events. Clinical observations shall include outcome of the resident care plan and shall be summarized by nursing staff at least quarterly unless the resident's condition dictates otherwise;

(g) Record of medication administration including name of drug, dosage, frequency, mode of administration, date, time and signature of the person administering medication. Documentation shall also include, when applicable, site of injection, reaction, reason for withholding any medication, and reason for administering any "prn" (as needed) medication;

(h) Record of treatments administered which shall be dated, timed and signed by those performing treatments;

(i) Miscellaneous items such as releases, consent forms, mortician's receipts, valuables list and medical correspondence as applicable;

(j) Discharge summary prepared in accordance with OAR 411-086-0160 and signed by the attending physician. The summary shall include admitting diagnosis/reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan if appropriate, condition on discharge or cause of death; and

(k) The "Directive to Physicians" ("Living Will"), the Power of Attorney for Health Care and similar legal documents regarding resident care directives, if any, shall be filed in the resident's clinical record in a manner which makes them prominent and conspicuous.

(6) Record Retention. All clinical records shall be kept for a period of five years after the date of last discharge of the resident. A clinical record for each resident for whom care has been provided in the previous six months shall be immediately available for review by Division representatives upon request.

(7) Resident Transfer. When a resident is transferred to another facility, the following information shall accompany the resident:

(a) The name of the facility from which transferred;

(b) The names of attending physicians prior to transfer;

(c) The name of physician to assume care;

(d) The date and time of discharge;

(e) Most recent history and physical;
Employee Orientation and In-Service Training

(1) Orientation. The nursing facility shall ensure that each employee, temporary employee, and volunteer completes an orientation program sufficient to ensure that the safety and comfort of all residents is assured in accordance with facility policies (OAR 411-085-0210). Orientation to each task must be completed prior to the employee or volunteer performing such task independently. Orientation for nursing staff and nursing assistants in training shall be supervised by a registered nurse. The orientation shall include:

(a) Explanation of facility organizational structure;

(b) Philosophy of care of the facility, including purpose of nursing facility requirements as defined in these administrative rules;

(c) Description of resident population;

(d) Employee rules; and

(e) Facility policy and procedures.

(2) Inservice. The Administrator or his/her designee shall coordinate all inservice training. Inservice training shall be designed to meet the needs of all facility staff in accordance with facility policy (OAR 411-085-0210). Each certified nursing assistant shall receive a minimum of three hours of inservice training each calendar quarter. Each calendar year the inservice training agenda shall include at least the following:

(a) Resident rights, including, but not limited to, those rights included in ORS 441.600-441.625;

(b) Rules and statutes pertaining to abuse, including, but not limited to, ORS 441.630-441.675;

(c) The transfer/discharge rules, including, but not limited to, the obligations of facility personnel to forward requests for conferences and hearings to the appropriate authorities;

(d) Measures to prevent cross-contamination, including universal precautions;

(e) Oral care, including oral screenings (required for nursing staff only);

(f) Emergency procedures, including, but not limited to, the disaster plan;
(g) Procedures for life-threatening situations, including, but not limited to, cardiopulmonary resuscitation and the life-saving techniques for choking victims (including abdominal thrust and chest thrust);

(h) Application and use of physical restraints (required for nursing staff only);

(i) Procedures to prevent residents from wandering away from the facility and how to deal with the wandering resident;

(j) Restorative services, including benefits thereof (required for nursing staff only);

(k) Activity program, including benefits thereof;

(l) The social services program, including benefits thereof;

(m) Accident prevention;

(n) Alzheimer's disease and other dementias, including recognition of symptoms, treatments, and behavioral management; and

(o) Other special needs of the facility population.

(3) Documentation. Inservice training and orientation shall be documented and shall include the date, content, and names of attendees.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90

411-086-0320

Emergency and Disaster Planning

An emergency preparedness plan is a written procedure that identifies a facility's response to an emergency or disaster for the purpose of minimizing loss of life, mitigating trauma, and to the extent possible, maintaining services for residents, and preventing or reducing property loss.


(2) The emergency preparedness plan must:

(a) Include analysis and response to potential emergency hazards including but not limited to:

(A) Evacuation of a facility;

(B) Fire, smoke, bomb threat, or explosion;

(C) Prolonged power failure, water, or sewer loss;

(D) Structural damage;

(E) Hurricane, tornado, tsunami, volcanic eruption, flood, and earthquake;

(F) Chemical spill or leak; and

(G) Pandemic.

(b) Address the medical needs of the residents including:

(A) Access to medical records necessary to provide care and treatment; and

(B) Access to pharmaceuticals, medical supplies, and equipment during and after an evacuation.

(c) Include provisions and supplies sufficient to shelter in place for a minimum of five days without electricity, running water, or replacement
(3) The facility must notify SPD, or the local AAA office or designee, of their status in the event of an emergency that requires evacuation and during any emergent situation when requested.

(4) The facility must conduct a drill of the emergency preparedness plan at least twice a year in accordance with the OFC in OAR chapter 837, division 040 and other applicable state and local codes as required. One of the practice drills may consist of a walk-through of the duties or a discussion exercise with a hypothetical event, commonly known as a tabletop exercise. These simulated drills do not take the place of the required fire drills.

(5) The facility must annually review or update the emergency preparedness plan as required by the OFC in OAR chapter 837, division 040 and the emergency preparedness plan must be available on-site for review upon request.

(6) A summary of the facility's emergency preparedness plan must be submitted to SPD annually on July 1, and at a change of ownership, in a format provided by SPD.

Stat. Auth.: ORS 410.070, 410.090, & 441.055
Stats. Implemented: ORS 441.055, 441.615, OL 2007 ch. 205
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 14-2009, f. 9-30-09, cert. ef. 10-1-09

411-086-0330

Infection Control and Universal Precautions

(1) Infection Control:

(a) The Quality Assurance and Assessment Committee shall establish, maintain and enforce an infection control program, including universal precautions and isolation procedures, which assures protection of residents and staff from infections;

(b) The committee shall meet quarterly and as needed to review facility policies, procedures, and monitor staff performance relative to infection control. These meetings and the results thereof shall be documented;

(c) In reviewing and developing facility infection control policies and procedures, the committee shall consider all guidelines relative to infection control issued by the Division and by the Center for Disease Control, Atlanta, GA.


(2) Simultaneous Duties. Personnel shall not be simultaneously responsible for duties which are incompatible with sanitation. This includes prohibiting personnel from being assigned to both resident care and work in the kitchen, laundry, or housekeeping. This also prohibits personnel from having responsibility for work in the kitchen combined with laundry, housekeeping or other such conflicting tasks.

(3) Communicable Disease. Each nursing facility shall maintain compliance with the Health Division rules for communicable disease, including rules relating to tuberculosis examinations for facility personnel and residents.

(4) Soiled Laundry. Soiled linen, toweling, clothing, and sickroom equipment shall not be sorted, laundered, rinsed, or stored in bathroom, kitchen, resident rooms or clean utility areas. Soiled linen, toweling and clothing shall be stored in a separate, ventilated room. Soiled clothing shall be washed separately from soiled linen. Soiled laundry must be transported and stored in a covered container impervious to moisture.

(5) Waste Disposal. All garbage, refuse, soiled surgical dressings and other similar wastes shall be disposed of in a manner that will not create a nuisance or a public health hazard and which is consistent with the State Health Division's rules for infectious waste (OAR 333, division 056). When community garbage collections and disposal service are not available, garbage and refuse shall be disposed of by some other equally effective and sanitary manner approved by the local health officer.

(6) Clean Linen Storage. All clean linen shall be stored in clean storage rooms or cupboards easily accessible to nursing personnel. Laundry carts used for storing clean linen shall be kept covered when not in use.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Pets

(1) Pets Allowed. Household pets (dogs, cats, birds, fish, hamsters, etc.) are permitted in the nursing facility under the following conditions:

(a) Pets must be clean and disease-free;

(b) Immediate environment of pets must be kept clean;

(c) Small pets (e.g., birds, hamsters) must be kept in appropriate enclosures;

(d) Pets not confined in enclosures must be hand held, under leash control, or under voice control; and

(e) Pets that are kept at the facility (or are frequent visitors) shall have current vaccinations as recommended by a designated licensed veterinarian (including, but not limited to, rabies).

(2) Areas Pets Prohibited. Pets are not permitted in food preparation or storage areas. Pets shall not be permitted in any area where their presence would create a significant risk or annoyance to residents.

(3) Administrative Control. The administrator or his/her designee shall determine which pets may be brought into the facility. Family members may bring resident's pets to visit provided they have approval from the administrator and offer reasonable assurance that the pets are clean, disease-free, and vaccinated as appropriate.

(4) Overnight Stay. Facilities with pets that are kept overnight shall have written policies and procedures for the care, feeding, and housing of such pets and for the proper storage of pet food and supplies.

(5) Birds. Facilities with birds shall have procedures which protect residents, staff, and visitors from psittacosis. Procedures should ensure minimum handling of droppings. Droppings shall be placed in a plastic bag for disposal. Persons caring for the bird(s) shall not have nursing care or food handling responsibilities.

(6) Exotic Pets Prohibited. Exotic pets (i.e., iguanas, snakes, other reptiles, monkeys, ferrets) shall not be kept at the facility. If exotic pets are brought in for a visit, they must be attended at all times by their owners. Skunks, foxes, and raccoons are not permitted in nursing facilities.

Smoking

(1) A nursing facility must be in compliance with:

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

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

(c) Any other applicable state and local laws.

(2) A facility must provide a place of employment that is free of tobacco smoke for all employees.

(3) Smoking may only be allowed outside the facility as prescribed by OAR 333-015-0064.

(4) The facility must take adequate precautions to protect all residents from injury where residents are allowed and choose to smoke.

(5) The facility must develop and implement a smoking policy that includes resident assessment and care planning.
(6) If the facility's smoking policy changes, the licensee must provide written notice to all residents 30 days' prior to such change.

(7) Nothing in this rule shall prevent the licensee from designating any part of the facility or the entire facility as a non-smoking area. If the facility decides to designate the entire facility as a non-smoking area, all persons admitted thereafter must be so notified by the facility prior to or at the time of admission. Such facility must continue to provide an outdoor smoking area as prescribed by OAR 333-015-0064 for residents who smoke and were admitted prior to the facility decision.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 433.835 to 433.990, 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SPD 14-2009, f. 9-30-09, cert. ef. 10-1-09

411-086-0360

Resident Furnishings, Equipment

(1) Resident Equipment:

(a) Each resident shall be provided a bed, mattress, pillow with water-proof protection, necessary bed coverings, bedside table and chair, reading light, and electrically operated call system which registers at the nurses' station. The call system cord shall be secured in a manner which makes it accessible to the resident and which prevents the resident from injuring himself/herself with it;

(b) According to his/her needs, each resident shall be provided with individual equipment, such as bedpans, bedpan covers, urinals, washbasins, emesis basins, mouthwash cups, soap, washcloths, towels, and drinking glasses;

(c) Equipment such as wheelchairs, walkers, geri-chairs and crutches shall be readily available for residents needing this equipment;

(d) After the discharge of any resident, the bed, bed furnishings, bedside furniture, and all multiple-use resident equipment shall be thoroughly cleansed and disinfected prior to re-use. Mattresses shall be professionally renovated when necessary;

(e) Single resident use items must be identified with resident name and disposed of upon resident discharge;

(f) Hot water bags and electric heating pads or blankets may be used only on the written order of the physician;

(g) In nursing facilities caring for pediatric residents, an emergency signaling system for use by attendants summoning assistance and a two-way voice intercommunication system between the nurses' station and rooms or wards housing pediatric residents shall be provided.

(2) Storage Space. Separate storage space for clothing, toilet articles, and other personal belongings of residents shall be provided.

(3) Privacy. In multiple-bed rooms, opportunity for privacy shall be provided by flame retardant curtains or screens. Cubicle curtains or screens are not required for beds assigned to pediatric residents.

(4) Linen Supply. The use of torn or unclean bed linen is prohibited. Facilities shall have a linen supply available for at least three times the usual bed occupancy.

Stat. Auth.: ORS 410.070, 410.090 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90
The Oregon Administrative Rules contain OARs filed through December 15, 2010

DEPARTMENT OF HUMAN SERVICES,
SENIORS AND PEOPLE WITH DISABILITIES DIVISION

DIVISION 87
NURSING FACILITIES/LICENSING -- PHYSICAL ENVIRONMENT

411-087-0005
Definitions

As used in OAR 411, division 87, the definitions in OAR 411, division 85 and following definitions apply:

(1) "ASHRAE" means the American Society of Heating, Refrigerating, and Air-Conditioning Engineers, Inc.

(2) "Calling Station" means an individual light, or other electrically operated visual signalling device, with or without audio signaling device, which is located at a nursing station and which effectively alerts nursing staff to a specific room or location from which a resident or other staff is requesting assistance.

(3) "Clearly Marked Emergency Power Duplex Receptacle" means an outlet for standard household current (110 volts) connected to an emergency power supply in accordance with the National Electrical Code and NFPA 99 and clearly marked to easily distinguish the outlet from an outlet not on the emergency power supply.

(4) "Continuously Licensed" means licensed as a nursing facility without interruption.

(5) "Easily Cleanable" means surfaces are readily accessible and made of materials and finish and fabricated so residue may be effectively removed by normal cleaning methods.

(6) "Locked Unit" means a nursing facility or a part of a nursing facility, including resident rooms, from which egress is restricted by secured doors.

(7) "NFPA" means National Fire Protection Association, Inc.

(8) "Nursing Station" means a location at which nursing staff perform charting and related activities throughout the day and at which a calling station exists.

(9) "Resident Room" means a room in the facility licensed for one or more beds.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
New and Old Construction, Remodeling, Certificate of Need

(1) New Construction. New construction shall not be eligible for "exceptions" as provided in these rules (OAR 411-087) unless specifically authorized by the Division. All such alterations, additions, conversions in use, and renovations shall be subject to plan review in accordance with section (3) of this rule.

(2) Old Construction:

(a) Where specifically provided within OAR 411-087-0010 - 411-087-0490, facilities which have been continuously licensed and operational since January 1, 1992 may be exempt from certain specified physical environment requirements. Such exemptions do not apply if there is a change in the purpose for which the room is licensed; e.g., a room which has not been continuously licensed as a resident room must comply with the requirements for new construction in order to be licensed as a resident room. The Division, however, may terminate an exemption if the Division determines that continuation of the exemption adversely impacts the facility's ability to otherwise meet nursing facility law. The exemption may be discontinued if the area subject to the exemption incurs major alterations as defined in OAR 411-085-0005;

(b) Notwithstanding the "exceptions" provided for in these rules, facilities constructed prior to January 1, 1992 shall, when replacing equipment or remodeling areas subject to such exceptions, comply with the rules to the greatest extent reasonable. Subsection (2)(b) of this rule does not apply to new construction;

(c) Under no circumstances are the "exceptions" provided for in these rules intended to allow a facility that already meets or previously met these rules without the exception provision to be exempt from meeting the rules without the "exception provision."

(3) Plan Review:

(a) Schematic Plans. Schematic plans may be submitted for review;

(b) Construction Plans. Two sets of project construction drawings and specifications must be submitted for review prior to initiation of related construction pursuant to subsection (3)(e) of this rule. Construction documents must be sufficient to allow the Division to determine if the project complies with OAR 411;

(c) Floor Plan. Projects involving addition, deletion or relocation of beds shall include a floor plan showing the proposed number and location of each bed for which licensure will be requested. The plan shall include dimensions, area and room number of each resident room;

(d) Program Narrative. All plans submitted shall be accompanied with a narrative description including:

(A) Identification of services which will not be provided directly, but will instead be provided via contract;

(B) All specialty services to be offered; and

(C) Modifications to be made to heating, ventilating, plumbing and electrical systems.

(e) Submission of Plans. All schematic and construction plans submitted shall be delivered to the Office of Health Policy (OHP), Public Health Division, Department of Human Services, State Office Building, Suite 640, 800 Oregon Street N.E., Portland, OR 97232, in accordance with OAR 409, division 17;

(f) When construction or remodeling includes an increase in bed capacity, exceptions allowed for size of dining, activities and living areas (OAR 411-087-0300) shall no longer be applicable unless specifically authorized by the Division.

(4) Certificate of Need. Before a facility may increase capacity, the licensee shall submit to the Division a Certificate of Need (CN) or a letter from the Office of Health Policy stating that a CN is not required.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0020
**Referenced Regulations**

In addition to meeting OAR 411, division 087, the following additional requirements must be met except where determined by the Division to not be applicable to nursing facilities. Licensure is contingent on approval of the agency having enforcement authority:

1. **Building and Fire Safety Codes:**
   
   (a) State Building Codes as adopted by the Oregon Building Codes Division;
   
   (b) Local building codes and requirements as adopted by local government agencies;
   
   (c) State and local fire codes, NFPA 101 and applicable referenced NFPA publications; and
   
   (d) All facilities and construction completed after January 1, 1992, shall comply with the American National Standards Institute's "Providing Accessibility and Usability for Physically Handicapped People" effective February 5, 1986, and Title III of the American with Disabilities Act of 1990.

2. **Food Sanitation Rules.** Food Sanitation Rules as adopted by the Public Health Division.

3. **Drinking Water.** Oregon Drinking Water Quality Act and the rules adopted thereunder by the Public Health Division. Documentation of conformance to this law is required except when the facility is served by an approved community water system.

4. **Sewage.** On-site sewage disposal rules as enforced by the Oregon Department of Environmental Quality (DEQ). Documentation of conformance to this law is required except when the facility is served by an approved community sewer system.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0030

**Waivers for Physical Environment Requirements**

1. **Request.** Any request for a waiver of these building requirements (OAR 411, division 087) shall comply with OAR 411-085-0040

2. **Duration.** The Division may grant waivers for building requirements for a period not to exceed ten years; however, such waiver may be rescinded if the Division determines continuance of the waiver has a potential adverse impact on resident well-being, privacy or dignity.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0100

**Physical Environment Generally**

1. **Good Repair and Cleanliness:**
   
   (a) All interior and exterior surfaces (e.g., floors, walls, roofs, ceilings, windows, and furniture) and equipment necessary for the health, safety, and comfort of the resident shall be kept clean and in good repair;
   
   (b) All interior surfaces shall be easily cleanable;
   
   (c) Measures shall be taken which prevent the entry of rodents, flies, mosquitoes, and other insects;
   
   (d) The facility grounds shall be kept orderly and free of litter and refuse.

2. **Outside Walkways, Parking:**

   (a) Walkways and curbs from the street, public transit or parking spaces to the building entrance shall be designed to facilitate travel by
people using wheelchairs or crutches;

(b) Disabled Parking Facilities. Parking spaces for disabled visitors and staff shall be provided.

(3) Entrance, Waiting Area. At least one primary grade level entrance to the building shall be sheltered from weather and be fully accessible to disabled persons. The facility shall have a waiting area or lounge located inside the main entrance.

(4) Drinking Fountains, Telephones. At least one drinking fountain and telephone shall be available on each floor for residents, staff, and visitors, including those physically disabled. Telephones and fountains shall be provided in accordance with the American National Standards Institute's "Providing Accessibility and Usability for Physically Handicapped People" effective February 5, 1986. The number of the fire department and police department shall be affixed to every telephone. The facility shall have telephones designated for use by residents which allow for privacy during conversation and are wheelchair accessible.

(5) Exceptions. Facilities continuously licensed since January 1, 1992 shall not be required to have drinking fountains on every floor, waiting area/lounge or a sheltered entrance as required by this rule unless otherwise provided by OAR 411-087-0010.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055  
Stats. Implemented: ORS 441.055 & 441.615  

411-087-0110

Administrative Area

(1) Office Space. General or individual office(s) shall be provided for business transactions, medical and financial records, and administrative and professional staff.

(2) Interview Space. Interview space(s) shall be provided for private interviews relating to social service, credit, and admissions.

(3) Storage. Storage for office equipment, supplies and clinical records shall be provided.

(4) Lighting. Lighting intensity shall comply with Table 4.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055  
Stats. Implemented: ORS 441.055 & 441.615  

411-087-0120

Signs

(1) Resident Rooms. All resident rooms shall be clearly identified by room number. Room numbers shall be no less than one inch high and shall contrast with their background (light characters on dark background or dark characters on light background). Such signs shall be located in order to be easily readable to all residents, including those in wheelchairs.

(2) Other Rooms. All other rooms used by residents shall be clearly identified by name (e.g., "Dining Room," "Activity Room") with letters as described in section (1) of this rule.

Stat. Auth.: ORS 410.070 & 441.055  
Stats. Implemented: ORS 441.055 & 441.615  

411-087-0130

Resident Care Unit
Each resident care unit shall provide the following:

(1) Resident Rooms. Each resident room shall meet the following requirements:

(a) Capacity. Maximum room capacity shall be four residents;

(b) Size:

(A) Minimum room areas exclusive of toilet rooms, closets, lockers or wardrobes, alcoves or vestibules shall be 120 square feet in single-bed rooms and 100 square feet per bed in multi-bed rooms:

(i) Room dimensions shall allow at least three feet between the side of each bed and any wall;

(ii) Room dimensions shall allow at least four feet between adjacent beds and three feet six inches at the foot of each bed;

(iii) Beds may be rearranged to satisfy the needs and desires of individual residents; and

(iv) At least 50 percent of the resident rooms shall be designed to allow a five foot diameter circle of clear floor area for turning of wheelchairs immediately inside the resident room entrance and immediately outside each resident toilet room.

(B) In facilities caring for pediatric residents where bed size does not exceed that of a six-year crib, the minimum floor space allowance shall be 60 square feet for each crib;

(C) Space shall be provided in each room for an armchair, geriatric chair or wheelchair for each resident.

(c) Closet. Each resident shall have a wardrobe locker or closet within the resident's room. Each locker or closet shall have minimum clear dimensions of 30 inches by 24 inches by 60 inches. The space shall include a rod, at least 15 inches long, with 54 inches (vertical) of hanging space;

(d) Lockable Storage. Each resident shall be provided with a lockable closet or drawer with a minimum of 0.5 cubic feet. The lockable storage space may be included within the closet space defined in subsection (1)(c) of this rule;

(e) Privacy. The facility shall provide full visual privacy by means of cubicle curtains for each resident in multi-bed rooms. Design for privacy shall not restrict the exit/access of other residents from/to the resident room, handwash sink, or toilet. "Full visual privacy" in a multi-bed room means curtains which prevent staff, visitors and other residents from seeing a resident in bed, but which allow staff, visitors and other residents access to the toilet room, handwash sink and entrance;

(f) Door. Each resident room shall have a door which directly accesses an exit corridor. The door opening shall have a horizontal clearance of 44 inches and shall not swing into the exit corridor;

(g) Other Requirements. See rules relating to lighting (OAR 411-087-0430), toilets and handwash sinks (OAR 411-087-0310), nurse call systems (OAR 411-087-0440) and windows (OAR 411-087-0400).

(2) Isolation Room. Each facility shall have at least one resident room capable of being designated as an isolation room which is equipped with a private toilet and handwash sink (see Table 2).

(3) Exceptions:

(a) Number of Residents Per Room. The number of residents in a room may exceed four if the room has been continuously licensed since January 1, 1992 for a number equal to or greater than the number of residents for which the license is requested unless otherwise provided by OAR 411-087-0010;

(b) Room Size. The dimensions of a resident room which has been continuously licensed since January 1, 1992 shall be considered to be in compliance with subsection (1)(b) of this rule unless otherwise provided by OAR 411-087-0010. In facilities which do not comply with subparagraph (1)(b) (A)(iv) of this rule, all new construction which increases licensed bed capacity shall be required to meet the clearance requirements in said subparagraph until the 50 percent requirement is met;

(c) Closet. The size and design of the resident closet in a room which has been continuously licensed since January 1, 1992 shall be considered to be in compliance with subsection (1)(c) of this rule unless otherwise provided by OAR 411-087-0010;
(d) Locked. Facilities continuously licensed since January 1, 1992, shall only be required to have locked storage in accordance with this rule if the resident or significant other requests locked storage.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0140

Locked Units

(1) Dining, Activities, Living Space. Each locked unit shall have dining, activities and living space within the locked unit. The total area of such space shall be the same as if the locked unit was a separately licensed nursing facility.

(2) Nurses' Station. There shall be at least one nurses' station within each locked unit.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0150

Nurses' Station

Each floor with resident rooms shall have a nurses' station with space for charting and storage for administrative supplies:

(1) Handwash Sink. There shall be a handwash sink, exclusive of resident and soiled utility room handwash sinks, within 20 feet of the nurses' station.

(2) Exceptions. The handwash sink required in section (1) of this rule is not required in a facility which has been continuously licensed since January 1, 1992 unless otherwise provided by OAR 411-087-0010.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0200

Dietary Services

(1) Food Sanitation Rules. Construction, equipment, and installation shall comply with OAR 333, division 150.

(2) Food Preparation Areas. The dietary services area shall include:

(a) Space and equipment for preparing, cooking, and baking;

(b) Ice making equipment which is easily cleanable. All ice dispensing equipment which is not in the dietary services area but is accessible to residents shall be self-dispensing;

(c) Space for tray assembly and distribution;

(d) Handwash sink; and

(e) Design shall provide for flow of clean items/food and soiled items/food in a manner which avoids potential for contamination.

(3) Food Receiving, Storage and Other Work Areas. The dietary services area shall include the following which shall not be in the food preparation area:

(a) Storage space for seven days' supply including cold storage for two days' food needs;
(b) An area designated for receiving food supplies;

(c) Dishwashing equipment and work area;

(d) Office or suitable work space for the dietitian or the dietary service manager;

(e) Janitor's closet for exclusive use of the dietary department. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies;

(f) Cart storage and cart sanitizing area. This area may be shared with other departments if located outside the dietary services area. If located outside, the area shall be covered and paved;

(g) Waste storage facilities in a separate area easily accessible to the outside for direct pickup or disposal; and

(h) Toilet room. There shall be a staff toilet room accessible within 25 feet of the dietary services area. The toilet room shall not open directly to the food preparation area.

(4) Exceptions:

(a) Toilet Room. The distance to the toilet room may exceed 25 feet if the facility has been continuously licensed since January 1, 1992 unless otherwise provided by OAR 411-087-0010;

(b) Office. The office space required in subsection (3)(d) of this rule may be outside the dietary services area if the facility has been continuously licensed since January 1, 1992 unless otherwise provided by OAR 411-087-0010;

(c) Closet. The janitor's closet required in subsection (3)(e) of this rule may be outside the dietary services area if the facility has been continuously licensed since January 1, 1992 unless otherwise provided by OAR 411-087-0010. In such circumstances, the facility shall have a documented system to ensure mops and other cleaning supplies used in nursing or laundry areas are not used in the dietary services area;

(d) Cart Storage/Sanitizing. If located outside, the cart sanitizing and storage area is not required to be paved and covered if the facility has been continuously licensed since January 1, 1992 unless otherwise provided by OAR 411-087-0010.

411-087-0210

Therapy Services

The facility shall have a therapy services room(s) to support services such as physical, occupational and speech therapy, and special programs:

(1) Treatment Areas. The therapy services area shall include:

(a) A minimum floor area of 250 square feet, sufficient to meet therapy service needs as outlined in facility policies;

(b) Space and equipment for facility programs which may include thermotherapy, diathermy, ultrasonics, and hydrotherapy. A cubicle curtain shall be provided around each individual treatment area. Provisions shall include handwash sink (one sink may serve more than one cubicle);

(c) Space and equipment for exercise;

(d) Storage for clean and soiled linens, supplies and equipment (including wheelchairs and stretchers); and

(e) Deep sink, a minimum of 22 inches by 21 inches by ten inches deep. The deep sink may also serve as the handwash sink.

(2) Exceptions. Facilities which have been continuously licensed since January 1, 1992 shall be considered to be in compliance with
section (1) of this rule unless otherwise provided by OAR 411-087-0010.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0220

Pharmacy Services

Provision shall be made for the procurement, storage, dispensing, and accounting of drugs and other pharmacy products:

(1) Off-Site Provider Allowance. Pharmaceutical services may be by arrangement with a convenient off-site facility but must include provisions for 24-hour emergency service.

(2) Pharmacy/Drug Room. When provided, the pharmacy/drug room shall be well-lighted (see Table 4), properly ventilated (see Table 2) and include a medication refrigerator and a sink with hot and cold running water. The pharmacy/drug room may be combined with the clean utility room (see OAR 411-087-0320).

(3) Drug Distribution Stations. Provision shall be made for convenient 24-hour distribution of medicine to residents. This may be a medicine preparation room or unit, a self-contained medicine dispensing unit or by another approved system. If used, a medicine preparation room shall be under the nursing staff's visual control and contain a work counter, handwash sink, refrigerator, and locked storage for biologicals and drugs. A medicine dispensing unit may be located at or near the nurses' station, in the clean utility room or in another space under direct control of the nursing staff.

(4) Exceptions. Facilities which have been continuously licensed since January 1, 1992 are not required to have a handwash sink within the drug distribution station unless otherwise provided by OAR 411-087-0010.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0230

Laundry Services

(1) On-Site Processing. If linen is to be processed on-site, the following shall be provided:

(a) A processing area which cannot be entered directly from the resident corridor;

(b) A laundry processing room with equipment which can process even days' needs within a regularly scheduled work week. The laundry services area shall include a handwash sink and soiled linen receiving, holding and sorting areas;

(c) Ventilation in accordance with Table 2;

(d) Storage for laundry supplies;

(e) Clean linen inspection, mending and folding room or area;

(f) Janitor's closet or alcove containing a floor receptor or service sink and storage space for housekeeping equipment and supplies; and

(g) The design shall provide for flow of clean and soiled laundry and supplies in a manner which avoids potential for contamination.

(2) Off-Site Processing. If linen is processed off-site, the facility shall have a soiled linen holding room ventilated in compliance with Table 2. The soiled linen holding room may also serve as the soiled utility room if sufficient space is provided (see OAR 441-087-0320).

(3) Clean Linen Storage. The facility shall have a separate or designated area within the clean utility room for linen storage. If a closed cart system is used, storage may be in an alcove.
(4) Cart Sanitizing and Storage. The facility shall have a cart sanitizing and storage area with running water. If located outside, the area shall be covered and paved. The area may be shared with dietary services only if located outside and directly accessible from both departments.

(5) Exceptions. In facilities continuously licensed since January 1, 1992, section (1) of this rule shall not apply unless otherwise provided by OAR 411-087-0010.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0240

Personal Care Services

Separate room or designated space and appropriate equipment shall be provided for hair care and grooming needs of residents.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0250

Day Care Services

(1) Facilities admitting day care residents shall have 40 square feet of dining, recreation, living and sleeping areas in addition to space required for other residents.

(2) Facilities admitting day care residents shall have either an unassigned bed or a folding cot in an area where rest and privacy can be provided for each resident.

(3) There shall be one toilet and one lavatory available for every 15 day care residents. Such facilities shall be in close proximity to the area used by day care residents.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0300

Residents' Dining, Activities and Living Areas

(1) Area Requirement. The total area available for dining, activities, visitor waiting and living shall be not less than 30 square feet per bed with a minimum size of 225 square feet. Additional space shall be provided for outpatients if they participate in a day care program.

(2) Storage. Storage space shall be provided for activity equipment and supplies.

(3) Living Areas. Each facility shall have a solarium, living room, or sun porch for the use of residents on each floor. Such rooms must be provided with mechanical ventilation or with windows that open.

(4) Lighting. Lighting intensity of all dining, activities and living areas shall comply with Table 4.

(5) Exceptions. Facilities continuously licensed since January 1, 1992, shall not be required to meet the area requirements for dining, activities, visitor area/lounge and living space (30 square feet per bed) unless otherwise provided by OAR 411-087-0010.

[ED. NOTE: Tables referenced are available from the agency.]
Toilet, Handwashing, and Bathing Areas

(1) General Requirements:

(a) Temperature. Hot water at shower, bathing and handwash sink areas shall not exceed 120 degrees Fahrenheit (49 degrees Celsius) or be lower than 105 degrees Fahrenheit (41.5 degrees Celsius);

(b) Grab Bars. Grab bars shall be provided at all residents' toilets, showers, tubs and sitz baths. The bars shall have 1-1/2 inch (3.8 cm) clearance to walls and shall have sufficient strength and anchorage to sustain a concentrated load of 250 pounds (113.4 kilograms). Grab bars shall be returned to the wall or otherwise be constructed to prevent snagging clothes;

(c) Emergency Access. All rooms containing bathtubs, sitz baths, showers, and toilets shall be equipped with doors and hardware which will permit access from the outside in any emergency. When such rooms have only one opening or are smaller than 25 square feet, the doors shall be capable of opening outward or be otherwise designed to be opened without need to push against a resident who may have collapsed within the room;

(d) Accessibility. Toilets, handwash sinks, and baths shall be provided in accordance with the American National Standards Institute's "Providing Accessibility and Usability for Physically Handicapped People," effective February 5, 1986, and Title III of the Americans with Disabilities Act of 1990;

(e) Nurse Call System. See OAR 411-087-0440.

(2) Toilet Facilities:

(a) Resident toilets:

(A) Access. Each resident room shall have direct access to a toilet room without entering the general corridor area;

(B) Number. One toilet room shall serve no more than four beds and no more than two resident rooms;

(C) Handwash sink. Each toilet room shall contain a toilet and a handwash sink. The handwash sink may be omitted from a toilet room serving only one resident room if the room is a single-bed room and contains a handwash sink;

(D) Dimensions. The dimensions of a resident toilet room shall be sufficient to allow access and self transfer by a resident in a wheelchair or with the assistance of an attendant. The distance from the toilet plumbing wall to the opposite wall shall be no less than six feet;

(E) Privacy. Partitions between toilet shall be provided. These partitions shall be at least six feet in height and provide for privacy. Privacy curtains may be used in bathing areas in lieu of fixed partitions.

(b) Employee/Visitor Toilets. In addition to the toilet rooms for residents, there shall be at least one toilet room on each floor with handwash sink available for facility employees and visitors. Such toilets shall be clearly identified for public use and shall be directly accessible from the corridor, public lounge or waiting area.

(3) Handwashing Facilities:

(a) Sinks, Water Supply Spouts, Faucet Handles:

(A) Each resident room shall have a handwash sink. The handwash sink may be omitted from a single-bed room if the adjacent toilet room serves only one resident room;

(B) Handwash sinks shall be securely anchored to withstand an applied vertical load of not less than 250 pounds (113.4 kilograms) on the front of the fixture;

(C) Handwash sinks shall be wheelchair accessible;
(D) Sink faucets shall have a single spout (outlet) which discharges both hot and cold water;

(E) All handwash sinks shall be trimmed with single-lever or write-blade faucet handles which are operable without the use of hands.

(b) Mirrors:

(A) Mirrors shall be arranged for convenient use by residents in wheelchairs and in a standing position. Mirrors are not required in rooms exclusively serving residents whose care plans indicate mirrors are contraindicated;

(B) Mirrors shall not be installed at handwash sinks in food preparation areas.

(c) Hand Drying. Provisions for hand drying shall be included at all handwash sinks except scrub sinks. These shall be single use separate individual paper or cloth units enclosed in such a way as to provide protection against dust or soil and insure single unit dispensing.

(4) Bathtubs and Showers:

(a) Number. Bathtubs or showers shall be provided at the rate of one for every 25 beds which are not otherwise served by bathing facilities within the residents’ rooms;

(b) Whirlpool Tubs. In addition to the requirements listed in subsection (4)(a) of this rule, at least one therapeutic whirlpool tub designed for disabled assist shall be provided on each floor. The facility shall have at least one therapeutic whirlpool-type tub for every 60 beds;

(c) Privacy. Each tub or shower shall be in an individual room or enclosure which provides space for the private use of the bathing fixture, for drying and dressing, and for a wheelchair and an attendant;

(d) Shower Dimensions:

(A) Each facility shall have at least one shower that is a minimum of four feet square, without curbs, and designed to permit use by a wheelchair resident with an assisting attendant;

(B) Showers for ambulatory residents shall be not less than four feet by three feet.

(e) Non-Slip Surface. Shower bases and tubs shall provide non-slip surfaces;

(f) Toilet/Sink Access. A toilet and handwash sink shall be accessible to each bathtub/shower without going through the central corridor.

(5) Exceptions:

(a) Whirlpool Tubs. The number of whirlpool tubs in facilities which have been continuously licensed since January 1, 1992 without modification of number or type of bathtubs/showers shall be considered to be in compliance with subsection (4)(b) of this rule unless otherwise provided by OAR 411-087-0010. Facilities which lack the required number of therapeutic tubs shall have a hospital-type tub on each floor which does not have a therapeutic whirlpool tub. As of January 1, 2000, all facilities shall have at least one therapeutic whirlpool tub (waivers may be provided on a case-by-case basis);

(b) Showers. Facilities which have been continuously licensed since January 1, 1992 shall not be required to meet the dimensions or design criteria defined in subsection (4)(d) of this rule or requirements for dressing and drying areas adjacent showers and tubs;

(c) Toilets. Facilities continuously licensed since January 1, 1992 shall be exempt from section (2) of this rule unless otherwise provided by OAR 411-087-0010;

(d) Handwash Sinks. In facilities with rooms continuously licensed since January 1, 1992, without meeting subsection (3)(a) of this rule, such rooms shall be exempt from this requirement unless otherwise provided by OAR 411-087-0010;

(e) Spouts, Faucet Handles. Facilities continuously licensed since January 1, 1992 without meeting paragraph (3)(a)(E) of this rule shall be exempt from such paragraph unless the spouts/faucets are replaced or otherwise provided by OAR 411-087-0010;

(f) Accessibility. Facilities continuously licensed since January 1, 1992 without meeting subsection (3)(a) of this rule shall be exempted from such subsection unless the spouts/faucets are replaced or otherwise provided by OAR 411-087-0010.

[Publications: Publications referenced are available from the agency.]
411-087-0320

Soiled and Clean Utility Rooms

(1) Soiled Utility Room. The facility shall have one or more soiled utility rooms equipped to pre-rinse soiled linens and equipment. Each floor with resident rooms shall have a soiled utility room on the same floor within 120 feet of each resident room. The soiled utility room shall be equipped with:

(a) Handwash sink.

NOTE: If a two compartment sink is used to meet subsection (1)(b) of this rule, a separate handwash sink is not required.

(b) A mechanical sanitizer or two compartment deep sink (minimum dimensions for each compartment of 19 inches by 22 inches by ten inches deep) with hot and cold running water large enough to provide for disinfection of resident care equipment;

(c) A flush rim clinical sink with washing device;

(d) A work counter;

(e) Area for storage of linen and trash receptacles;

(f) Mechanical ventilation (see Table 2); and

(g) Storage space. Clean urinals and bedpans may be stored in a closable cabinet in the soiled utility room. Other clean supplies and equipment may not be stored in the soiled utility room.

(2) Clean Utility Room. Each floor with resident rooms shall have a clean utility room with a work counter, handwash sink and space for storage and distribution of clean and sterile supply materials. The clean utility room may be used for storage of clean linens.

(3) Exceptions:

(a) Locations. The maximum distance from resident room to soiled utility room in facilities which have been continuously licensed since January 1, 1992 may exceed 120 feet unless otherwise provided by OAR 411-087-0010;

(b) Ventilation. Facilities continuously licensed since January 1, 1992 without meeting subsection (1)(f) of this rule shall be exempt from such subsection unless otherwise provided by OAR 411-087-0010;

(c) Sink. Facilities continuously licensed since January 1, 1992 with a single compartment deep sink shall not be required to have a double deep sink or mechanical sanitizer in the soiled utility room unless the sink is replaced or otherwise provided by OAR 411-087-0010.

[ED. NOTE: Tables referenced are available from the agency.]

411-087-0330

Employee Rooms

(1) Rooms Required. The facility shall have an employee lounge and room(s) for conferences, meetings and inservice training. This requirement may be met with a multi-purpose room, but must be in addition to space required for residents.

(2) Exceptions. Facilities continuously licensed since January 1, 1992 shall be exempt from section (1) of this rule unless otherwise provided by OAR 411-087-0010.
Storage Rooms

(1) General Storage. General storage room(s) shall have a total area of not less than five square feet per bed. This space shall include an equipment storage room on each floor (which has resident rooms) for equipment such as I.V. stands, inhalators, air mattresses, and walkers. Separate storage space shall be provided for storage of commodes (this may be in the soiled utility room). There shall also be space located out of the path of normal traffic on each floor for stretchers and wheelchairs.

(2) Linen, Food. There shall be separate areas for storage of clean linens and food.

(3) Maintenance Equipment and Supplies. Space shall be provided for storage of building and yard maintenance equipment and supplies which are kept at the facility.

(4) Exceptions. Facilities continuously licensed since January 1, 1992 shall be exempt from the square footage requirements in section (1) of this rule unless otherwise provided by OAR 411-087-0010.

Maintenance and Housekeeping

(1) Maintenance Areas. The facility shall have a maintenance shop or area and tools required for equipment maintenance.

(2) Janitor's Closet:

(a) Location. In addition to the janitor's closet required in dietary, there shall be a minimum of one janitor's closet on each floor. There shall be a janitor's closet within 120 feet of every resident room;

(b) Design. Each janitor's closet shall contain a floor receptor or service sink with hot and cold running water and storage space for housekeeping equipment and supplies. All such closets shall have mechanical ventilation pursuant to Table 2 and a light fixture and wall switch.

(3) Exceptions. Facilities continuously licensed since January 1, 1992 shall be exempt from section (1) and subsection (2)(a) of this rule unless otherwise provided by OAR 411-087-0010.

Hallways, Corridors and Stairways

(1) Dimensions. All resident corridors/hallways serving resident living areas shall be a minimum of eight feet in width.

(2) Obstructions. Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.

(3) Handrails:
(a) Handrails shall be provided on both sides of corridors used by residents and on all stairways. A minimum clear distance of 1-1/2 inches (3.8 cm) shall be provided between the handrail and the wall;

(b) Ends of handrails shall be returned to the wall or otherwise be constructed to prevent snagging the clothes of residents.

(4) Exceptions. Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992 shall be exempt from sections (1) and (2) of this rule.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0400

Doors and Windows

(1) Doors:

(a) Interior doors:

(A) The minimum width of all doors to rooms with beds shall be three feet, eight inches (1.12) meters clear opening and six feet, eight inches (2.03 meters) high. Doors to rooms needing access for stretchers, residents' toilet rooms and rooms needing access for wheelchairs shall have a minimum width of two feet, eight inches (85.82 cm) clear opening;

(B) Doors on all openings to corridors shall be swing type;

(C) Space shall be provided in front and adjacent to doors to allow space for persons in wheelchairs;

(D) Doors, except those to spaces such as small closets (less than ten cubic feet) which are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width. Closet that are ten or more cubic feet are considered as occupiable spaces;

(E) Interior doors which go between areas frequented by residents and which may be locked shall have electromagnetic locks which automatically release in the event of fire alarm or power failure.

(b) Exterior doors:

(A) Exit/entrance doors with electromagnetic locks shall automatically release in the event of fire alarm or power failure;

(B) Exit/entrance doors shall be keyed or otherwise designed to allow all staff to promptly and easily exit;

(C) Exit/entrance door locks shall be approved by the Office of the State Fire Marshal;

(D) Space shall be provided in front of and adjacent to doors to allow space for persons in wheelchairs.

(2) Windows:

(a) All outer windows that open shall have insect screens;

(b) Windows above the first floor shall be designed to minimize potential for accidental falls when open;

(c) All resident rooms shall have outside windows with sills not more than three feet above the floor with a minimum area of ten percent of the floor area. The window will must be above ground level;

(d) Window shades, draperies, or blinds must be provided to control the amount of outside light and to assure the privacy of residents;

(e) Windows in resident rooms shall open without the use of tools. Windows in buildings designed with an engineered smoke control system in accordance with NFPA 90A are not required to be operable.

(3) Exceptions:
Floors, Ceilings and Walls

(1) General Requirements:

(a) Finish, trim, wall and floor construction shall be free from spaces that can harbor rodents and insects;

(b) Finish on walls, floors and ceilings in resident areas shall provide for a low sheen surface to minimize reflected glare;

(c) Rooms containing heat producing equipment (such as boiler or heater rooms and laundries) shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature ten degrees Fahrenheit (six degrees Celsius) above the ambient room temperature;

(d) The noise reduction criteria shown on Table 1 shall apply to partition, floor, and ceiling construction in resident areas.

(2) Floors and Wall Base:

(a) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved. Floors in shower and bath areas shall have a non-slip surface;

(b) Thresholds shall be constructed to facilitate use of wheelchairs and carts;

(c) Rugs or carpeting shall be Class I or II in accordance with NFPA 101, Chapter 6;

(d) Wall bases in kitchens, soiled utility rooms, central bathing areas, resident toilet rooms and janitor closets shall be self-coved (six inch minimum height), tightly sealed with the wall;

(e) Top-set rubber or vinyl base, where used, shall be sealed to the floor and walls.

(3) Ceilings:

(a) The minimum ceiling height shall be a nominal eight feet (2.44 m) with the following exceptions:

(A) Boiler rooms shall have ceiling clearances not less than two feet, six inches (76 cm) above the main boiler header and connecting piping;

(B) Rooms containing ceiling-mounted equipment shall have height required to accommodate the equipment;

(C) Ceilings in corridors, storage rooms, toilet rooms, and closets shall be not less than seven feet, six inches (2.29 m);

(D) Suspended tracks, rails, and pipes located in path of normal traffic shall be not less than six feet, eight inches (2.03 m) above the floor;

(E) Activity, recreation and exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over resident bed areas unless special provisions are made to minimize such noise.

(b) Ceilings in the dietary and food preparation areas shall have a smooth surface, be light in color, and cover all overhead piping and duct work;

(c) Acoustical ceilings (i.e., acoustical tile) shall be provided for corridors in resident areas, nurses' stations, dayrooms, recreation rooms, dining areas, and waiting areas. Other methods of sound control (e.g., carpeting) will be accepted by the Division if they meet STC...
classification requirements in Table 1 of these rules).

(4) Walls:

(a) Wall finishes shall be easily cleanable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant;

(b) All walls of rooms in which food or drink is prepared or stored and in dishwashing areas shall be smooth, moisture resistant and light in color.

(5) Exceptions:

(a) Self-Covered Wall Base. Facilities which have been continuously licensed since January 1, 1992 shall not be required to have self-covered base as required in subsection (2)(d) of this rule unless otherwise provided by OAR 411-087-0010;

(b) Noise Reduction. Facilities which have been continuously licensed since January 1, 1992 shall not be required to meet noise reduction criteria as required in subsection (1)(d) of this rule unless otherwise provided by OAR 411-087-0010;

(C) Acoustical Ceilings. Facilities which have been continuously licensed since January 1, 1992 shall not be required to have acoustical ceilings as required in subsection (3)(c) of this rule unless otherwise provided by OAR 411-087-0010.

[ED. NOTE: Tables referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0420

Electrical Systems: General

(1) Panelboards. Panelboards serving lighting and appliance circuits shall be located on the same floor as the circuits they serve. This requirement does not apply to emergency system circuits.

(2) Receptacles (Convenience Outlets):

(a) Resident Room. Each resident room shall have duplex grounding type receptacles as follows: Two located near the head of each bed, and one for television if used, and one on another wall;

(b) Corridors. Duplex grounding receptacles for general use shall be installed approximately 50 feet (15.24 m) apart in all corridors and within 25 feet (7.62 m) of ends of corridors;

(c) GFI Outlets. All outlets within five feet of a sink shall be a GFI type outlet. The resident sink located either in the resident room or the adjacent resident toilet room shall have a GFI type outlet located within five feet of the sink.

(3) Emergency Electrical Service:

(a) General. To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power as follows:

(A) Illumination for means of egress as required in NFPA Life Safety Code 101;

(B) Illumination for exit signs and exit directional signs as required in NFPA Life Safety Code 101;

(C) At least one clearly marked emergency power duplex receptacle in each dining area, food preparation area, and restorative care room;

(D) At least one clearly marked emergency power duplex receptacle in each resident room and at each nursing station;
(E) Nurses' calling systems;

(F) Equipment necessary for maintaining telephone service;

(G) Elevator service that will reach every resident floor when resident rooms are located on other than ground floor;

(H) Equipment for heating resident rooms to maintain a minimum temperature of 65 degrees in each resident room;

(I) General illumination at the nurses' stations, in the kitchen, and at selected receptacles in the vicinity of the generator set;

(J) Paging or speaker systems if intended for communication during emergency;

(K) Alarm systems including fire alarms activated at manual stations, water flow alarm devices of sprinkler system if electrically operated, fire and smoke detecting systems, and alarms required for nonflammable medical gas systems if installed; and

(L) Coolers for storage of food.

(b) Details. Emergency lighting and emergency outlets in resident rooms shall be in operation within ten seconds after the interruption of normal electric power supply. Emergency service to other receptacles and equipment may be delayed automatic or manually connected. Receptacles connected to emergency power shall be distinctively marked. Stored fuel capacity shall be sufficient for not less than 24-hour operation of the generator;

(c) Referenced Regulations. Note: OAR 411-087-0020;

(d) Flashlights. Functioning flashlights shall be readily available in the kitchen, administrator's office, and at each nursing station.

(4) Exceptions. Resident rooms in facilities which have been continuously licensed since January 1, 1992 and which are not used for residents using life-support equipment (e.g., ventilators, continuous suction devices) shall not be required to meet paragraphs (3)(a)(C)-(L) of this rule unless otherwise provided by OAR 411-087-0010.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0430

Electrical Systems: Lighting

(1) Purpose. The purpose of this rule is to help ensure nursing facility lighting which provides the best visual acuity possible for nursing facility residents. Facility design should consider that, due to the normal aging process, the older person requires higher levels of illumination, is much more sensitive to glare, and requires greater time to adapt to changes in light levels. The older adult generally has reduced contrast sensitivity. Proper lighting is important in promoting personal independence, psychosocial well-being, minimizing need for staff intervention and preventing accidents.

(2) Lighting Required:

(a) All spaces occupied by people, machinery, equipment within buildings, approaches to buildings, and parking lots shall have lighting;

(b) Light Fixtures. Light fixtures shall be designed to minimize direct glare; e.g., indirect or diffused lighting, and to minimize energy consumption. Bare light bulbs or tubes are not allowed in resident areas or food preparation areas;

(c) Lighting Intensity. Lighting fixtures and circuitry shall have the capability of providing the lighting intensities shown in Table 4.

(3) Natural Light. Windows and skylights shall be utilized to minimize the need for artificial light and to allow residents to experience the natural daylight cycle. The use of windows and skylights is especially important near entrances/exits, in order to avoid difficulty in adjusting to light levels when entering or leaving the facility.

(4) Walls, Floors, Ceilings, Doors, Windows. Wall, floor and ceiling surfaces shall be designed/finished to minimize reflected glare. High
contrast surfaces shall be used to assist residents with limited visual acuity to recognize the juncture between floor and wall, between wall and door, and between floor and other objects (e.g., toilet):

(a) On or after January 1, 1994, new paint and other new finishes used on ceiling shall have a reflectance value of 80 percent or higher. Such paint/finishes shall have a low sheen or matte finish;

(b) On or after January 1, 1994, new paint and other new finishes used on walls above 36 inches from the floor shall have a reflectance value of 60 percent or higher. Such paint/finishes shall have a low sheen or matte finish;

(c) Floors shall have a low sheen or matte finish;

(d) By January 1, 1997, all windows shall have coverings which minimize glare without blocking out all light.

(5) Resident Rooms. Residents’ rooms shall have general lighting switchable at the doorway. Resident rooms shall also have lighting for each bed suitable for reading and indirect low level night illumination switchable at the bed. At least one light fixture for night lighting shall be switchable at the entrance to each resident room. All switches for control of lighting in resident areas shall be of the quiet operating type.

(6) Exceptions:

(a) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be exempt from section (3) of this rule;

(b) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be required to have 20 percent of the resident rooms (including wardrobe, toilet room entry, toilet room and make-up/shaving area) in compliance with Table 4 by January 1, 1995. One year after January 1, 1995, and every year thereafter, such facility shall be required to have an additional 20 percent of the resident rooms in compliance with Table 4 until January 1, 1999, at which time all resident rooms shall comply;

(c) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be required to meet task lighting requirements for medicine preparation area(s) and nurses station(s) as described in Table 4 by January 1, 1995;

(d) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be required to meet task lighting requirements for food preparation areas, occupational therapy area and activity area(s) as described in Table 4 by January 1, 1996;

(e) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be required to meet task lighting requirements for laundry, examination room(s), and physical therapy area as described in Table 4 by January 1, 1997;

(f) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be required to meet task lighting requirements for staff toilet(s) and administrative offices as described in Table 4 by January 1, 1998;

(g) Except as provided in OAR 411-087-0010, facilities continuously licensed since January 1, 1992, shall be required to have a minimum interior entry area ambient lighting of 50 foot candles instead of 100 foot candles as described in Table 4. [ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0440

**Electrical Systems: Alarm and Nurse Call Systems**

(1) Exit Door Alarm. The facility shall have an exit door alarm system which alerts the staff when an exit door is opened or when a resident departs, or any other system determined to be acceptable to the Division (such determination shall be in writing).

(2) Nurse Call System:

(a) Resident Rooms. Each resident room shall be served by an electric nurse call system. Each resident shall have a nurse call button which may be easily located to allow the resident to summon nursing staff. Two call buttons serving adjacent beds may be served by one calling
(b) Bath, Toilet and Shower Rooms. Each bath, toilet and shower room must have an electric call system;

(c) Nurses’ Station. The nurse call system shall register all calls at the nurses’ station by both a visible and audible signal. The nurse call system shall also register a visible signal in the corridor adjacent to the door of the room from which the signal originated:

(A) The visible signal shall remain on until turned off at the location where the signal originated;

(B) In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections.

(3) Fire/Smoke Alarm System. Fire and smoke detection/alarm systems shall comply with OAR 411-087-0020 ("Referenced Regulations").

(4) Exceptions:

(a) Pediatric Units. Rooms in pediatric units may have two-way voice communications in lieu of call buttons required under subsection (2) (a) of this rule. Such systems shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating;

(b) Locked Units. Rooms in locked units serving residents with Alzheimers or other dementias may have wall-mounted call buttons in lieu of call buttons on cords when necessary for resident safety;

(c) Audible Signal. Call systems in facilities continuously licensed since January 1, 1992 shall not be required to have an audible call feature at the nurses' station unless required to conform pursuant to OAR 411-087-0010.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0450

Heating and Ventilating Systems

(1) Energy Conservation. Special design considerations should be given to energy conservation in accordance with Section 53 of the Oregon Structural Specialty Code.

(2) Temperature:

(a) Design. For all areas occupied by residents, the indoor winter design temperature shall be 75 degrees Fahrenheit (24 degrees Celsius). For all other occupied areas, the indoor winter design temperature shall be 72 degrees Fahrenheit (22 degrees Celsius).

NOTE: This does not preclude operation at lower temperatures where appropriate and resident safety is not affected.

(b) Function. For all areas occupied by residents, the indoor temperature shall be maintained at not less than 70 degrees Fahrenheit (21 degrees Celsius).

(3) Ventilation Design. In the interest of energy conservation, the facility is encouraged to utilize recognized procedures such as variable air volume and load shedding systems in areas not listed in Table 2 and where direct care is not affected such as administrative and public areas, general storage, etc. Consideration may be given to special design innovations of Table 2 provided that pressure relationships as an indication of direction of air flow and total number of air changes as listed is maintained. All such proposed design innovations are subject to review and approval by the Division.

(4) Ventilation System Details. All air-supply and air-exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at the discharge end of the system and have motor life ratings suitable for continuous use (20,000 hours minimum). The ventilation rates shown in Table 2 shall be considered as minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates when needed for temperature control or control of odors:

(a) Outdoor air intakes shall be located as far as practical but not less than 25 feet (7.62 m) from exhaust outlets of ventilating systems, combustion equipment stacks, vacuum systems, plumbing vent stacks, or from areas which may collect vehicular exhaust and other noxious...
fumes (plumbing and vacuum vents that terminate above the level of the top of the air intakes may be located as close as ten feet (3.05 m)). The bottom of outdoor air intakes serving central systems shall be located as high as practical but not less than six feet (1.83 m) above ground level, or if installed above the roof, three feet (91 cm) above roof level;

(b) The ventilation systems shall be designed and balanced to provide the air exchange rate and pressure relationship shown in Table 2;

c) The bottoms of ventilation openings shall be not less than three inches (7.6 cm) above the floor of any room;

d) Corridors shall not be used to supply air or exhaust air from any occupiable room. Pressurization of corridors for odor control will be allowed within limits established by the agency having jurisdiction for enforcement of the Oregon Mechanical Specialty Code;

e) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies no less than those specified in Table 3. The filter bed shall be located upstream of the air conditioning equipment unless a pre-filter is employed. In this case, the pre-filter shall be upstream of the equipment and the main filter bed shall be located further downstream. Electronic filter systems meeting required efficiency ratings may be proposed as an acceptable alternative when installed and maintained in accord with recommendations of the manufacturer. Manufacturer's specifications and recommendations for installation shall be submitted for approval by the Division. If electronic filters are used, the facility shall comply with the manufacturer's specifications and recommendations for maintenance and cleaning. This information, including a copy of the manufacturer's specifications and recommendations, shall be documented and available in the facility;

(f) All filter(s) efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with ASHRAE Standard 52-76. Filter frames shall be durable and carefully dimensioned and shall provide an airtight fit with the enclosing duct work. All joints between filter segments and the enclosed duct work shall have gaskets or seals to prevent air leakage. A manometer shall be installed across each filter bed serving central air systems;

g) Air handling duct systems shall meet the requirements of NFPA Standard 90A;

(h) Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA Standard 90A except that all systems, regardless of size, serving more than one smoke or fire zone shall be equipped with smoke detectors to shut down fans automatically as delineated in Paragraph 4-3.2 of the Standard. Access for maintenance shall be provided at all dampers. Switching for restart of fans may be conveniently located for fire department use to assist in evacuation of smoke after the fire is controlled, provided provisions are made to avoid possible damage to the system because of closed dampers.

(5) Testing Required. Prior to facility licensure, all mechanical systems shall be tested, balanced, and operated to demonstrate to the design engineer or his/her representative that installation and performance of these systems conform to the design intent. Test results shall be made available on request to representatives of the Division.

(6) Exceptions. Facilities continuously licensed since January 1, 1992 shall not be required to meet sections (1), (3), (4) and (5) of this rule unless required to conform pursuant to OAR 411-087-0010.

[ED. NOTE: Tables referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0460

Water Supply, Sewage Disposal, and Other Piping Systems

(1) Plumbing System. All interior plumbing systems shall be installed and maintained in conformance with the State Plumbing Code which was current at the time of construction, municipal or county ordinances and to m rules of the Building Codes Division governing the installation of interior supplies in buildings:

(a) The material used for plumbing fixtures shall be of nonabsorbent acid-resistant material;

(b) Hot water heaters and tanks:
(A) The hot water heating equipment shall have sufficient capacity to supply water at sinks, showers, and tubs at 105 to 120 degrees Fahrenheit. Hot water supply in these areas shall not exceed 120 degrees Fahrenheit and not be less than 100 degrees Fahrenheit;

(B) The hot water heating equipment shall have sufficient capacity to provide water in the laundry and dietary areas at a minimum temperature of 160 degrees Fahrenheit;

(C) Storage tank(s) shall be fabricated of corrosion-resistant metal or lined with noncorrosive material.

(c) Drainage systems. Insofar as possible, draining piping shall not be installed within the ceiling nor installed in an exposed location in food preparation centers, food serving facilities, food storage areas, and other critical areas. Special precautions shall be taken to protect these areas from possible leakage or condensation from necessary overhead piping systems;

(d) Nonflammable medical gas systems. If used, nonflammable medical gas system installations shall conform to the requirements of NFPA 99, Chapter 4, 1990 Edition;

(e) Clinical vacuum (suction) systems. If used, clinical vacuum system installations shall be in accordance with the requirements of NFPA 99, Chapter 4, 1990 Edition;

(f) Identification. All piping in the heating, ventilation, air conditioning (HVAC) and service water systems shall be color coded or otherwise marked for easy identification.

(2) Water Supply. Hot and cold water, safe, sanitary and suitable for domestic use, shall be distributed at 20 pounds per square inch pressure or greater to conveniently located taps throughout the building. When the water supply is not obtained from the community water supply system and an independent supply is used, such water supply shall be in compliance with the Health Division Administrative Rules.

(3) Sewage and Wastewater:

(a) All sewage and liquid wastes shall be disposed of in a municipal sewer system if such facilities are available. When a municipal sewer system is not available, sewage and liquid wastes shall be collected, treated, and disposed of in an independent sewer system which conforms to the applicable minimum standards of the Department of Environmental Quality;

(b) All drainage and other arrangements for the disposal of excreta, infectious discharges, institutional and kitchen wastes shall conform to the State Plumbing Code, municipal or county ordinances, and to the rules of the State Health Division and the Department of Environmental Quality.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0470

Building Sprinkler Systems

(1) Applicable Codes. Facilities with sprinkler systems for fire suppression shall be installed to comply with the Oregon Structural and Life Safety Code as adopted by the Oregon Building Codes Division or local jurisdictions having authority.

(2) Unheated Areas. Sprinkler systems located in unheated areas or above the insulated ceiling system shall be of a dry type, have automatic heaters that maintain a minimum temperature of 40 degrees Fahrenheit, or have an antifreeze system.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0480

Waste Processing Systems

ardweb.sos.state.or.us/.../411_087.html
Storage and disposal. Space and facilities shall be provided for the sanitary storage and disposal of waste. Incinerator units must be a system approved by the Department of Environmental Quality. Compliance with OAR 333, division 18 is required.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615

411-087-0490

Elevator Systems

All buildings having residents' facilities (such as bedrooms, dining rooms, or recreation areas) or resident services (such as diagnostic or therapy) located on a floor other than the main entrance floor shall have electric or electro-hydraulic elevators. Installation and testing of elevators shall comply with requirements of the Oregon Building Codes Division Elevator Safety Section:

(1) Number:

(a) Buildings required to have elevators under this rule shall have at least one hospital-type elevator;

(b) Buildings with 60 to 200 beds located on floors other than the main entrance floor or where the major inpatient services are located on a floor other than those containing resident beds shall have at least two elevators;

(c) Buildings with more than 200 beds located on floors other than the main entrance floor shall have at least three elevators.

(2) Cars and Platforms:

(a) Dimensions. Cars of hospital-type elevators shall have inside dimensions that will accommodate a resident bed and attendants and shall be at least five feet (1.52 m) wide by seven feet six inches (2.29 m) deep. The car door shall have a clear opening of not less than three feet eight inches (1.12 m);

(b) Leveling. Elevators shall be equipped with an automatic leveling device on the two-way automatic maintaining type with an accuracy of 1/2 inch (1.3 cm);

(c) Operation. Elevators, except freight elevators, shall be equipped with a two-way special service switch to permit cars to bypass all landing button calls and be dispatched directly to any floor. Elevator call buttons, controls, and door safety stops shall be of a type that will not be activated by heat or smoke;

(d) Disabled Access. Elevator controls, alarm buttons, signals and telephones shall be accessible to wheelchair occupants and usable by the blind.

(3) Exceptions. Facilities continuously licensed since January 1, 1992 shall be exempt from this rule unless otherwise provided by OAR 411-087-0010.

Stat. Auth.: ORS 410.070 & 441.055
Stats. Implemented: ORS 441.055 & 441.615
The Oregon Administrative Rules contain OARs filed through December 15, 2010

DEPARTMENT OF HUMAN SERVICES,
SENIORS AND PEOPLE WITH DISABILITIES DIVISION

DIVISION 88

NURSING FACILITIES/LICENSING – TRANSFERS

411-088-0000

Purpose

These Oregon Administrative Rules, OAR 411-088-0000 through 411-088-0080, shall be known as the "Transfer Rules." The purpose of these rules is to ensure that:

1) Unnecessary transfers do not occur;

2) When transfers are necessary, precautions are taken by the facility to minimize risk to the resident and to help ensure the transfer will result in an environment that is suited to meet the resident's needs; and

3) Residents who leave to go to a hospital, or who choose to go to any other environment (except another nursing facility), may return; and

4) Residents are provided with information on their rights relative to the transfer process prior to a voluntary or involuntary transfer.

Stat. Auth.: ORS 410 & ORS 411.055
Stats. Implemented: ORS 441.055, ORS 441.600 & ORS 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93

411-088-0005

Definitions

As used in OAR Chapter 411, Division 088, unless the context requires otherwise, the following definitions apply:

1) "Hearing" means a contested case hearing according to the Administrative Procedures Act and the Rules of the Division.

2) "Involuntary Transfer" means a transfer which is not a voluntary transfer as defined in this rule.

3) "Legal Representative" means attorney-at-law, person holding a general power of attorney or power of attorney for health care, guardian, conservator or any person appointed by a court to manage the personal or financial affairs of the resident, or person or agency legally responsible for the welfare or support of the resident, other than the facility.

4) "Medical Emergency" means a medical condition which, in the exercise of medical judgment, requires immediate health care of a level higher than the facility is capable of delivering.
(5) "Notice" means a notice as specifically described within OAR Chapter 411, Division 088.

(6) "Post-hospital extended care services" means a prescribed course of treatment following discharge from a hospital, or following outpatient surgical services or emergency treatment in a hospital.

(7) "Private Pay Resident" means a resident who does not receive public assistance under ORS Chapters 411 or 414.

(8) "Rehabilitative Services" means specialized services by a therapist or a therapist assistant to a resident to attain optimal functioning including but not limited to physical therapy, occupational therapy, speech and language therapy and audiology.

(9) "Right of Readmission" means the right to occupy the first vacancy in the facility regardless of any other waiting list following the resident's request for readmission.

(10) "Right of Return" means the right of a person to return to his/her nursing facility bed following transfer to a hospital.

(11) "Specialized Services" means a program of care including hospice, rehabilitative services, respite care, a skilled nursing treatment regime, or be a part of a cooperative effort between the nursing facility and a hospital. The skilled treatment regime must be a regime for which the facility has established a specialty and which is designed to heal or stabilize a medical condition. The cooperative effort between hospital and nursing facility must be for the purposes of assessment and evaluation, monitoring, or for a joint effort in treating a medical condition.

(12) "Transfer" means termination of an individual as a resident of a facility. The term "transfer" does not include death nor does it include a temporary relocation in which the resident's bed remains available for the resident's immediate return.

(13) "Voluntary Transfer" means a transfer for which the resident has given consent after receipt and understanding of the notice, and after the receipt and understanding of the Division's brochure, "Leaving the Nursing Facility".

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: ORS 411.055 & ORS 411.605
Stats. Implemented: ORS 441.055, ORS 441.600 & ORS 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SSD 2-1995, f. & cert. ef. 2-15-95

411-088-0007

Voluntary Transfer

(1) Written Consent Required. Written consent for a voluntary transfer is required. Consent must be in writing on the form provided by the Division on the back page of the brochure, "Leaving the Nursing Facility". If a resident has substantially impaired cognitive powers, consent may only be given by a person designated by the resident to receive notice or, if none, the resident's legal representative.

(2) Documentation. The completed consent form must be kept in the resident's clinical record.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: ORS 410 & ORS 441.055
Stats. Implemented: ORS 441.055, ORS 441.600 & ORS 441.615
Hist.: SSD 8-1993, f. & cert. ef. 10-1-93

411-088-0010

Involuntary Transfer

Unless a transfer is voluntary, no resident may be transferred from a facility except for the reasons and according to the procedures described in these Transfer Rules. These rules shall only apply to residents in nursing facility beds or persons returning to nursing facility beds.

Stat. Auth.: ORS 410 & ORS 441
Stats. Implemented: ORS 441.055, ORS 441.600 & ORS 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90
Basis for Involuntary Transfer

Upon compliance with these Transfer rules (OAR 411-088), an involuntary transfer of a resident may be made when one of the reasons specified in section (1) or section (2) of this rule exists.

(1) MEDICAL and WELFARE REASONS.

(a) A resident may be transferred when the resident's physician states in writing that:

(A) The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; or

(B) The facility is unable to meet the resident's care needs and the facility has identified another environment available to the resident which can better meet the resident's needs. The Division shall assist the facility in the effort.

(b) A resident may be transferred when the Division Administrator or the State Fire Marshal states in writing the safety of the resident (or other persons in the facility) is endangered and justifies the transfer;

(c) A resident may be transferred when the behavior of the resident creates a serious and immediate threat to the resident or to other residents or persons in the facility and all reasonable alternatives to transfer (consistent with the attending physician's orders) have been attempted and documented in the resident's medical record. Such alternatives may include but are not limited to chemical or physical restraints and medication;

(d) A resident may be transferred when the resident has a medical emergency;

(e) A resident may be transferred when governmental action results in the revoking or declining to renew a facility's certification or license;

(f) A resident may be transferred when the facility intends to terminate operation as a nursing facility, and:

(A) Certifies in writing to the Division the license is to be irrevocably terminated; and

(B) Establishes to the satisfaction of the Division it has made arrangements to accomplish all necessary transfers in a safe manner with adequate resident involvement and follow-up or each resident to minimize negative effects of the transfer;

(g) A resident may be transferred from a facility when the resident has been accepted for the purpose of receiving post-hospital extended care services or specialized services, as physician's orders for such facility services and has, according to the physician's written opinion, improved sufficiently so the resident no longer needs the post-hospital extended care services or specialized services provided by the facility. The purpose of the admission, including the program of care, and the expected length of stay must have been agreed to in writing by the resident (or his/her legal representative who is so authorized to make such an agreement) at or prior to admission. The facility shall identify another environment available to the resident which is appropriate to meet the resident's needs. The Notice may be issued at the time of admission or later and shall be based upon the projected course of treatment.

(2) NON-PAYMENT REASONS. A resident may be transferred when there is a non-payment of facility charges for the resident and payment for the stay is not available through Medicaid, Medicare or other third party reimbursement. A resident may not be transferred if, prior to actual transfer, delinquent charges are paid. A resident may not be transferred for delinquent charges if payment for current charges is available through Medicaid, Medicare or other third party reimbursement.

(3) CONVICTION OF A SEX CRIME. A resident who was admitted January 1, 2006 or later may be moved without advance notice if all of the following are met:

(a) The facility was not notified prior to admission that the resident is on probation, parole or post-prison supervision after being convicted of a sex crime, and

(b) The facility learns that the resident is on probation, parole or post-prison supervision after being convicted of a sex crime, and

(c) The resident presents a current risk of harm to another resident, staff or visitor in the facility, as evidenced by:

(A) Current or recent sexual inappropriateness, aggressive behavior of a sexual nature or verbal threats of a sexual nature; and
(B) Current communication from the State Board of Parole and Post-Prison Supervision, Department of Corrections or community corrections agency parole or probation officer that the individual's Static 99 score or other assessment indicates a probable sexual re-offense risk to others in the facility.

(d) Prior to the move, the facility must contact DHS Central Office by telephone and review the criteria in paragraphs (8)(c)(A)&(B) of this rule. DHS will respond within one working day of contact by the facility. The Department of Corrections parole or probation officer will be included in the review, if available. DHS will advise the facility if rule criteria for immediate move out are not met. DHS will assist in locating placement options.

(e) A written move-out notice must be completed on a Department approved form. The form must be filled out in its entirety and a copy of the notice delivered in person, to the resident, or the resident's legal representative, if applicable. Where a person lacks capacity and there is no legal representative, a copy of the notice to move-out must be immediately faxed to the State Long Term Care Ombudsman.

(f) Prior to the move, the facility must orally review the notice and right to object with the resident or legal representative and determine if a hearing is requested. A request for hearing does not delay the involuntary move-out. The facility will immediately telephone DHS Central Office when a hearing is requested. The hearing will be held within five business days of the resident's move. No informal conference will be held prior to the hearing.

Stat. Auth.: ORS 441.055, 441.605, & 443.410
Stats. Implemented: ORS 441.055, 441.600, 441.615, 443.410 & 181.586
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SSD 2-1995, f. & cert. ef. 2-15-95; SPD 6-2006(Temp), f. & cert. ef. 1-18-06 thru 7-1-06; SPD 21-2006, f. 6-27-06 cert. ef. 7-1-06

411-088-0030

Considerations Required Prior to Involuntary Transfer

Prior to issuing a notice for an involuntary transfer, in order to determine the appropriateness of transfer, the facility shall consider the following:

(1) The availability of alternatives to transfer.

(2) The resident's ties to family and community.

(3) The relationships the resident has developed with other residents and facility staff.

(4) The duration of the resident's stay at the facility.

(5) The medical needs of the resident and the availability of medical services.

(6) The age of the resident and degree of physical and cognitive impairment.

(7) The availability of a receiving facility that would accept the resident and provide service consistent with the resident's need for care.

(8) The consistency of the receiving facility's services with the activities and routine with which the resident is familiar, and the receiving facility's ability to provide the resident with similar access to personal items significant to the resident and enjoyed by the resident at the transferring facility.

(9) The probability that the transfer would result in improved or worsened mental, physical, or social functioning, or in reduced dependency of the resident.

(10) The type and amount of preparation for the move, including but not limited to:

(a) Solicitation of the resident's friends and/or family in preparing the resident for the move;

(b) Visitation by the resident to (prior to actual transfer) or familiarity of the resident with the place to which the resident is to be transferred.

(11) On-site consultation by an individual with specific expertise in mental health services if the basis for considering transfer is behavioral, e.g., gero-psychiatric consultation.

arcweb.sos.state.or.us/.../411_088.html
411-088-0040

Involuntary Transfer Prohibited

(1) The facility shall not involuntarily transfer a resident for medical or welfare reasons under OAR 411-088-0020(1)(a) through (f) if the risk of physical or emotional trauma significantly outweighs the risk to the resident and/or to other residents if no transfer were to occur.

(2) The facility shall not involuntarily transfer a resident for any other reasons under OAR 411-088-0020 if the transfer presents a substantial risk of morbidity or mortality to the resident.

411-088-0050

Right to Return from Hospital

(1) If a resident is transferred to a hospital, the facility shall not fill the resident's bed with another person if the resident or the resident's legal representative offers payment, or reimbursement is available from the Division, for the period of the hospital stay. If payment/reimbursement is offered or available, from or on behalf of the resident or the Division or a combination thereof, or if the facility has not complied in full with section (2) of this rule, the resident shall have the right of return to his/her bed immediately after the period of hospital stay.

(2) The Administrator, or his/her designee, is responsible for notifying the resident/legal representative and any agency responsible for the welfare or support of the resident of the option to offer payment to hold the bed prior to filling the bed with another person. This notification shall be documented in the resident's record by either the resident's or legal representative's written agreement to pay or rejection of the option to pay.

(3) If the resident is unable due to physical or mental incapacity to enter such agreement and there is no legal representative known to the facility, this fact shall be documented in the resident's record and the resident's bed may thereafter be filled upon issuance of the notice (Exhibit 2).

(4) If the resident's bed has been given to another person because payment was not offered, the resident shall have priority for readmission over all other persons with a right to readmission and over any other waiting list.

(5) If a former resident or his/her legal representative requests right of return and the facility denies right of return, then the facility shall give written notice (Exhibit 2).

(6) Persons with right of return have priority over all persons with right of readmission.

(7) Residents with a right of return are entitled to return to the facility immediately upon discharge from the hospital unless the resident's bed has been filled in compliance with OAR 411-088-0050 and there is no available bed in the facility.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

411-088-0060

Right to Readmission

(1) Any person transferred from a facility voluntarily or involuntarily shall have the right of readmission to the facility from which the person was transferred, provided that:
(a) A request for readmission is made within 180 days of the date of transfer; and

(b) The person is eligible by means of payment and requires nursing facility care; and

(c) No determination was made at informal conference or hearing that the person would not have the right of readmission.

(2) Section (1) of this rule does not require a facility to accept a person in a bed located in a room which is occupied by a resident of the opposite sex at the time of the request.

**EXCEPTION:** A facility is required to accept a person to a room occupied by a resident of the opposite sex if the respective resident previously shared a room in the facility and if neither resident objects to the admission.

(3) Section (1) of this rule does not require a facility to accept a person who voluntarily transferred from the facility directly to another nursing facility.

(4) If a person, or his/her legal representative, request readmission, and the facility denies readmission, then the facility shall give written notice (Exhibit 2).

(5) A former resident who receives Medicaid does not have the right to be readmitted to a facility which is not Medicaid certified unless reimbursement is available pursuant to OAR 411-070-0010.

(6) If more than one person has a right of readmission, priority in allocation of vacancies shall be determined by the earliest date of application for readmission.

(7) Exception. A person whose stay(s) in the facility totals 30 or fewer days and was transferred pursuant to OAR 411-088-0070(1)(d) (post-hospital extended care services or specialized services) shall not have a right of readmission.

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 441.055 & ORS 441.605
Stats. Implemented: ORS 441.055, ORS 441.600 & ORS 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SSD 2-1995, f. & cert. ef. 2-15-95

411-088-0070

**Notice Requirements**

(1) NOTICE LENGTH:

(a) Any person transferred shall be provided a minimum of 30 days prior written notice (Exhibit 1) by the facility unless otherwise provided under this section.

(b) Any person may be transferred under OAR 411-088-0020(1)(b) (Life or Safety Threat) or 411-088-0020(1)(c) (Behavior Problem) with fewer than 30 days prior written notice (Exhibit 1) if the reason for such transfer constitutes an emergency. However, the facility shall give as much prior written notice (Exhibit 1) as the emergency permits.

(c) Any resident may be involuntarily transferred under OAR 411-088-0020(1)(d) (Medical Emergency) with no prior notice. However, the facility shall give notice (Exhibit 1 or 2) before giving the resident's bed to another person.

(d) Any person involuntarily transferred under OAR 411-088-0020(1)(g) (Post-Hospital Extended Care Services or Specialized Services) and cared for in the facility for less than 30 days may be transferred with fewer than 30 days' notice.

(A) In such cases the person shall be provided with notice no shorter than the length of current stay in the nursing facility.

(B) The notice shall be issued at the time of admission or as soon as the length of time for projected course of treatment can be estimated.

(C) Section (1)(d) of this rule does not apply if the resident had a right of readmission to the same facility prior to the hospital, surgical or emergency department services.
(e) Any resident involuntarily transferred under OAR 411-088-0020(1)(b) or (e) (Governmental Action) shall be provided a minimum of 14 days prior written notice (Exhibit 1).

(f) Any person denied the right of return or the right of readmission shall be notified by the facility immediately and provided written notice (Exhibit 2), mailed (registered or certified) or delivered in person within five days from date of request for return or readmission. A denial of right of return or readmission is allowable only if there is good cause to believe the resident lacks such right (see OAR 411-088-0050, 411-088-0060 and 411-088-0080).

(g) Any resident may voluntarily transfer from a facility. However, the facility shall provide notice (Exhibit 1) pursuant to this rule and shall maintain the signed consent form in the resident's medical record.

(2) NOTIFICATION LIST. The facility shall maintain and keep current in the resident's record the name, address and telephone number of the resident's legal representative, if any, and of any person designated by the resident or the resident's legal representative to receive notice of the transfer. The facility shall also record the name, address, and telephone number of any person who has demonstrated consistent concern for the resident if the resident has no one who is currently involved and who has been designated by the resident.

(3) NOTICE DISTRIBUTION. Notice shall be provided to:

(a) The resident or former resident, as appropriate;

(b) All persons required to be listed in the resident's medical record under section (2) of this rule;

(c) The local unit of the Seniors and People with Disabilities Division or Type B Area Agency on Aging. The notice does not need to be provided to the local unit of the Seniors and People with Disabilities Division or Type B Area Agency on Aging if the resident is private pay and the resident's stay(s) in the facility total 30 days or less; and

(d) The Long-Term Care Ombudsman if there is no one currently involved and designated by the resident.

(4) NOTICE FORMAT. Each notice shall be in the same format and shall have the same content as that provided in Exhibit 1 (Notice of Transfer) or Exhibit 2 (Denial of Readmission/Return) as appropriate.

(a) Each notice provided to residents, and persons required to be listed in the resident's medical record under section (2) of this rule shall be accompanied by a copy of the Seniors and People with Disabilities Division's brochure, "Leaving the Nursing Facility".

(b) If the person is a resident at the facility, the notice shall be served personally to the resident. All other notices required by this rule, including notices to persons who are no longer residents, must be either served personally or delivered by registered or certified mail.

(c) Both exhibits are incorporated by this reference as a part of this rule.

[ED. NOTE: Exhibits referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 441.055 & 441.605
Stats. Implemented: ORS 441.055, 441.600 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SSD 2-1995, f. & cert. ef. 2-15-95; SPD 3-2008, f. & cert. ef. 3-6-08

411-088-0080

Informal Conference and Hearing

(1) Conference and Hearing Required. A person who is to be involuntarily transferred, or refused the right of return or readmission, shall be entitled to an informal conference and hearing as provided in this rule.

(2) Conference Request:

(a) Upon receipt of a notice, the resident or any agency designated to receive the notice or person acting in the resident's or former resident's behalf, may request an informal conference on the form provided on the brochure, "Leaving the Nursing Facility":

arcweb.sos.state.or.us/.../411_088.html
(A) The request for informal conference must be mailed to the Division within ten days of the service or delivery of the notice. The Division shall immediately notify the licensee of the request;

(B) The Division may extend the time allowed for requesting an informal conference if it determines that good cause exists for failure to make a timely request;

(C) Any facility management personnel, or employee involved in providing nursing or other direct care, who receives any oral or written indication of a desire for an informal conference from a resident shall immediately notify the facility administrator. The administrator shall immediately thereupon provide notification to the Division.

(b) A resident may not be transferred after having requested an informal conference, or after facility staff or the licensee has knowledge of any indication of a desire for an informal conference, until:

(A) Disposition of the request has been completed to the satisfaction of all parties; or

(B) Authorization is provided by the Hearings Officer pursuant to this section.

(3) Informal Conference:

(a) The Division will hold an informal conference as promptly as reasonably possible, but in no event later than ten days (unless a later date is agreed upon by both the facility and the persons/agencies requesting the conference) after the request is received. The Division shall give telephone notice (where a telephone number is available) and send written notice of the time and place of the conference to the facility and all persons entitled to the notice. The purpose of the informal conference is to resolve the matter without a formal hearing. If a resolution is reached at the informal conference, it will be reduced to writing and no formal hearing will be held;

(b) The proceedings will be conducted at the facility where the resident is located unless an alternate site is agreed upon by both the licensee and the persons/agencies requesting the conference;

(c) At the end of the informal conference, if the licensee wishes to proceed with the transfer, the Division shall ask if any party representing the resident wishes to request a hearing.

(4) Hearing:

(a) Hearings shall be conducted as a contested case in accordance with the Administrative Procedures Act, ORS Chapter 183, and the rules of the Division adopted thereunder. Parties to the hearing shall be the resident (or former resident) and the licensee. The Hearings Officer is delegated the authority to issue the final order and shall do so;

(b) If, pursuant to section (3) of this rule, the Division receive (orally or in writing) a request for a hearing, the Division will set the date, time and place of the hearing as promptly as possible. Unless a later date is agreed upon by both the licensee and the person(s) requesting the hearing, the hearing shall be held no later than 30 days after the informal conference;

(c) Nothing herein shall be construed to prohibit, at the election of the Division and with the consent of all interested parties, a hearing immediately following the informal conference;

(d) The Division shall provide all persons and entities listed in OAR 411-088-0070(3) and the licensee with notification of the hearing. The hearing notification shall be served on the parties personally or by registered or certified mail;

(e) At the hearing the facility shall proceed first by presentation of evidence in support of the transfer of the resident, or of refusal to provide right of return or readmission of the former resident. The person or persons requesting the hearing shall follow the facility by presentation of evidence in support of their objection to the transfer, or of the request of right of return or readmission:

(A) In a hearing concerning right of readmission, the only questions raised shall be whether the application was timely, whether the former resident is eligible by means of payment, and whether another person was/is entitled to the bed;

(B) In a hearing concerning right of return, the only question raised shall be whether full payment is or was available for the period of hospital stay and whether there was authority under OAR 411-088-0050(2) for another person to be given the bed.

(f) The licensee shall have the burden of establishing that the transfer, or denial of return or readmission, is permitted by law;

(g) The Hearings Officer shall, in determining the appropriateness and timeliness of an involuntary transfer, or a refusal of return or
readmission, consider factors including, but not limited to, the factors listed in OAR 411-088-0030. The Hearings Officer shall not approve a transfer:

(A) For medical or welfare reasons (under OAR 411-088-0020(1)(a) through (d) if the risks of physical or emotional trauma significantly outweighs the risk to the resident and/or to other residents if no transfer were to occur;

(B) For any other reason if the transfer presents a substantial risk of morbidity or mortality to the resident.

(h) Conclusion of Hearing. The hearing shall be concluded by the issuance of findings and an order:

(A) Affirming the transfer, of the refusal to provide right of return or readmission;

(B) Granting conditional approval of a transfer when necessary or appropriate for the welfare of the resident. Conditions may include without limitation the occurrence of any or all of the following incidents in preparation for a transfer:

(i) Selecting a location for the person to be placed consistent with his/her need for care and as consistent as possible with his/her ties, if any, with friends and family;

(ii) Soliciting and encouraging participation of the resident's friends and family in preparing the resident for transfer;

(iii) Visits by the resident to the proposed site of relocation prior to the actual transfer, accompanied by a person with whom the resident is familiar and comfortable, unless the resident is already familiar with the proposed site;

(iv) Arranging at the proposed site of relocation for continuation (as much as possible) of activities and routines with which the resident has become familiar;

(v) Ensuring that the resident is afforded continuity in the arrangement of an access to personal items significant to the resident.

(C) Ordering the licensee to retain the resident or to readmit the former resident if he or she has been transferred; or to provide the former resident with the right of return or readmission; or

(D) Ordering the licensee to retain the resident and establishing standards of behavior for family members or other visitors necessary for the welfare of residents;

(E) Making such further provisions as are reasonably necessary to give full force and effect to any order that a licensee retain or readmit the resident or provide the resident the right of return or readmission.

(i) If the Division approves a transfer subject to one or more conditions pursuant to this rule, the transfer shall not occur until the licensee has notified the person(s) requesting the hearing and certified to the Division in writing that all of such conditions have been complied with and the Division has acknowledged to the licensee in writing the receipt and sufficiency of such certification. The Division may, upon request, allow verbal certification and give verbal acknowledgement subject to subsequent certification and acknowledgement in writing.

(5) Exceptions. A person who is to be involuntarily transferred, or refused the right of return or readmission, as a result of governmental action pursuant to OAR 411-088-0020(1)(b) shall not be entitled to a hearing prior to transfer.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: ORS 410 & ORS 441.055
Stats. Implemented: ORS 441.055, ORS 441.600 & ORS 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93
The Oregon Administrative Rules contain OARs filed through December 15, 2010

DEPARTMENT OF HUMAN SERVICES,
SENIORS AND PEOPLE WITH DISABILITIES DIVISION

DIVISION 89

NURSING FACILITIES/LICENSEING -- COMPLAINTS, INSPECTIONS, AND SANCTIONS

411-089-0010

Inspections/Surveys

(1) Frequency. The Division shall, in addition to any investigations conducted pursuant to complaints, conduct a general inspection of each facility to determine compliance with nursing facility laws on a schedule consistent with the survey schedule defined by the Health Care Financing Administration, and at such other times as the Division deems necessary.

(2) Content. The general inspection will include a review of resident care practices. Results of the review shall be summarized on the survey form.

(3) Documentation: A nursing facility shall maintain all written documentation required by Oregon law. Such written documentation shall be kept on the facility premises. When documents and records are requested by the Division, the facility shall make the requested materials available to the investigator or inspector for review and copying.

Stat. Auth.: ORS 410.070, 441.055 & 441.615
Stats. Implemented: ORS 441.087, 441.050, 441.615, 441.630, 441.690, 441.695 & 441.710
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95

411-089-0020

Sanctions, Generally

(1) Information collected during a visit by any Division or Area Agency on Aging representative, regardless of the reason for the visit, may be used as a basis for any sanction imposed by the Division.

(2) The use of any one sanction by the Division does not preclude the implementation of any other sanction(s) for the same deficiencies.

(3) The Division may seek appropriate administrative or injunctive relief prior to the completion of an investigation or inspection if it appears that a resident might otherwise be deprived of rights secured by federal or state law.

(4) If after an investigation or inspection the Division believes there is substantial evidence that a violation has occurred or is occurring, the Division may seek by administrative or judicial means to obtain such remedial relief as may be appropriate, including voluntary compliance, contested case, and injunction proceedings.

Stat. Auth.: ORS 441.055, 441.615 & 441.070
Stats. Implemented: ORS 411.050, 441.615 & 441.710
Civil Penalties

(1) CONSIDERATIONS. In determining the amount of a civil penalty the Division shall consider:

(a) Any prior violations of statute or rule by the facility or licensee that relates to operation of a nursing facility;

(b) The financial benefits, if any, realized by the facility as a result of the violation, such as costs avoided as a result of not having obtained sufficient staffing, equipment, or supplies;

(c) The gravity of the violation including the actual and potential threat to health, safety, and well-being of residents, the duration of the threat or number or times the threat occurred, and the number of residents threatened;

(d) The severity of the actual or potential harm caused by the violation including whether the actual or potential harm included loss of life or serious physical or emotional injury;

(e) The facility's history of correcting violations and preventing recurrence of violations; and

(f) Exhibit 89-1, Civil Penalty Chart, which is incorporated by reference and is a part of this rule.

(2) SINGLE VIOLATION CIVIL PENALTIES. Violations of any requirement within any part of the following statutes, rules, or sections of the following rules are a violation that may result in a civil penalty after a single occurrence.

(a) Violations involving direct resident care, feeding, or sanitation involving direct resident care including any violation of:

(A) OAR 411-085-0060 (Specialty Nursing Facilities);

(B) OAR 411-085-0200(2) (Facility Employees);

(C) OAR 411-085-0210 to 411-085-0220 (Facility Policies, Quality Assurance);

(D) OAR 411-085-0360 (Abuse);

(E) OAR 411-086-0010 to 411-086-0020 (Administrator, Director of Nursing Services);

(F) OAR 411-086-0040 (except section (3)) (Admission of Residents);

(G) OAR 411-086-0050 to 411-086-0060 (Day Care, Assessment, Care Plan);

(H) OAR 411-086-0110 to 411-086-0150 (Nursing Services);

(I) OAR 411-086-0200 to 411-086-0260 (Physician, Dental, Rehabilitative, Activity, Social, Dietary, and Pharmaceutical Services);

(J) OAR 411-086-0300 (except section (6)) (Clinical Records);

(K) OAR 411-086-0310 to 411-086-0360 (Employee Orientation and Training, Disaster Preparation, Infection Control, Smoking, Furnishings, and Equipment);

(L) OAR 411-087-0100(1)(a) and (c) (Repair and Cleanliness); or

(M) OAR 411-087-0440 (Alarm and Nurse Call Systems).

(b) Violation involving failure to provide staff-to-resident ratio including any violation of:

(A) OAR 411-086-0030 (except section (1)) (RN Care Manager); or

(B) OAR 411-086-0100 (Nursing Staffing).
(c) Violation of any rule adopted pursuant to ORS 441.610 including:

(A) OAR 411-085-0300 to 411-085-0350 (Resident Rights);

(B) OAR 411-086-0040(3) (Advance Directives);

(C) OAR 411-086-0300(6) (Record Retention); or

(D) OAR chapter 411, division 088 (Rights Regarding Transfers).

(d) Violation of ORS 441.605 (Resident Rights) or any general or final order of the Division.

(3) CIVIL PENALTIES REQUIRING REPEAT VIOLATIONS. Violation of any Division rule not listed in section (2) of this rule is subject to a civil penalty under the following circumstances:

(a) Such violation is determined to exist on two consecutive surveys, inspections, or visits; and

(b) The Division prescribed a reasonable time for elimination of the violation at the time of, or subsequent to, the first citation.

(4) AMOUNT OF CIVIL PENALTY.

(a) Violation of any requirement or order listed in section (2) of this rule is subject to a civil penalty of not more than $500 for each day the violation occurs, unless otherwise provided by this section;

(b) Violation of any requirement listed in section (3) of this rule is subject to a civil penalty of not more than $500 per violation, unless otherwise provided by this section;

(c) Violation involving resident abuse that resulted in serious injury or death is subject to a civil penalty of not less than $500 nor more than $1,000, or as otherwise required by federal law (ORS 441.995(3) and ORS 441.715(1)(c));

(d) The Division shall impose a civil penalty of not less than $2,500 for each occurrence of substantiated abuse that resulted in the death, serious injury, rape, or sexual abuse of a resident. The civil penalty may not exceed $15,000 in any 90-day period.

(A) To impose this civil penalty, the Division shall establish that:

(i) The abuse arose from deliberate or other than accidental action or inaction;

(ii) The conduct resulting in the abuse was likely to cause death, serious injury, rape, or sexual abuse of a resident; and

(iii) The person substantiated for the abuse had a duty of care toward the resident.

(B) For the purposes of this civil penalty, the following definitions apply:

(i) "Serious injury" means a physical injury that creates a substantial risk of death or that causes serious disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

(ii) "Rape" means rape in the first, second, or third degree as described in ORS 163.355, 163.365, and 163.375.

(iii) "Sexual abuse" means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, sodomy, sexual coercion, sexually explicit photographing, or sexual harassment. The sexual contact must be in the form of any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.

(iv) "Other than accidental" means failure on the part of the licensee, or licensee’s employees, agents, or volunteers for whose conduct licensee is responsible, to comply with applicable Oregon Administrative Rules.

(5) PAYMENT TO BE CONSIDERED ADMISSION OF VIOLATION. Unless the Division agrees otherwise, for purposes of history of the facility, any payment of a civil penalty shall be treated by the Division as a violation of the statutes or rules alleged in the civil penalty notice for which the civil penalty was paid for.

(6) All penalties recovered shall be deposited in the Quality Care Fund.
(7) NOTICE. The Division's notice of its intent to impose a civil penalty shall include the statements set out in OAR 411-089-0040(3)(a)-(f), and shall also include a statement that if the licensee fails to request a hearing within 10 days of the date the notice was mailed, the licensee shall have waived the right to a hearing.

(8) HEARING REQUEST.

(a) If the Division issues a notice of intent to impose a civil penalty, the licensee shall be entitled to a hearing in accordance with ORS chapter 183.

(b) A request for a hearing must be in writing and must be received by the Division within 10 days of the date the notice of intent to impose a civil penalty was mailed to the licensee. The hearing request must include an admission or denial of each factual matter alleged in the notice and shall affirmatively allege a short plain statement of each relevant affirmative defense the licensee may have. The Division may extend the time allowed for submission of the admission or denial and affirmative defenses for up to 30 calendar days.

(9) DEFAULT ORDER. If a hearing is not timely requested, or if the licensee withdraws a hearing request or fails to appear at a scheduled hearing, the Division may enter a final order by default imposing the civil penalty. In the event of a default, the Division's file on the subject of the civil penalty automatically becomes a part of the record for purposes of proving the Division's prima facie case.

[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy of table(s).]

Stat. Auth.: ORS 441.615, 441.637, 441.710, 441.715 & 441.990
Stats. Implemented: ORS 410.070, 441.055, 441.615, 441.637, 441.715, 441.990
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95; SPD 24-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 11-2010, f. 6-30-10, cert. ef. 7-1-10

411-089-0040

Nursing Facility License Denial, Suspension, Revocation

(1) Basis for Denial, Revocation -- Mandatory. A license shall be suspended and/or revoked or denied if a certificate of noncompliance is issued by the State Fire Marshal, Deputy or other approved representative pursuant to ORS Chapter 479.

(2) Basis for Denial or Revocation -- Discretionary. A license may be denied or revoked by the Division when it finds that the licensee or applicant:

(a) Failed to comply with nursing facility law such that the health, safety or welfare of residents is or was jeopardized; or

(b) Failed to substantially comply with nursing facility law during any three inspections within a five year period (for the purpose of this rule, "inspection" means an on-site visit to the facility by the Division for licensing or certification); or

(c) Has been convicted, under any state or federal law, of a felony or of a misdemeanor associated with the operation of a health care facility or agency within the previous ten years; or

(d) Had an incident of ownership of ten percent or greater in or had a management or control interest in any facility in any state when the facility was terminated from participation in the Medicaid or Medicare program, or at a time when the facility voluntarily terminated participation in the Medicaid or Medicare program during any state or federal termination process; or

(e) Had an incident of ownership of ten percent or greater in any facility in any state which failed to reimburse any state or the federal government for Medicaid or Medicare overpayments on a timely basis within the preceding five year period; or

(f) Had an incident of ownership of ten percent or greater or a management or control interest in a health care facility or agency whose license was involuntarily suspended, revoked or not renewed within the preceding five years; or

(g) Had a nursing home administrator's license revoked, suspended or not renewed in any state (excluding revocation based on failure to pay license fee or failure to maintain required continuing education requirements when not serving as an administrator) within the preceding five year period; or

(h) Provided false, incorrect or misleading information to the Division on the license application form; or
(i) Provided false, incorrect or misleading information to the Division regarding care of residents, facility finances or resident funds; or

(j) Failed to provide workers’ compensation coverage for health care facility employees when required by state law in any state; or

(k) Permitted, aided or abetted any illegal act which had a significant adverse impact on resident health, safety or welfare within the preceding five year period; or

(l) Had an incident of ownership of ten percent or greater in any health care facility in any state at a time when the facility was denied an operating license (excluding denial based upon absence of bed need); or

(m) Demonstrated fiscal instability within the preceding five years and such instability relates to the licensee/applicant’s ability to provide care and/or operate a facility. Examples of fiscal instability include but are not limited to the experiencing of more than one instance of any of the following events or the experiencing of more than one of the following events:

(A) Failure to compensate employees in a timely manner;

(B) Failure to maintain in any facility an adequate inventory of medical supplies, personal supplies, or food;

(C) Failure to promptly pay any judgments, taxes, warrants or other liens;

(D) Failure to pay utility bills or other bills related to the operation or maintenance of any facility (excluding failure to pay when the facility has a clear basis to dispute the billing); or

(E) A poor credit rating; or

(n) Has demonstrated fiscal instability within the past five years by having experienced any other history of poor credit or poor financial management; or

(o) Has failed to pay a civil penalty imposed by the Division.

(3) Notice of Intent to Revoke or Deny. The Division's notice of its intent to deny or revoke a nursing facility license shall include:

(a) A statement that the licensee or applicant has a right to a contested case hearing or a statement of the time and place of the hearing;

(b) A statement of the authority and jurisdiction under which the hearing is to be held;

(c) A reference to the particular sections of the statute and rules involved;

(d) A short and plain statement of the matters asserted or charged;

(e) A statement that the licensee or applicant is entitled to be represented by counsel and to respond and to present evidence and argument on all issues involved;

(f) A statement that the record of the proceeding to date, including information in the Division file or files on the subject of the revocation or denial of the license automatically becomes part of the contested case record upon default for purposes of proving the Division's prima facie case; and

(g) A statement that if the licensee or applicant fails to request a hearing within 21 days of the date the notice of revocation was received, or within 60 days of the date the notice of denial was received, whichever is applicable, the licensee or applicant shall have waived the right to a hearing.

(4) Informal Conference. When the Division issues a notice of intent to revoke or deny a license, the licensee or applicant shall be entitled to an informal conference to respond to the notice. The conference shall be held before a person authorized to issue the order or to make recommendations regarding issuance of the order. A request for an informal conference must be received in writing and must be received by the Division within ten days of the date of the notice of the intent to revoke or deny the license was received by the licensee or applicant. If the licensee or applicant fails to submit a timely request for a conference, the licensee or applicant shall have waived the right to the conference.

(5) Hearing:
(a) Right to Hearing. When the Division issues a notice of intent to revoke or deny a license, the licensee or applicant shall be entitled to a contested case hearing in accordance with the provisions of ORS Chapter 183;

(b) Request for Hearing. A request for hearing must be in writing and must be received by the Division within:

(A) Twenty-one days of the date the licensee received the notice of revocation; or

(B) Sixty days of the date the applicant received the notice of denial of licensure.

(c) Date of Hearing. The hearing shall be held within 60 days of the request for hearing unless the Division and the licensee or applicant agree to a later date;

(d) Continued Operation Prohibited. A facility may not continue operation if the facility license is immediately suspended because of serious and immediate danger to resident health or safety pursuant to OAR 411-089-0040(2).

(6) Default Order. If the licensee or applicant fails to request a contested case hearing within the prescribed time period, withdraws a previous hearing request, or fails to appear at a scheduled hearing, the Division may enter an order denying or revoking the license by default. In the event of a default, the Division's file(s) on the subject of revocation or denial automatically become part of a contested case record for the purposes of proving the Division's prima facie case.

(7) Emergency Suspension Order:

(a) When the Division finds that a serious and immediate threat to resident health and safety exists, the Division may immediately suspend a nursing facility license. An emergency suspension order must be in writing. The order may be issued without prior notice to the licensee and without a prior opportunity for a contested case hearing;

(b) Except where the threat to residents is so imminent that the Division determines that pre-suspension notice is not practical, the Division will provide the licensee with a pre-suspension notice and an opportunity to object prior to issuing an emergency suspension order. The pre-suspension order shall:

(A) Describe generally the acts of the licensee and/or circumstances that would be grounds for an emergency suspension order under this rule; and

(B) Describe generally the reasons why the acts of the licensee and/or the circumstances seriously and immediately endanger resident health and safety; and

(C) Identify the person at the Division whom the licensee may contact and who is authorized to make recommendations regarding issuance of the order.

(c) If pre-suspension notice is issued, the licensee shall be entitled to an immediate opportunity to respond to the notice before a person authorized to issue the order or to make recommendations regarding issuance of the order. The emergency suspension order may be issued at any time thereafter;

(d) When an emergency suspension order is issued, the Division will serve the order on the licensee either personally or by registered or certified mail. The order shall include the following statements:

(A) The licensee's right to a hearing, or a statement of the time and place of the hearing;

(B) The authority and jurisdiction under which the hearing is to be held;

(C) A short plain statement of the matters asserted or charged;

(D) A reference to the particular sections of the statutes and rules involved;

(E) That the licensee may elect to be represented by counsel and may respond and present evidence and argument on all issues involved;

(F) That the licensee has a right to demand that a hearing, if requested, be held as soon as practical;

(G) That if the demand for a hearing is not received by the Division within 90 days of the date of the emergency suspension order the licensee shall have waived its right to a hearing under ORS Chapter 183;
Restriction of Admissions

(1) Purpose. The purpose of this rule is to protect nursing facility residents and prospective residents from threats to their health, safety and welfare, and to help ensure that the attention of facilities with serious deficiencies is directed toward correcting those deficiencies.

(2) Basis for Admission Restriction. When the Division finds an immediate threat to resident health and safety, the Division may order an immediate restriction of admissions, or may immediately restrict the number or type of admissions at the facility. An Admission Restriction Order shall be in writing and may be issued without prior notice to the licensee and without an opportunity for a contested case hearing:

(a) In determining whether to order a restriction of admission under this rule, the Division shall consider:

(A) The needs of the residents and prospective residents;
(B) The severity of the threat to current and prospective residents; and
(C) The history of the care provided by the licensee.

(b) For the purposes of this rule, an immediate threat to resident health and safety may exist when a facility lacks adequate alarm systems including, but not limited to, call bells, fire, door alarm and/or any other means to protect against a threat to resident health and safety;

(c) For the purposes of this rule, an immediate threat to resident health and safety exists when:

(A) The Division finds a pattern of:

(i) Failure to assess or take action to prevent or treat decubitus ulcers, weight loss, infection, dehydration or other changes in the physical condition of residents; or
(ii) Failure to follow physician’s orders, including failure to correctly administer medications; or
(iii) Abuse as defined by ORS 441.630, or preventable injuries; or

(B) The Division finds that any other condition or combination of conditions exists which, in the opinion of the Division, constitute an immediate threat to resident health and safety, or a potential threat to new residents.

(3) Impending Admission Restriction Notice. Except where the threat to residents is so imminent that the Division determines pre-
restriction notice is not practical, the Division will provide the licensee with a pre-restriction notice and an opportunity for an informal conference at least 48 hours prior to issuing an Admission Restriction Order. The Notice of Impending Restriction of Admission may be provided in writing, sent by certified or registered mail to the licensee, or provided orally in person or by telephone to the licensee or to the person apparently in charge at the facility. When the notice is delivered orally, the Division shall subsequently provide written notice to the licensee by registered or certified mail. The pre-restriction notice shall:

(a) Describe generally the acts or omissions of the licensee and the circumstances which led to the finding that an immediate threat to resident health and safety exists at the facility;

(b) Describe generally why the acts or omissions and the circumstances create an immediate threat to resident or prospective resident health and safety; and

(c) Identify a person at the Division whom the licensee may contact and who is authorized to enter the Admission Restriction Order or to make recommendations regarding issuance of an order; and

(d) Specify the date and time the Admission Restriction Order will take effect.

(4) Informal Conference. If an informal conference is requested, the conference shall be held at a location designated by the Division. If determined to be appropriate by the Division, the conference may be held by telephone:

(a) With Pre-Admission Restriction Notice. If a pre-admission restriction notice is issued, the licensee shall be provided with an opportunity for an informal conference to object to the Division's proposed action. The Admission Restriction Order may be issued at any time after the informal conference;

(b) Without Pre-Admission Restriction Notice. If an Admission Restriction Order is issued without prior notice, the licensee may request an immediate informal conference to object to the Division's action.

(5) Admission Restriction Order. When an Admission Restriction Order is issued, the Division shall serve the order on the licensee either personally or by registered or certified mail. The order shall include the following statements:

(a) The licensee's right to a hearing or a statement of the time and place of the hearing;

(b) The authority and jurisdiction under which the hearing is being held;

(c) A reference to the particular sections of the statute and rules involved;

(d) The effective date of the restriction;

(e) A short and plain statement of the nature of the matter asserted or charged;

(f) That the licensee may elect to be represented by counsel and to respond and present evidence and argument on all issues involved. If the licensee is to be represented by counsel, the licensee shall notify the Division;

(g) That the licensee has the right to demand that a hearing, if requested, be held as soon as practical;

(h) That if a demand for hearing is not received by the Division within 90 days of the date of the notice of the Admission Restriction Order, the licensee shall have waived the right to a hearing under ORS Chapter 183;

(i) Findings of specific acts or omissions of the licensee are grounds for the admission restriction, and the reasons these acts or omissions constitute an immediate and serious threat to the health and safety of the residents; and

(j) That the Division may combine the hearing on the Admission Restriction Order with any other Division proceeding affecting the licensee. The procedures for the combined proceeding shall be those applicable to the other proceedings affecting the license.

(6) Posting of Admission Restriction Order. A licensee who has been ordered to restrict admissions to a facility shall immediately post a "Restriction of Admissions Notice" on both the inside and outside faces of each door of the facility through which any person may enter or exit the facility. Such public notices shall be provided by the Division. The notices shall not be removed, altered or obscured until the restriction has been lifted by the Division. Removal of the notice without Division authorization is a Class C misdemeanor.

(7) Hearing:
(a) Right to Hearing. If the Division issues an Admission Restriction Order, the licensee is entitled to a contested case hearing pursuant to ORS Chapter 183;

(b) Hearing Request. The request for a hearing must be received within 90 days of the Admission Restriction Order;

(c) Date of Hearing. When a timely request for hearing is received, the hearing will be held as soon as practical, but not later than 30 days after the request for hearing, unless the Division and the licensee agree to a later date;

(d) At the hearing, the Division shall consider the facts and the circumstances including, but not limited to:

(A) Whether at the time of the issuance of the restriction there was probable cause from evidence available to the Division to believe there were grounds for the Admission Restriction Order;

(B) Whether the acts or omissions of the licensee posed an immediate threat to resident health and safety;

(C) Whether changed circumstances, including implementation of effective systems to help ensure deficiencies causing the restriction do not recur, eliminate the need for continuing the restriction; and

(D) Whether the agency followed the appropriate procedures in issuing the restriction.

(8) Request for Reinspection. When the licensee determines the circumstances causing the restriction no longer exist, and that effective systems are in place to help ensure similar deficiencies do not recur, the licensee may make written request to the Division for a reinspection. The Division will conduct the reinspection within 15 working days following receipt of the written request.

(9) Reinspection.

(a) If the Division finds there is no longer an immediate threat to resident health and safety as defined in this rule, and finds effective systems are in place to ensure similar deficiencies do not recur, the restriction will be lifted. The Division will notify the facility by telephone of the decision to lift or not lift the restriction within five working days from the completion of the reinspection. Telephone notification will be followed by written notification;

(b) If the Division determines an immediate threat to resident health and safety continues to exist after a reinspection, the admission restriction will not be lifted and the Division is not obligated to reinspect again for at least 45 days. A decision not to rescind the Admission Restriction Order shall be given to the licensee in writing and the licensee shall be informed of the right to a contested case hearing pursuant to ORS Chapter 183. Nothing in this rule is intended to limit the Division's authority to visit or inspect the facility at any time.

(10) Exceptions to Admission Restriction Order. While an Admission Restriction Order is in place, the Division, in its sole discretion, may authorize the facility to admit former residents with a right of return or right of readmission. The Division, in its sole discretion, may also authorize the facility to admit new residents for whom the Division determines that alternate placement is not feasible.

Stat. Auth.: ORS 410.070, 441.030, 441.055 & 441.615
Stats. Implemented: ORS 441.030 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93

411-089-0070

Facility Fund

(1) Moneys in the Facility Fund are appropriated to the Division to pay for the reasonable expenses of a trustee or temporary manager.

(2) BASIS FOR APPOINTMENT.

(a) A trustee may be appointed when a court finds that the health and welfare of facility residents are in jeopardy pursuant to ORS 441.281.

(b) A temporary manager may be appointed by the Division, with consent of the licensee, if the Division determines that the health or safety of facility residents is in jeopardy pursuant to OAR 411-089-0075.

(3) LICENSEE REPAYMENT TO FACILITY FUND. When the Division is required to utilize the Facility Fund to meet expenses of a trustee or temporary manager, the amount used shall constitute a loan to the facility and shall be repayable to the Facility Fund.
(4) FACILITY FUND FEE ASSESSMENT.

(a) Licensees shall pay an annual fee that does not exceed the annual license fee until the Facility Fund balance reaches $750,000.

(b) When the Facility Fund balance reaches $750,000, annual fee collection shall be discontinued.

(c) When the Facility Fund balance falls below $600,000, annual fee collection shall be reinstituted.

(5) ALLOWABLE COST. The facility payment described in section (4)(a) of this rule shall be considered an allowable cost.

Stat Auth: ORS 441.341, 441.615, 441.637, 441.710, 441.715, & 441.990
Stats Implemented: ORS 441.301, 441.303, and 441.336
Hist.: SPD 11-2010, f. 6-30-10, cert. ef. 7-1-10

411-089-0075

Temporary Manager

(1) APPOINTMENT. The Division, with the consent of the licensee, may appoint a temporary manager to assume control of the day-to-day operation of the facility in accordance with Oregon Laws 2009, chapter 539, sections 14 through 18. The appointment may be for a period not to exceed six months.

(2) CRITERIA. A temporary manager may be appointed if the Division determines that the health or safety of residents in the facility are, or in the immediate future shall be, in jeopardy based upon:

(a) The licensee’s unwillingness or inability to comply with Division rules in the operation of the facility;

(b) The imminent insolvency of the facility;

(c) The Division’s revocation or suspension of the license of the facility; or

(d) The Division’s determination that the licensee intends to cease operations and to close the facility without adequate arrangements for the relocation of the residents.

(3) DUTIES AND POWERS. The temporary manager has all of the duties and powers, as agreed upon between the Division and the licensee that are necessary to ensure the safety and well-being of the residents and the continued operation of the facility.

(4) QUALIFICATIONS. In order to qualify for appointment as temporary manager, the prospective appointee must:

(a) Be familiar with the Division's rules for the operation of the facility to be served;

(b) Be familiar with the needs of the resident population in the facility to be served; and

(c) Have a demonstrated history (five year minimum) of operating and managing a similar facility in substantial compliance with Division rules.

Stat. Auth.: ORS 441.615, 441.637, 441.710, 441.715 & 441.990
Stats. Implemented: ORS 410.070, 441.055, 441.615, 441.637, 441.715, 441.990
Hist.: SPD 24-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 11-2010, f. 6-30-10, cert. ef. 7-1-10

Complaints, Inspections & Sanctions

411-089-0100

Complaint Intake, Investigation

(1) Complaint Intake. The local SPD/AAA office receiving a complaint shall ask questions to obtain as much of the information requested on the SPD Complaint Intake Form as possible. The local office of the Division or Type B AAA shall have at least one person designated and available to receive complaint calls throughout the work day.

(2) Complaint Investigation.
(a) All Complaints Investigated. The Division shall ensure all complaints, including anonymous complaints, received regarding violation of nursing facility laws are investigated.

(b) Multiple Problems. If the complaint alleges more than one problem, each allegation of abuse or another rule violation shall be treated as a separate complaint, and shall be given a separate finding. This is not intended to require a separate status report or complaint investigation report for each allegation.

(c) Complainant Interview. The SPD/AAA office representative shall interview the complainant immediately and as necessary during the investigation.

(d) Accompany Investigator. The investigator shall ask if the complainant and/or a designee wish to accompany the investigator to the site. The purpose of allowing the complainant or a designee to accompany the investigator is to identify individuals and circumstances relevant to the complaint. If someone is to accompany the investigator, the investigator shall notify such party of the time and allow the party to accompany the investigator during the site visit.

(e) Timeframe to Begin Investigation. The investigations shall be initiated as follows:

(A) If the complaint alleges a resident's health or safety is in imminent danger or the resident has recently, died, been hospitalized or been treated in an emergency department the on-site investigation shall begin within two hours of the complaint.

(B) If the complainant alleges circumstances that could result in abuse and the circumstances could place a resident's health or safety in imminent danger, the on-site investigation shall begin prior to the end of the first work day following receipt of the complaint.

(C) All other complaint investigations shall begin and be completed within 90 days following receipt of the complaint.

(f) Prior Notification Prohibited. The Division/AAA shall not contact the facility prior to the on-site investigation.

(g) Facility Visit. The investigation shall include at least one unannounced visit to the facility. Upon arrival at the facility, the investigator shall announce his/her presence to the administrator or other person designated to be in charge. The investigator shall explain the purpose of the visit unless the investigator has reason to believe that disclosing the purpose of the visit would impede the investigation.

(h) Witness Interview. Reasonable effort shall be made to interview all possible witnesses, including the alleged perpetrator(s), if any, the resident(s) and any other person(s), including residents, identified by any source as having personal knowledge about the allegation(s).

(A) Investigators have the authority to conduct the interview in private unless the witness expressly makes an unsolicited request that a third party be present.

(B) The investigator shall obtain the mailing address of the alleged perpetrator.

(C) If the investigator is unable to interview a witness identified by the complainant, the complainant shall be notified before the investigation is concluded.

(i) Investigation Format. In addition to interviews, the investigator shall make personal observations of physical circumstances and review documentation, including clinical records. The facility shall promptly provide all requested documentation available for review and copying.

Stat. Auth.: ORS 410.070, 441.055 & 441.637
Stats. Implemented: ORS 441.637 & 441.650
Hist.: SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95

411-089-0110

Initial Status Report (Abuse Complaints Only)

(1) Initial Status Report for Abuse Investigations (Local SPD/AAA Office). Except in cases where the investigation is part of a general inspection pursuant to federal law, the Division or Type B AAA shall complete an Initial Status Report for all abuse investigations within two work days of the start of the investigation.

(2) Content. The Initial Status Report shall include:
(a) A summary of the complaint identifying each alleged incident or problem. The Initial Status Report shall not include names of residents, complainants or other people interviewed during the investigation;

(b) The status of the investigation:

(c) Whether the complaint was filed at the direction of facility administration:

(d) A determination of whether action to protect the resident(s) is needed and whether the facility must take action:

(e) The name and telephone number of the investigator:

(f) The projected date the Complaint Investigation Report will be completed; and

(g) A statement that the Complaint Investigation Report will be available upon request after the Division issues a Letter of Determination.

(3) Distribution. The Initial Status Report shall be provided either in person or by mail to the following individuals as soon as practical, but no later than two work days after its completion:

(a) The complainant, unless the complainant waives the requirement;

(b) If the complaint involves a specific resident or residents, to the resident(s) or person(s) designated to receive information concerning the resident(s);

(c) A representative of the Long Term Care Ombudsman, upon request:

(d) The facility; and

(e) SPD Central Office.

(4) Availability of Initial Status Report. The Initial Status Report shall be placed in the local SPD/AAA facility files and available for public inspection upon completion.

Stat. Auth.: ORS 410.070, 441.055 & 441.637
Stats. Implemented: ORS 441.637 & 441.650
Hist.: SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95

411-089-0120

Complaint Investigation Report (Local SPD/AAA Office)

(1) Report Required. The investigator shall write a complaint investigation report after each investigation is completed.

(2) Content. The complaint investigation and the findings shall be summarized on the SDS Complaint Investigation Report Form. The Form shall not include the names of any resident, complainant or person(s) interviewed. The investigation report shall include:

(a) The nature of the allegation(s);

(b) The investigator's personal observations relating to relevant evidence, including the date(s) and time(s) of each incident (as appropriate);

(c) A summary of the documents reviewed;

(d) A summary of each interview.

(e) The investigator's findings regarding the incident or problem alleged in each allegation; and

(f) The factual basis for the finding.

(3) Investigator's Conclusions. For each alleged wrong doing the investigator shall prepare a separate evaluation and written conclusion. The conclusion shall be:

(a) The alleged wrong doing is substantiated;
(b) The alleged wrong doing is not substantiated; or

(c) The investigator is unable to determine whether the alleged wrong doing is substantiated or not substantiated because necessary, relevant information could not be obtained; or that following a complete investigation, a reasonable person could not objectively conclude whether it was likely the wrong doing occurred.

(4) Timeframe for Completion Processing (Local Office).

(a) If a complaint alleges abuse, the complaint report shall be completed within 5 work days after the investigation is completed, but not later than 62 days after receipt of the complaint.

(b) All other complaint investigation reports shall be completed within 90 days of the receipt of the complaint.

(c) Investigation reports shall be sent to SPD Central Office promptly upon completion.

Stat. Auth.: ORS 410.070, 441.055 & 441.637
Stats. Implemented: ORS 441.637, 441.650 & 441.676
Hist.: SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95

411-089-0130

Division Findings for Complaint Investigations (Central Office)

Central Office Review. The Division shall review the Complaint Investigation Report and any evidence submitted with the report.

(1) Central Office Determination. The Division shall review the Complaint Investigation Report and shall determine for each alleged violation there is:

(a) "Substantiated abuse" (a reasonable person could objectively conclude it is more likely than not abuse occurred), including identification of rule violated;

(b) "Substantiated, non-abuse" (a reasonable person could objectively conclude it is more likely than not a rule violation, other than abuse, occurred), including identification of rule violated;

(c) "Unsubstantiated" (a reasonable person could objectively conclude it is unlikely any rule violation occurred); or

(d) "Unable to Substantiate" (an investigation could not be completed because necessary, relevant information could not be obtained; or that following a complete investigation, a reasonable person could not objectively conclude whether it was more or less likely a rule violation occurred).

(2) If the Division determines there is substantiated abuse, the Division shall determine whether the facility was responsible, or individual(s) responsible, or both. In determining responsibility, the Division shall consider intent, knowledge, ability to control, and adherence to professional standards, as applicable.

(a) Facility Responsible. Examples of when the Division shall determine the facility is responsible for the abuse include but are not limited to the following:

(A) Failure to provide minimum staffing in accordance with OAR 411-086-0100(2) without reasonable effort to correct; or

(B) Failure to check for or act upon relevant information available from a licensing board; or

(C) Failure to act upon information from any source regarding a possible history of abuse by any staff or prospective staff; or

(D) Failure to adequately train or orient staff; or

(E) Failure to provide adequate supervision of staff/residents; or

(F) Failure to allow sufficient time to accomplish assigned tasks; or

(G) Failure to provide adequate services; or
(H) Failure to provide adequate equipment or supplies; or

(I) Failure to follow orders for treatment or medication.

(b) Individual Responsible. Examples of when the Division shall determine the individual is responsible shall include but are not limited to:

(A) Intentional acts against a resident(s) including assault, rape, kidnapping, murder, sexual abuse, or verbal or mental abuse;

(B) Acts contradictory to clear instructions from facility, unless the act is determined by the Division to be caused by a "facility problem" such as those identified in paragraph (2)(b)(A) of this rule:

(C) Callous disregard for resident rights or safety; or

(D) Intentional acts against a resident's property (e.g., theft, misuse of funds).

(c) An individual shall not be considered responsible for the abuse if the individual demonstrates the abuse was caused by factors beyond the individual's control. "Factors beyond the individual's control" are not intended to include such factors as misuse of alcohol or drugs or lapses in sanity.

Stat. Auth.: ORS 410.070, 441.055 & 441.637
Stats. Implemented: ORS 441.637, 441.650, 441.665 & 441.677
Hist.: SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95

411-089-0140

Letters of Determination

Within 60 days of receipt by the Division of the investigation report, the Division shall issue a letter of determination.

(1) CONTENT. The letter of determination shall:

(a) Explain the nature of each allegation;

(b) Include the date and time of each occurrence;

(c) For each allegation, include a determination of whether the allegation is substantiated, unsubstantiated, or unable to substantiate;

(d) For each substantiated allegation, state whether the violation was abuse or another rule violation;

(e) For each substantiated allegation of abuse, explain the Division's determination of responsibility;

(f) Include a copy of the complaint investigation report;

(g) State that the complainant, any individual found responsible for abuse, and the facility have 10 days to provide additional or different information; and

(h) Explain, when applicable, if sanctions (e.g., civil penalty, license revocation) are pursued, a formal appeal process shall be available.

(2) APPEAL RIGHTS, NURSING ASSISTANT. The letter of determination, in cases of substantiated abuse by a nursing assistant, shall explain the following:

(a) The Division's intent to enter the finding of abuse into the Nursing Assistant Registry;

(b) The nursing assistant may provide additional information for inclusion in the Nursing Assistant Registry if provided within 10 days;

(c) The Nursing Assistant Registry;

(d) The nursing assistant has 10 days to respond in writing with different or additional information, 30 days to request in writing a contested case hearing as provided in ORS 183.411 to 183.470, and the consequences of failure to respond; and

(e) If the opportunity to request a contested case hearing expires without a request for hearing by the nursing assistant, the nursing assistant
shall be found responsible for the abuse and the finding shall be entered in the Nursing Assistant Registry.

(3) DISTRIBUTION.

(a) The letter of determination shall be distributed to the facility, the complainant (if known), and the Division or Type B AAA office;

(b) The letter of determination shall be sent by certified mail or delivered in person to any nursing assistant found responsible for abuse. In the case of a nursing assistant, notice sent to the nursing assistant's last known address is sufficient to meet the requirements of this rule;

(c) The letter of determination shall also be mailed to any health related board or agency that certified or licensed an individual determined to be responsible for abuse. EXCEPTION: If the party determined to be responsible is a nursing assistant, the letter may not be mailed to the State Board of Nursing until the nursing assistant has exhausted all his or her appeal rights; and

(d) A copy of the letter of determination shall be placed in the Division's facility complaint file.

(4) REVISION.

(a) The Division may reinvestigate a complaint, issue a revised letter of determination, or both if the Division determines further information provided by the complainant, accused individual, or facility merits such action.

(b) If the Division issues a revised letter of determination, the letter shall be distributed to all individuals identified in section (3) of this rule.

(5) FAILURE TO REQUEST HEARING OR TO APPEAR.

(a) If the nursing assistant fails to request a contested case hearing in writing within 30 days of the letter of determination, or if the nursing assistant scheduled to attend the hearing fails to attend, the Division shall affirm the letter of determination and notify the State Board of Nursing of the Division's finding. The abuse finding shall be entered into the Nursing Assistant Registry.

(b) If the nursing assistant is scheduled to appear at a contested case hearing but fails to attend at the scheduled time, or within 15 minutes thereafter, the nursing assistant shall be considered to have waived the right to a hearing. The hearing may be rescheduled if:

(A) A written request to reschedule the hearing is received by the Division within 10 days after the scheduled hearing; and

(B) The causes for not attending at the scheduled time for the hearing and for not requesting a postponement of the hearing prior to the hearing were beyond the control of the nursing assistant.

(6) JUDICIAL REVIEW. The nursing assistant found to be responsible for abuse shall be provided notice of the opportunity for judicial review pursuant to ORS 183.484. This notice shall accompany or be incorporated within the Division’s final order regarding the nursing assistant’s responsibility for abuse.

Stat. Auth.: ORS 410.070, 441.055 & 441.637
Stats. Implemented: ORS 441.637 & 441.677
Hist.: SSD 1-1995, f. 1-30-95, cert. ef. 2-1-95; Administrative correction, 6-24-99; SPD 24-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 11-2010, f. 6-30-10, cert. ef. 7-1-10

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853-010-0010

Definitions

(1) "Board" means the Board of Examiners of Nursing Home Administrators.

(2) "Continuing Education" means post-licensure education in health care administration undertaken to maintain professional competency to practice nursing home administration, improve administration skills and effect standards of excellence in the interest of safety, health and welfare of the people served.

(3) "Experience" means prior performance in administration, including planning, organizing, directing, staffing, and budgeting of a licensed long-term care facility.

(4) "Licensee" means a person who is issued a nursing home administrator license upon making application and meeting training, experience, and education requirements; or a person who is issued a provisional license.

(5) "Long-Term Care Facility" means a licensed facility as defined in ORS 441.005.

(6) "Nursing Home Administrator" means an individual responsible for planning, organizing, directing, and controlling the operation of a nursing home.

(7) "One Year" when related to employment means a period equivalent to 40 hours a week for 48 weeks.

(8) "Trainee"; "Administrator-in-Training"; or "AIT" means a person who is completing the training requirements leading to licensure as a nursing home administrator.
(9) "Experience in health care management" means experience in administration, planning, organizing, directing, staffing and budgeting of a licensed health care facility.

Stat. Auth.: ORS 678
Stats. Implemented: ORS 678.710, 678.730, 678.760, 678.780 & 678.820
Hist.: NHA 1(Temp), f. & ef. 9-29-71; NHA 4, f. 1-5-72, ef. 1-28-72; NHA 8, f. 2-6-74, ef. 2-25-74; NHA 9(Temp), f. & ef. 3-6-75; NHA 10, f. 7-3-75, ef. 7-25-75; NHA 1-1982, f. 12-15-82, ef. 1-1-83; NHA 1-1989, f. & cert. ef. 2-15-89; NHA 1-1996, f. & cert. ef. 7-31-96; BENHA 1-2003, f. & cert. ef. 11-12-03; BENHA 1-2006, f. & cert. ef. 7-14-06

853-010-0015

Application for Examination and Licensure

(1) An applicant for the nursing home administrator examination shall:

(a) Apply to the Board on a form approved by the Board;

(b) Submit the required $125 examination fee or $300 reciprocity fee.

(2) Any individual is qualified for licensure as a nursing home administrator who:

(a) Is of good moral character;

(b) Is in good physical and mental health;

(c) Has a baccalaureate degree or higher from an accredited school of higher education. The educational requirement will not apply to any person who was a licensed administrator in any jurisdiction of the United States prior to January 1, 1983; or to any person who meets the training, experience, and other standards in a supervised internship.

(d) In lieu of any residency or intern requirement, the Board shall accept one year of experience as a hospital administrator, chief operating officer, president, vice president, or administrative director who is responsible for the operation of a nursing facility physically attached to a hospital.

(3) An applicant for examination who has been convicted of a felony by any court in this state, or by any court of the United States shall not be permitted to take the examination provided herein, unless the applicant first files with the Board a parole
termination certificate and restoration of forfeited rights of citizenship issued by the Board of Parole and Post-Prison Supervision, or in the case of a conviction in any jurisdiction, wherein the laws do not provide for the issuance of a parole termination certificate, an equivalent written statement or document.

(4) At the discretion of the Board an applicant for licensure by endorsement may be personally interviewed by the Board. An applicant for endorsement who has not worked as an administrator of a nursing facility for a minimum of six months within five years of the application for endorsement to Oregon, shall be interviewed by the Board.

(5) An application for endorsement from an individual who is certified by the American College of Health Care Administrators and who meets the education requirement in 853-010-0015(2)(c) may be approved for the state examination by the Executive Officer of the Board.

(6) Administrators-in-Training shall be personally interviewed by the Board prior to examination.

(7) An Administrator-in-Training applicant may be disqualified from taking the examination. Reasons for disqualification from taking the examination includes but is not limited to the following:

(a) Failure to graduate from an accredited university except as stated in paragraph (2)(c) of this rule.

(b) Failure to submit application and fee by deadline date.

(c) Failure to submit college transcript and reference letters.

(d) Applicant does not demonstrate adequate training.

(e) Preceptor does not recommend that applicant take the examination.

(f) Failure to appear for personal interview unless excused with good reason by an authorized representative of the Board.

(8) An Administrator-in-Training applicant for licensure who has been disqualified shall be given written notification by the Board of applicant’s disqualification and the reasons therefore and of the right to a hearing:
(a) An applicant for licensure who has been disqualified, may petition the Board in writing within 30 days of notification of disqualification for a hearing and an application review.

(b) When an applicant for licensure has been disqualified, the applicant may submit a new application to qualify for licensure; however, the applicant shall be required to meet the requirements for licensure as shall be in force at the time of such re-examination.

(9) An applicant shall be deemed to have abandoned the application if the applicant does not take such examination within 180 days after Board approval to take such examination.

(10) An application submitted subsequent to the abandonment of a former application shall be treated as a new application and the rules in force at the time of such new application shall apply.

Stat. Auth.: ORS 678.740(1), 678.760(1), 678.760(2), 678.760(3), 678.770(2) & 678.775
Stats. Implemented: ORS 678.740(1), 678.760(1), 678.760(2), 678.760(3), 678.770(2) & 678.775

853-010-0017

Application for Licensure Under ORS 678.730(4)

(1) A health care administrator is deemed to meet requirements for licensure as a nursing home administrator without examination who:

(a) Has a request for licensure authorized by the hospital governing body;

(b) Has a postgraduate degree in management from an accredited school of higher education;
(c) Has at least ten years of experience in health care management as defined in OAR 853-010-0010(12).

(2) An applicant for a nursing home administrator license under ORS 678.730(4) shall:

(a) Apply to the Board on a form approved by the Board;

(b) Submit the required license fee;

(c) Attach a letter of request from the chairperson of the governing body of the health care facility.

(d) Attach proof of completion of a postgraduate management degree;

(e) Attach résumé of at least ten years of work history as a health care manager.

(3) A license issued to an individual shall be only for the facility for which the governing body made the request and shall not be portable.

Stat. Auth.: ORS 678.820
Stats. Implemented: ORS 678.730(4)
Hist.: NHA 1-1996, f. & cert. ef. 7-31-96

853-010-0020

Examination

(1) One part of the examination for nursing home administrators shall be the one developed and provided by the National Association of Boards of Examiners for Nursing Home Administrators. The minimum passing score for the examination shall be 113.

(2) For reciprocity purposes, the Board shall accept a passing grade as established by the Board from persons taking the examination developed by the National Association of Boards of Examiners for Nursing Home Administrators, Inc. or the Professional Examination Service. The passing grades are as follows:

(a) September 29, 1971 to June 5, 1973 -- 1.5 Standard Deviation on a curve established by the Professional Examination Service;

(b) June 6, 1973 to March 16, 1983 -- 105;
(c) March 17, 1983 to present -- 113.

(3) Individuals who are currently licensed in another state in which the requirements for licensure of nursing home administrators are not less than those required in Oregon, are exempt from taking this part of the examination.

(4) In addition to the examination in section (1) of this rule and as the sole examination for out-of-state licensed individuals exempt under section (3) of this rule, the Board shall administer a written examination which shall demonstrate an applicant's proficiency in the practice and knowledge of applicable rules of health and safety with the state. The minimum passing score shall be 84 percent.

(5) Examinations for initial licensure as a nursing home administrator shall be conducted at least once a year or as often as necessary, as determined by the Board.

(6) Examinations will be administered only to applicants who have applied 30 days or more in advance of the date of examination.

(7) Failure to pass either portion of the written examination shall not preclude the applicant from applying for re-examination of either or both portions at any subsequent regular examination conducted by the Board. A retake fee for the NAB examination only shall be determined by the National Association of Boards of Examiners for Long-Term Care Administrators, Inc. payable to the NAB. A retake of the state examination only shall be $125.

(8) An applicant must complete successfully the licensure examination within one calendar year from the time of notification of failure to pass the original examination.

(9) After failing the examination developed by the National Association of Boards of Examiners for Nursing Home Administrators, the applicant may request and shall be permitted to examine the Master Copy of the examination and the answer sheet completed by the examinee:

(a) Upon receipt of the required fee payable to the examination service, the Board shall request a Master Copy of the examination and the answer sheet;

(b) The Board will ensure the security of the examination prior to and during review of the examination. The examination will be returned to the examination service immediately following review by the applicant.

Stat. Auth.: ORS 678.740(1), ORS 678.760(1), ORS 678.760(2), ORS 678.760(3), ORS 678.770(2) & ORS 678.775
Licensure

(1) Licenses shall be issued to persons successfully passing the required examinations upon receipt of an application for licensure on a form approved by the Board and the required $250 license fee. Initial licenses may be pro-rated according to date of licensure. An initial license shall be applied for within six months of receiving examination results.

(2) Applicants for licensure are required to provide Social Security numbers as required by ORS 215.785, 305. 385, 42 USC § 405(c)(2)(i), and 42 USC § 666(a)(13) for child support enforcement purposes and Department of Revenue purposes. Upon completion of a "Voluntary Consent to Disclosure of Social Security Number" form, a licensee's Social Security number will be provided to the Oregon Student Assistance Commission upon the agency's request.

(3) Each nursing home administrator shall keep on file with the Board his or her name, home address, and telephone number, and the name, address, and telephone number of any nursing home which he or she is administering, and, if he or she is administering no nursing home, a statement to this effect. Whenever any of the information required in this section changes, the nursing home administrator shall immediately notify the Board.

(4) At the Board's discretion, licensees of the Board may be required to appear before the Board.

(5) Verification of licensure forms for licensure in another state will be completed for a fee of $25.
Provisional Licenses -- Application and Issuance

(1) Whenever a bona fide emergency exists such as, but not limited to, the death, incapacitation, or unexpected resignation of a licensed nursing home administrator and the nursing home which such person was administering is unable to employ a regularly licensed nursing home administrator, the long-term care facility may be administered by a provisionally licensed nursing home administrator until a licensed nursing home administrator can be employed, but not to exceed 200 days. An application for a provisional license shall state the applicant's qualifications, the circumstances creating the need for a provisional license, and said application shall be verified by the applicant and the owner or manager of the nursing home.

(2) Persons applying for a provisional license or renewal of a provisional license shall:

(a) Submit an application on a form approved by the Board;

(b) Submit a fee of $300.

(c) Have worked in the long term health care field either as an assistant administrator or director of nursing services whose job description reflects duties or responsibilities in an administrative capacity;

(d) Meet qualifications in OAR 853-010-0015.

(3) Provisional licenses will be issued by the Board if the Board approves of the applicant's qualifications and determines that the nursing home requires the services of an acting licensed administrator through no fault of its own.

(4) Provisional licenses will permit the holder to practice only at the nursing home to which the license applies until a regularly licensed nursing home administrator can be employed, but for a period not to exceed 100 days initially.
(5) Provisional licenses may be renewed at the discretion of the Board not to exceed 100 days for one renewal. The period of initial licensure and renewal shall not exceed 200 days.

(6) Provisional licenses may be denied or revoked in accordance with ORS 678.780, 678.820, and ORS 183.310 to 183.500, including a failure to meet conditions of this section or the availability for employment of a regularly licensed nursing home administrator to administer the nursing home to which the provisional license applies.

Stat. Auth.: ORS 678.740(1), ORS 678.760(1), ORS 678.760(2), ORS 678.760(3), ORS 678.770(2) & ORS 678.775
Stats. Implemented: ORS 678.740(1), ORS 678.760(1), ORS 678.760(2), ORS 678.760(3), ORS 678.770(2) & ORS 678.775
Hist.: NHA 4, f. 1-5-72, ef. 1-28-72; NHA 7(Temp), f. & ef. 10-29-73; NHA 8, f. 2-6-74, ef. 2-25-74; NHA 11, f. 7-3-75, ef. 7-25-75; NHA 1-1983, f. & ef. 3-17-83; NHA 1-1989, f. & cert. ef. 2-15-89; NHA 1-1993(Temp), f. 6-30-93, cert. ef. 10-1-93; NHA 5-1993, f. 10-15-93, cert. ef. 11-4-93; NHA 2-1994, f. & cert. ef. 7-14-94; BENHA 1-2002, f. 1-31-02, cert. ef. 2-1-02

853-010-0040

Renewal of Licenses

(1) Nursing home administrators' licenses will expire on June 30th following date of issue and shall be renewed by applying to the Board, remitting a $100 fee. For renewal licenses effective July 1, 2001 and thereafter, upon payment of a fee of $400 the Board shall issue a license effective for two years are met and the licensee is employed as a nursing home administrator in Oregon. For renewal licenses effective July 1, 2001 and thereafter, upon payment of $300 the Board shall issue a license effective for two years provided the continuing education requirements are met and the licensee is not employed as a nursing home administrator in Oregon.

(2) A licensee who is not employed at the time of renewal who works six months or more as a nursing home administrator in Oregon during the two year renewal period, shall pay an activation fee of $100 upon receipt of notice of payment due.

(3) Beginning with the initial licensing date commencing July 1, 1992, each individual holding a permanent nursing home administrator license for 12 months or longer shall submit evidence satisfactory to the Board that 30 classroom hours of continuing education have been completed annually as required by OAR 853-010-0050, and, if not accomplished, the license is not renewable. Beginning with the renewal licensing date commencing July 1, 1995, an individual shall submit evidence satisfactory to the
Board that sixty (60) classroom hours of continuing education have been completed every two years, if the licensee has been employed as a nursing home administrator in Oregon for twelve months or more during the two year period. Beginning July 1, 1999, at least five (5) of the sixty (60) classroom hours must be in the area of personal/professional ethics. A licensee who is employed as a nursing home administrator may submit continuing education hours after the time specified upon payment of a late fee of $10 for each credit hour submitted. The nursing home administrator who is not employed as a nursing home administrator and who has not completed the continuing education requirement will have one (1) year to make up the deficit hours. Beginning July 1, 1995, an inactive administrator shall submit thirty (30) hours of continuing education by evidence satisfactory to the Board every two years. Beginning July 1, 1999, at least three (3) of the thirty (30) classroom hours must be in the area of personal/professional ethics. Administrators who fail to make up the deficit hours in the period specified shall meet the requirements of OAR 853-010-0015. The Board may grant exceptions to the continuing education requirement for good reasons such as, but not limited to personal health and military conflict;

(4) Upon completion of the thirty (30) or sixty (60) classroom hours of continuing education, the licensee must wait until the next July to begin accruing continuing education credits;

(5) A nursing home administrator who has had a license issued by the Board less than one year shall be required to complete the following number of continuing education hours:

<table>
<thead>
<tr>
<th>For a person initially licensed # of CE Hours Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>July–September 30</td>
</tr>
<tr>
<td>October–December 15</td>
</tr>
<tr>
<td>January–March 7</td>
</tr>
<tr>
<td>April–June 0</td>
</tr>
</tbody>
</table>

(6) Beginning July 1, 1995 a nursing home administrator who has had a license issued by the Board for less than two years shall be required to complete the following number of continuing education hours:

For a person initially licensed # of CE Hours Required

July–December 60
(7) Upon application within one (1) year following expiration of an original or renewal license and the payment of $100, the Board shall issue a renewal license, provided the continuing education requirements are met. Beginning July 1, 1995 upon application within two (2) years following expiration of an original or renewal license and the payment of $300, the Board shall issue a renewal license provided the continuing education requirements are met.

Stat. Auth.: ORS 678.740(1), ORS 678.760(1), ORS 678.760(2), ORS 678.760(3), ORS 678.770(2) & ORS 678.775
Stats. Implemented: ORS 678.740(1), ORS 678.760(1), ORS 678.760(2), ORS 678.760(3), ORS 678.770(2) & ORS 678.775

**853-010-0045**

**Posting of License**

Each person licensed as a nursing home administrator shall be required to display his or her license certificate in a conspicuous place in the nursing home which he or she is administering.

Stat. Auth.: ORS 678.990(2)
Stats. Implemented: ORS 678.820(1)
Hist.: NHA 4, f. 1-5-72, ef. 1-28-72; NHA 1-1991, f. & cert. ef. 5-3-91;

**853-010-0050**

**Continuing Education**
(1) Consideration for approval will be given to courses dealing with the planning, organizing, directing, and controlling the operation of a long term care facility. The subjects will include, but not be limited to the following: Personnel management, fiscal management, physical plant management, federal and state rules and regulation, gerontology, program implementation (medical, nursing, dietary, pharmacy, recreational activities, records, any other relating directly to long term care administration).

(2) Courses of study in the field of long-term care administration are considered approved courses if offered by:

(a) An institution of higher learning accredited by the Northwest Association of Secondary and Higher Schools or a comparable accrediting agency;

(b) A nationally recognized organization or association.

(3) Application for approval of all other courses of study must be submitted to the Board on a form approved by the Board at least 30 days prior to the scheduled date of such course. In addition to the date, time, name, and sponsor of the course, each application shall include the following:

(a) Agenda or outline and course content;

(b) Background resume of speakers or instructors; and

(c) Method of recording attendance.

(4) Courses of study include, but are not limited to, workshops, seminars, training sessions, and correspondence courses.

(5) Time spent in teaching a course of study may be counted as part of continuing education subject to application to and approval by the Board.

Stat. Auth.: ORS 678
Stats. Implemented: ORS 678.820(8)
Hist.: NHA 8, f. 2-6-74, ef. 2-25-74; NHA 1-1989, f. & cert. ef. 2-15-89

853-010-0055

Relicensing

(1) A nursing home administrator whose license has expired for less than twelve months may be relicensed upon completion of a license application and a fee of $425.
(2) A nursing home administrator whose license has lapsed for a period longer than one year but less than five years may be relicensed upon completion of a license application and a fee of $500. The Board may require the applicant to present evidence of continuing education in long-term care or to complete a specified period of time in an Administrator-in-Training program prior to issuing the license.

(3) A nursing home administrator requesting reinstatement of a license that has been lapsed for a period of five years or longer shall be subject to all current criteria for examination and licensing.

Stat. Auth.: ORS 678.740(1), 678.760(1), (2) & (3), 678.770(2) & 678.775
Stats. Implemented: ORS 678.740(1), 678.760(1), (2) & (3), 678.770(2) & 678.775
Hist.: NHA 12, f. 7-3-75, ef. 7-25-75; NHA 1-1983, f. & ef. 3-17-83; NHA 1-1989, f. & cert. ef. 2-15-89; BENHA 1-2002, f. 1-31-02, cert. ef. 2-1-02; BENHA 2-2006, f. & cert. ef. 8-31-06

853-010-0060

Registration of Trainees and Supervising Preceptors

(1) Any trainee who begins to accumulate experience as defined in OAR 853-010-0010(3), shall register with the Board within 15 working days and submit a registration fee of $100. Acceptance into the AIT program in no way authorizes a trainee to serve in the capacity of a nursing home administrator; such action by the trainee is a violation to ORS 678.720(1), and the Board may disqualify part or the entire period of the AIT program.

(2) Every trainee shall undergo a training program and be supervised by a preceptor as defined in OAR 853-010-0060(9). The Board may grant exceptions to the supervision requirement for good reasons such as, but not limited to geographical location.

(3) "Training" means the completion of a supervised program/internship comprised of a minimum 960 hours. Training shall be directed by a preceptor and conducted regularly for a six month to one year period averaging 40 hours per week, with no fewer than 20 hours and no more than 50 hours per week, except at the discretion of the Board.

(4) The outline of the training curriculum shall be submitted to the Board for approval at the time the trainee registration form is submitted. This outline shall include 40 hours participation in a CNA training course for the AIT or a comparable review of the CNA training manual coupled with a minimum of 40 hours spent shadowing a CNA. If the CNA training or manual review is not completed prior to the end of the
training period, proof of such completion must be submitted prior to taking the national examination. Exceptions to this training requirement would be:

(a) AIT is or has been an RN, LPN, or CNA in a long-term care facility; or

(b) AIT is training in a facility that does not have a CNA class or is not located within 60 miles of a facility with a CNA class.

(5) Every trainee shall submit periodic reports on forms provided by the Board, outlining specifically all aspects of training. These reports shall be submitted every two to four months based on the length of the training program. The preceptor shall countersign each report. If the trainee does not submit the required reports, the Board may discontinue the training.

(6) A hospital administrator who has less than one year experience in a hospital with a physically attached nursing home shall receive credit of 80 hours of AIT experience for every month of prior experience accumulated in the hospital/nursing home facility. Additional training required to meet the minimum of 960 hours AIT training shall be gained in an Administrator-in-Training program in a long-term care facility or under the supervision of a preceptor in the hospital/nursing home facility.

(7) Accredited university or college coursework in advanced degree programs specializing in long-term care may replace no more than 480 hours of the 960 hours of training. Such coursework must be approved by the Board.

(8) A trainee with significant experience within the long-term care field may petition the Board for credit hours. The Board may grant credit for relevant experience gained within a qualifying long-term care facility. Such experience may replace no more than 480 hours of the 960 hours of training.

(9) "Preceptor" means a person who:

(a) Holds a current Oregon nursing home administrator license; and

(b) Has been a licensed nursing home administrator for at least three years. The Board may grant exceptions to the three-year requirement for good reason, but not limited to experience in long-term care; and

(c) Has attended a Board-approved workshop for preceptors in Oregon and actively engaged as a preceptor within five years of completing the workshop; and
(d) Has not been disciplined by the Board in the prior five (5) years. The Board may grant exceptions to this requirement based on the type and severity of the violation related to the discipline.

(10) The preceptor shall:

(a) Possess sufficient training, knowledge, and ability.

(b) **Have a facility or organizational setting at their disposal to participate actively in the development of trainees.**

(c) Meet with the AIT and make a pre-training assessment of the AIT applicant's background, including both education and experience. Based on the assessment, the preceptor and AIT shall prepare a detailed curriculum of the training program to be completed.

(d) Identify the nursing home that will serve as the primary facility for the AIT's training activities, recognizing that the AIT may be dispatched to other training sites--as needed--to gain experience in the required training areas.

(e) Ensure that all nursing home training sites employ an on-site, licensed administrator with facility teaching staff comprised of personnel who are proficient in the field of practice to which they devote themselves and who are willing to assume responsibility individually and as a group for imparting instruction to the AIT.

(f) Provide the AIT a minimum of eight (8) hours a week of face-to-face supervision, to apprise the AIT of areas of competency and/or weakness, to identify problem areas and to modify the plan to reflect changes which meet altered needs.

(g) Train only one AIT at any one time unless otherwise approved by the Board.

(h) Provide a letter to the Board at the completion of a training program that evaluates the AIT's professional competence and general suitability for the profession.

(i) Participate as a preceptor in the AIT program within five (5) years of completing the preceptor training workshop. A preceptor who fails to participate in the AIT program within the five (5) year timeframe must re-complete the preceptor training workshop prior to commencing an AIT program.

(11) An AIT may be disqualified from continuing training. Reasons for disqualification from training includes but is not limited to the following:
(a) Failure to submit a training plan.

(b) Failure to submit timely and satisfactory training reports.

(c) Submitting false training reports.

(d) Interruption of training exceeding the period established in 853-010-0060(12).

(e) Inadequate training or supervision.

(12) Discontinued and Interrupted Programs

(a) The preceptor or AIT will notify the Board if the AIT's training is discontinued or interrupted at the long-term care facility. A traineeship that has been discontinued or interrupted for six months or longer may not be resumed without Board approval.

(b) The Board will approve an interruption of an AIT program for the compulsory service of the AIT in the armed forces of the United States. The AIT may resume training at any time within six months of discharge from active duty.

(13) The Board reserves the right to take appropriate action if a preceptor fails to provide the trainee with adequate training and supervision or to comply with the training program requirements. The Board may disqualify a preceptor from training until such time the preceptor completes additional training or other requirements as prescribed by the Board.

(14) At the Board's discretion the preceptor may be required to appear before the Board.

Stat. Auth.: ORS 678.740(1), 678.760(1), (2) & (3), 678.770(2) & 678.775
Stats. Implemented: ORS 678.740(1), 678.760(1)-(3), 678.770(2) & 678.775

853-010-0065

Standards for Nursing Home Administrators

The Board adopts the following standards of practice for nursing home administrators:
(1) Organizational Management and General Administration:

(a) Exercise ethical and sound decision making and judgment.

(b) Assume leadership in his/her facility.

(c) Demonstrates supervisory techniques which through professional experience have become established by the consensus of the expert opinion of practicing nursing home administrators.

(d) Delegates responsibility and authority to appropriate staff in order to carry out the work of the facility and hold department heads accountable for the performance of their respective departments.

(e) Promote residents and families/responsible parties' satisfaction with quality of care and quality of life.

(f) Exercises technical competence in carrying out nursing home administration.

(g) Seeks proper education and preparation for new nursing home administrator techniques or procedures.

(h) Ensure that resources (for example, supplies, medical equipment, technology, trained staff) are in place to provide resident care and to promote quality of life.

(i) Maintains a safe working environment for staff in order to provide quality care.

(2) Resident Care:

(a) Ensure that nursing services are planned, implemented, and evaluated to maximize resident quality of life and quality of care.

(b) Ensure that medical services are planned, implemented, and evaluated to maximize resident quality of life and quality of care.

(c) Ensure the integration of resident rights with all aspects of resident care.

(d) Ensure that the facility complies with applicable federal, state, and local standards and regulations.

(e) Ensure that the following services are planned, implemented, and evaluated to maximize resident quality of life and quality of care: social services, dietary services,
activities, clinical records program, pharmaceutical program, rehabilitation services, auxiliary services, and environmental services.

(f) Recruits, hires and provides ongoing education for a health care team in order to assure quality care of the long-term care resident.

(g) Obtains and coordinates consultant services as needed.

(h) Coordinates the development and evaluation with the health care team of resident care goals and policies in order to assure that adequate resources, environments, and services are provided to residents.

(i) Meets regularly with health care team to assure highest practicable care is being delivered.

(j) Recruits a qualified medical director and ensures a well planned and implemented medical care program.

(k) Ensures that staff make appropriate discharge decisions.

(l) Ensures the information or knowledge concerning the resident is made available only to those stated in state or federal regulations.

(m) Evaluates the quality of resident care, residents' rights, and quality of life. Identify strengths and weaknesses and set in place measures for the improvement where necessary, evaluate progress, and institute appropriate follow-up activities.

(n) Ensure residents' dignity and right to privacy and that residents are free from sexual abuse, physical abuse, mental abuse, corporal punishment, exploitation, neglect and involuntary seclusion.

(o) Protect residents funds and property.

(p) Ensure development, implementation, and review of resident care policies and procedures.

(q) Ensure that a health information management program for resident care is planned, implemented, and evaluated to meet documentation requirements.

(r) Identify, monitor, and ensure that quality indicators and quality assurance programs are utilized to maximize effectiveness in resident care and services.

(3) Personnel Management:
(a) Ensure that personnel are present in number and ability to attain or maintain the highest practicable level of physical, mental and psychosocial well being for each resident.

(b) Coordinates the development and dissemination of written personnel policies and procedures to assure procedures are followed in recruitment, hiring, employment and termination of staff.

(c) Establishes safety rules and procedures that incorporate federal regulations and OSHA requirements to ensure employee health and safety.

(d) Assures adherence to established personnel policies and procedures including timely criminal background checks.

(e) Establishes clear lines of authority and responsibility within the staff in order to assure understanding and production of quality work.

(f) Recruits and hires qualified supervisors to meet the requirements of their position.

(g) Plans, implement and evaluates an orientation program.

(h) Ensure that human resource management policies and programs are planned, implemented, and evaluated in compliance with governmental entities, laws and regulations (for example, job descriptions, education programs, union relations).

(4) Financial Management:

(a) Coordinates the development of a budget which assures allocation of fiscal resources to meet regulatory requirements and provides quality services.

(b) Evaluates the implication of budget on the quality of care.

(c) Analyzes financial performance to ensure conformance with standards of quality.

(d) Manage and implement corporate compliance programs and train staff.

(e) Protect resident funds.

(5) Environmental Management.

(a) Evaluates maintenance of building grounds and equipment and recommends corrections as needed.
(b) Ensure development, implementation and review of environmental policies and procedures.

(c) Ensure that the facility provides a clean environment for residents, staff and visitors.

(d) Develops, implemented and evaluates fire, emergency and disaster plans to protect the safety and welfare of residents, staff and property.

(e) Ensure the planning, implementation, and evaluation of any environmental safety program that will maintain the health, welfare, and safety of residents, staff and visitors.

(f) Identify, monitor, and ensure that the quality assurance programs are utilized to maximize effectiveness in environmental services.

(g) Ensure that facility complies with applicable, federal, state and local standards and regulations (for example, ADA, OSHA, CMS, Life Safety Code).

(6) Regulatory Management/Governance:

(a) Ensures compliance with federal and state regulations to assure compliance and efficient integration with established policies and procedures at the facility.

(b) Direct compliance of the facility with government regulations, including protecting residents, employees or staff from discrimination.

(c) Protect resident records from unauthorized disclosure of confidential information.

(d) Monitors medical reporting, staffing and procedures in order to assure compliance with regulations and quality care.

(e) Evaluates staff work procedures and policies to assure compliance with federal and state regulations.

(f) Ensure that policies and procedures are developed, implemented, monitored, and evaluated in order to maintain compliance with directives of governing entities.

(g) Observe, monitor, and evaluate outcomes of all of the facility's programs, policies and procedures to ensure effectiveness, and to fulfill administrative responsibility (for example, facility license) and professional responsibility (for example, personal NHA license).
(h) Identify areas of potential legal liability, and develop and implement an administrative intervention or risk management program to minimize or eliminate exposure.

(i) Ensure that resources (for example, supplies, medical equipment, technology, trained staff) are in place to provide resident care and to promote quality of life.

Stat. Auth.: ORS 678.820 & ORS 678.760
Stats. Implemented: ORS 678.820(1)

853-010-0070

Filing of Complaints with the Board

(1) Any person, agency, association, or member of the Board may file a complaint against any licensee. The complaint shall be submitted to the Board in writing, and facts which provide the basis for the complaint shall be described.

(2) The Board shall also evaluate complaints and investigative information received from the Senior and Disabled Services Division, the Long-Term Care Ombudsman, or any other source.

(3) A complaint received by the Board shall be referred to the appropriate agency or agencies for investigation.

(4) The findings and the corrective measures taken by the investigating agency or agencies, with any other information deemed appropriate, shall be reviewed by the Board. The Board, upon making or receiving the findings, may dismiss the charges, inquire further, or take disciplinary action.

(5) The Board shall notify the complainant and the licensee of the final action taken by the Board.

Stat. Auth.: ORS 678
Stats. Implemented: ORS 678.820(5)
Hist.: NHA 1-1989, f. & cert. ef. 2-15-89
Unprofessional Conduct

"Unprofessional Conduct" by a nursing home administrator includes, but is not limited, to the following:

(1) Failing to follow the rules and statutes regulating nursing facilities.

(2) Failing to act in a manner consistent with the care for the welfare and the health and safety of the residents of the nursing facility in which he/she is the administrator.

(3) Failing to follow facility policies or practices in the administration of a nursing facility.

(4) Failing or allowing the failure of employees to comply with standards for the operation of the nursing home for which the administrator is responsible.

(5) Failing to correct deficiencies or failure to maintain corrective measures in the nursing homes as cited by any agency of government which has nursing home administration responsibility.

(6) Violating the confidentiality of information or knowledge concerning the resident.

(7) Allowing harassment or mental, verbal, or physical abuse of residents.

(8) Using alcohol or other drugs to the extent that there is interference with job performance.

(9) Misusing of drug supplies, narcotics, or altering or discarding residents' records.

(10) Engaging in sexual harassment, making sexual advances toward, or engaging in sexual contact with any resident, or trainee under the licensee's supervision or engaging in sexual harassment of an employee, consultant or visitor to the facility in which the licensee practices.

(11) Appropriating medications, supplies, or personal items of the resident or nursing facility for personal use.

(12) Forging prescriptions or making drugs available to self, friends, or family members.

(13) Failing to take appropriate action on an employee who diverts drugs or medications prescribed for residents.
(14) Falsifying any records relating to the operation of the nursing facility.

(15) Failing to cooperate with an authorized investigation of a complaint.

(16) Failing to designate a designee to perform the functions, tasks or responsibilities in the absence of the administrator to the detriment of resident safety.

(17) Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed professional.

(18) Failing to report to the appropriate licensing board and/or law enforcement the incompetent, unethical, or illegal practice of any person who is providing or who is purporting to provide health care.

(19) Violating an order of the Board.

(20) Using the licensee's professional status, title, position, or relationship as a nursing home administrator or licensee to coerce, improperly influence, or obtain money, property, or services from a resident, resident's family member or visitor, employee, or any person served by or doing business with the nursing facility that the licensee administers or is employed by.

(21) Leaving employment as a nursing facility administrator without notifying Board and notifying state agency responsible for regulating nursing facilities.

(22) Permitting an unlicensed person to use a nursing facility administrator license for any purpose.

(23) Advertising in a manner which is false, deceptive or misleading.

(24) Failing to notify the Board when a license or certificate in a related health care discipline in Oregon or in another state has been denied, refused renewal, revoked, or suspended for unprofessional conduct.

Stat. Auth.: ORS 678
Stats. Implemented: ORS 678.710, 678.730, 678.760, 678.780 & 678.820
Hist.: BENHA 1-2003, f. & cert. ef. 11-12-03

853-010-0075

Grounds for License Denial or Revocation
(1) The Board may deny, suspend, revoke, or taken any other action in relation to the disciplining of a licensee or such applicant for licensure as the Board in its discretion considers proper after due notice, and an opportunity to be heard upon proof the nursing home administrator:

(a) Has willfully or repeatedly violated any of the provisions of the laws, rules, or regulations of the licensing authority of the state having jurisdiction of the operation and licensing of long-term care facilities;

(b) Has committed any act which, in the opinion of the Board, shall constitute unprofessional conduct, intemperance, or negligence in the performance of duties required and privileges conferred by licensure;

(c) Has violated the standards of practice for nursing home administrators in OAR 853-010-0065;

(d) Has otherwise violated any of the provisions of the laws, rules or regulations of the Board;

(e) Has borrowed or attempted to borrow money or other thing of value from a resident unless the resident is a relative;

(f) Has borrowed or attempted to borrow money or other thing of value from a former resident of the nursing facility who currently resides in an adult foster home, assisted-living facility, or residential care facility;

(g) Has permitted or condoned any person employed by the facility from borrowing or attempting to borrow money or any other thing of value from a nursing facility resident unless the resident is a relative of the employee;

(h) Has accepted or permitted or condoned any person employed by the facility accepting a personal gift of a value in excess of $50 in any calendar year from a nursing facility unless the resident is a relative of the employee;

(i) Deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's money or belongings;

(j) Has failed to report to the board facts known regarding conduct by a nursing home administrator that the licensee or applicant knew, or reasonably should have known, violates the disciplinary standards of the board.
(2) Voluntary surrender of a licensee is allowed provided a statement is signed by licensee stating his/her desire to submit to voluntary surrender of license and all benefits thereof.

Stat. Auth.: ORS 678.820
Stats. Implemented: ORS 678.820

853-010-0076

Philosophy Governing Voluntary Substance Abuse Treatment Programs

1) The board recognizes the need to establish a means of proactively providing early recognition and treatment options for licensees whose competency may be impaired due to the abuse of drugs or alcohol. The board intends that such licensees are treated and their treatment monitored, so that they can return to or continue to practice their profession in a manner which safeguards the public. To accomplish this, the board may refer licensees impaired by substance abuse to board-approved treatment programs as an alternative to instituting disciplinary proceedings defined in OAR 853-10-075.

(2) The board shall collect records and information required to be submitted by the board-approved alcohol and chemical dependency treatment program pursuant to 853-10-079(1)(e). The board shall not release records collected under this rule unless the records indicate a failure to successfully complete the treatment program or other violation of the rule.

Stat. Auth. : ORS 678.820(9)
Stats. Implemented ORS 678.780(f), (2)(d)
Hist.: BENHA 2-2000, f. & cert. ef. 10-11-00

853-010-0077

Definitions

As used in this rule

(1) "Abstinence" means the avoidance of alcohol, mind-altering, or potentially addictive drugs.
(2) "Addiction Specialist" means a health care professional who has special education in the evaluation and treatment of chemical dependency and other addictive disorders. They may include, but are not limited to:

(a) Certified alcohol and drug counselor;

(b) Nurse Practitioner;

(c) Physician;

(d) Psychologist

(3) "Approved treatment program" means an organized program in an inpatient, outpatient, or residential setting whose primary function is the evaluation and treatment of clients with chemical dependency, psychiatric or physical disorders. The treatment program shall meet the following criteria:

(a) Employ staff qualified by education and experience to treat the client's disorder;

(b) Have a formalized plan of care which includes:

(A) Assessment and diagnosis;

(B) Treatment goals including establishing and evaluating treatment outcomes;

(C) Discharge criteria;

(D) Guidelines for continuing recovery;

(c) Provide a written report addressing all parts of the plan of care;

(d) Provide evidence of the ability to meet the above criteria on an annual basis.

(4) "Body Fluid Testing" means the collection of blood or urine at irregular intervals not known in advance by the person being tested, for the purpose of evaluating the presence of prescription or non-prescription drugs and alcohol. A pre-approved laboratory, in a manner which preserves the integrity of the specimen shall perform the collection and testing.

(5) "Cause" means any non-compliance with the treatment program's regime as agreed to by the licensee, the leaders of the treatment program and the board. This includes but is not limited to illegal behavior, positive drug screens, no show to scheduled meeting(s) and/or evidence of relapse.
(6) "Contract" means an individualized written agreement between the recovering licensee, the board, and the substance abuse treatment program stipulating the licensee's consent to comply with the treatment program and its required components of the licensee's recovery activity.

(7) "Intake Evaluation" means an assessment of the licensee's disorder by an addiction specialist for the purpose of treatment recommendations and referral.

(8) "Relapse" means the use of alcohol, mind altering, or potentially addictive drugs for non-therapeutic reasons after sobriety has been demonstrated.

(9) "Substance Abuse" means the impairment, as determined by the board, of licensee's professional services by an addiction to, a dependency on or the use of alcohol, legend drugs or controlled substances.

(10) "Support Group" means an organized meeting of individuals with similar disorders for the support of encouraging wellness and continued recovery.

Stat. Auth. : ORS 678.820(9)
Stats. Implemented ORS 678.780(f), (2)(d)
Hist.: BENHA 2-2000, f. & cert. ef. 10-11-00

853-010-0078

Admission to Approved Substance Abuse Treatment Program

(1) A licensee may seek admission to a substance abuse treatment program in one of the following ways:

(a) by admission to the board of addiction to alcohol or prescription drugs, the diversion and use of unauthorized drugs, or the abuse of other potentially addicting substances

(b) by referral from a family member, friend, administrator peer, or employer;

(c) by identification of chemical dependency in a complaint filed against the licensee;

(d) in lieu of disciplinary action for chemical dependency or conduct caused or related to chemical dependency, the licensee may accept board referral;

(2) Upon identification of a problem of chemical dependency, and the licensee's admission to the same, the licensee shall:
(a) Undergo a medical examination (history and physical examination, appropriate blood chemistry, and urine drug screen) and an evaluation by an addiction specialist.

(b) Obtain an intake evaluation from an addiction specialist

(c) Enter an approved treatment program specific for chemical dependency

3. The licensee shall enter into a contract with the board and the treatment program to comply with the requirements of the program which shall include, but not be limited to "Conditions of Participation in the Substance Abuse Treatment Program".

Stat. Auth. : ORS 678.820(9)
Stats. Implemented ORS 678.780(f), (2)(d)
Hist.: BENHA 2-2000, f. & cert. ef. 10-11-00

853-010-0079

Conditions of Participation in Substance Abuse Treatment Program

1. The licensee shall enter into a contract with the board and the approved substance abuse treatment program to comply with the requirements of this program which may include, but not be limited to:

(a) Successful completion of an approved treatment program and continuing care for a period of one year

(b) Continued abstinence from mind-altering or potentially addictive drugs, including both over-the-counter and prescription drugs, except for medications prescribed by an authorized prescriber if the authorized prescriber is aware of the licensee's participation in a substance abuse program.

(c) Random body fluid testing. The board may require that urine collection be witnessed

(d) Attendance at support groups, e.g., 12-step groups

(e) Submission of reports by addiction specialist at specified intervals. Reports shall include treatment, prognosis and goals.

(f) Submission of report by addiction specialist to the NHA Board monthly for three months and quarterly thereafter. Report shall include results of drug screenings, positive updates and compliance issues.
(g) Meeting with the NHA Board at the board's discretion

(2) The licensee shall comply with specified employment conditions and restrictions which shall include, but not be limited to:

(a) Leave of absence from nursing home administrator position until approved by an addiction specialist and the board to return to work;

(b) Notification to the employer of participation in the substance abuse treatment program if licensee is currently in program;

(c) Disclosure to a prospective employer of participation in the substance abuse treatment program once a job offer has been made if licensee is currently in program;

(d) Disclosure of participation in the substance abuse treatment program when the nursing home administrator applies for licensure in any other state if licensee is currently in program.

(3) The licensee shall sign a waiver allowing the substance abuse treatment program to release information to the board if the licensee does not comply with the requirements of the program.

(4) The licensee is financially responsible for all costs of participation in the substance abuse treatment program, including the cost of random body fluid testing and the cost of treatment.

(5) The licensee may be subject to disciplinary action if the licensee does not consent to be referred to a substance abuse treatment program, does not comply with employment restrictions, does not successfully complete the program, or has a relapse after completing the program.

(6) A licensee who is not being investigated by the board, or is not subject to current disciplinary action, or is not currently being monitored by the board for substance abuse may voluntarily participate in a substance abuse treatment without being referred by the board. Such voluntary participants shall not be subject to disciplinary action for their substance abuse and shall not have their participation made known to the board if they meet the requirements of the substance abuse treatment program as stated in (3) through (6).

(7) The treatment and pre-treatment records of licensees referred to or voluntarily participating in a substance abuse treatment program shall be confidential and shall not be subject to discovery by subpoena or admissible as evidence, except for
treatment records reported to the board for cause. Records held by the board under this section shall not be subject to discovery by subpoena, except by the licensee.

Stat. Auth. ORS 678.820(9)
Stats. Implemented ORS 678.780(f), (2)(d)
Hist.: BENHA 2-2000, f. & cert. ef. 10-11-00

853-010-0080

Restoration and Reinstatement of Licenses

(1) The Board may, in its discretion, reissue a license to any person whose license has been revoked. Any such request shall be in writing and shall include attested documents demonstrating that the cause of the revocation is no longer in existence or that the objectives of the revocation have been successfully accomplished.

(2) Should the Board determine to restore the license, it may require the administrator to pay the examination fee as provided in OAR 835-010-0015 and sit for the examination described in OAR 853-010-0020(2) to satisfy the Board that the administrator has kept himself/herself current with the laws and rules.

(3) Upon the decision of the Board to restore the license, the administrator shall pay to the Board a fee as provided in OAR 853-010-0025 for licensure.

(4) If a license is revoked due to a conviction of a crime and the conviction is subsequently reversed on appeal and the accused acquitted or discharged, his/her license shall become operative retroactively from the date it was revoked without any penalty or loss of privileges.

(5) Suspended licenses are automatically in force at the expiration of the period of suspension set forth in the Board's order, but must be renewed in the normal course if the license expires during the period of suspension.

Stat. Auth.: ORS 678.740, ORS 678.760, ORS 678.770, ORS 678.820(1) & ORS 678.820(9)
Stats. Implemented: ORS 678.790 & ORS 678.820
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(Generally)

678.010 Definitions for ORS 678.010 to 678.410. As used in ORS 678.010 to 678.410, unless the context requires otherwise:

(1) “Board” means the Oregon State Board of Nursing.
(2) “Clinical nurse specialist” means a licensed registered nurse who has been certified by the board as qualified to practice the expanded clinical specialty nursing role.
(3) “Diagnosing” in the context of the practice of nursing means identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing care.
(4) “Human responses” means those signs, symptoms and processes which denote the person’s interaction with an actual or potential health problem.
(5) “Long term care facility” means a licensed skilled nursing facility or intermediate care facility as those terms are used in ORS 442.015, an adult foster home as defined in ORS 443.705 that has residents over 60 years of age, a residential care facility as defined in ORS 443.400 or an assisted living facility.
(6) “Nurse practitioner” means a registered nurse who has been certified by the board as qualified to practice in an expanded specialty role within the practice of nursing.
(7) “Physician” means a person licensed to practice under ORS chapter 677.
(8) “Practice of nursing” means diagnosing and treating human responses to actual or potential health problems through such services as identification thereof, health teaching, health counseling and providing care supportive to or restorative of life and well-being and including the performance of such additional services requiring education and training which are recognized by the nursing profession as proper to be performed by nurses licensed under ORS 678.010 to 678.410 and which are recognized by rules of the board. “Practice of nursing” includes executing medical orders as prescribed by a physician or dentist but does not include such execution by a member of the immediate family for another member or execution by a person designated by or on behalf of a person requiring care as provided by board rule where the person executing the care is not licensed under ORS 678.010 to 678.410. The practice of nursing includes providing supervision of nursing assistants.
(9) “Practice of practical nursing” means the application of knowledge drawn from basic education in the social and physical sciences in planning and giving nursing care and in assisting persons toward achieving of health and well-being.
(10) “Practice of registered nursing” means the application of knowledge drawn from broad in-depth education in the social and physical sciences in assessing, planning, ordering, giving, delegating, teaching and supervising care which promotes the person’s optimum health and independence.
(11) “Treating” means selection and performance of those therapeutic measures essential to the effective execution and management of the nursing care and execution of the prescribed medical orders. [Amended by 1957 c.316 §2; 1973 c.584 §1; 1975 c.205 §1; 1975 c.659 §1; 1995 c.763 §3; 1997 c.204 §1; 1999 c.498 §4; 2001 c.465 §1]

678.015 [1957 c.316 §6; repealed by 1973 c.584 §24]

678.020 [Amended by 1953 c.254 §16; repealed by 1957 c.316 §3 (678.021 enacted in lieu of 678.020)]
678.021 License required to practice nursing. It shall be unlawful for any person to practice nursing or offer to practice nursing in this state or to use any title or abbreviation, sign, card or device to indicate the person is practicing either practical or registered nursing unless the person is licensed under ORS 678.010 to 678.410 at the level for which the indication of practice is made and the license is valid and in effect. [1957 c.316 §4 (enacted in lieu of 678.020); 1973 c.584 §2; 2003 c.14 §431]

678.030 [Repealed by 1957 c.316 §7 (678.031 enacted in lieu of 678.030)]

678.031 Application of ORS 678.010 to 678.410. ORS 678.010 to 678.410 do not apply to:
(1) The employment of nurses in institutions or agencies of the federal government.
(2) The practice of nursing incidental to the planned program of study for students enrolled in nursing education programs accredited by the Oregon State Board of Nursing or accredited by another state or United States territory as described under ORS 678.040 and approved by the board.
(3) Nursing practiced outside this state that is incidental to a distance learning program provided by an institution of higher education located in Oregon.
(4) The furnishing of nursing assistance in an emergency.
(5) The practice of any other occupation or profession licensed under the laws of this state.
(6) Care of the sick with or without compensation when performed in connection with the practice of the religious tenets of a well-recognized church or denomination that relies exclusively on treatment by prayer and spiritual means by adherents thereof so long as the adherent does not engage in the practice of nursing as defined in ORS 678.010 to 678.410 and 678.990 or hold oneself out as a registered nurse or a licensed practical nurse.
(7) Nonresident nurses licensed and in good standing in another state if they are practicing in Oregon on a single, temporary assignment of not to exceed 30 days, renewable for not to exceed 30 days, for assignments that are for the general public benefit limited to the following:
(a) Transport teams;
(b) Red Cross Blood Services personnel;
(c) Presentation of educational programs;
(d) Disaster teams;
(e) Staffing a coronary care unit, intensive care unit or emergency department in a hospital that is responding to a temporary staffing shortage and would be otherwise unable to meet its critical care staffing requirements; or
(f) Staffing a long term care facility that is responding to a temporary staffing shortage and would be otherwise unable to meet its staffing requirements. [1957 c.316 §8 (enacted in lieu of 678.030); 1973 c.584 §3; 1981 c.369 §1; 1997 c.110 §1; 2001 c.465 §2; 2001 c.568 §1]

678.034 Hospitals to notify board of nurses employed to meet temporary staffing shortage. (1) Hospitals and long term care facilities employing nurses under ORS 678.031 (7)(e) and (f) shall notify the Oregon State Board of Nursing in writing of the number of nurses so employed, the times of employment, the nature of the staffing shortage and certify that there is no labor dispute affecting nurses at the hospital or long term care facility. In addition, at the request of the board, the hospital or long term care facility shall provide documentation that the nurses so employed are licensed and in good standing in another state or United States territory.
(2) Nurses employed in this state under ORS 678.031 (7)(e) and (f), at the time of employment, also must apply for an Oregon license by indorsement. [1981 c.369 §1a; 2001 c.465 §3; 2001 c.568 §2]

678.035 [1975 c.659 §4; 1977 c.309 §3; repealed by 1981 c.369 §16]
678.036 Liability of nurse supervising nursing assistants; liability when duties delegated. (1) A nurse who is responsible for supervising nursing assistants shall not be considered to be supervising a nursing assistant who administers noninjectable medication while the nurse is absent from the facility at which the administration occurs unless the nursing assistant is acting pursuant to specific instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so.

(2) A nurse who is responsible for supervising nursing assistants shall not be subject to an action for civil damages for the failure of a nursing assistant who administers noninjectable medication to notify the nurse of any patient reaction to the medication perceived by the assistant.

(3) A nurse who delegates the provision of nursing care to another person pursuant to ORS 678.150 shall not be subject to an action for civil damages for the performance of a person to whom nursing care is delegated unless the person is acting pursuant to specific instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so. [1981 c.431 §2; 1987 c.369 §3]

(Licensing)

678.040 Qualifications of applicants for license. Each applicant for a license under ORS 678.010 to 678.445 shall furnish satisfactory evidence that the applicant’s physical and mental health is such that it is safe for the applicant to practice, and that:

(1) The applicant has graduated from a registered nurse or licensed practical nurse nursing education program accredited by the Oregon State Board of Nursing;

(2) The applicant has graduated from a nursing program in the United States which program is either accredited by the licensing board for nurses in a particular state or United States territory, or, if the licensing board is not the accrediting agency in that state or United States territory, the program is accredited by the appropriate accrediting agency for that state or United States territory; or

(3) The applicant has graduated in another country and has an education equivalent to that provided by accredited programs in this country. [Amended by 1953 c.254 §16; 1957 c.316 §9; 1973 c.584 §4; 1981 c.369 §2]

678.045 [Formerly 678.250; repealed by 1981 c.369 §16]

678.050 Examining applicants; issuing license; license by indorsement; processing license by indorsement application; limited license; rules. (1) Examinations for the licensing of applicants under ORS 678.010 to 678.445 shall be held at least once a year, and at such times and places as the Oregon State Board of Nursing may determine. Notice of the examination dates shall be given by mail to all accredited nursing education programs in Oregon. The applicant shall be required to pass an examination in such subjects relating to nursing at the practical or registered level as the board may determine necessary to protect the public health and welfare.

(2) All duly qualified applicants who pass the examination and meet other standards established by the board shall be issued the license provided for in ORS 678.010 to 678.445 according to the nature of the license for which application is made and examination taken and passed. The board shall provide evidence of current licensure. The board shall determine by rule the form and manner of the evidence of current licensure.

(3)(a) The board may issue a license by indorsement to an applicant qualified as provided in ORS 678.040 who has passed the examination used by the Oregon State Board of Nursing and meets other standards established by the board. The board may also require evidence of competency to practice nursing at the level for which application is made.
(b) For the purposes of the licensing procedure, the board shall not accept monetary assistance from anyone except the nurse applying for licensure by indorsement.

(c) The board shall process in order applications for licensure by indorsement of qualified applicants and immediately issue licenses or license memoranda when the applications are received and review of supportive documentation is completed. However, this paragraph does not prohibit the board from immediately issuing a license out of order to applicants appearing in person.

(d) The provisions of paragraphs (b) and (c) of this subsection do not prohibit the board from processing requests to employ nurses to meet temporary staffing shortages, as described in ORS 678.031 or 678.034, in facilities in this state not involved in labor disputes.

(4) Subject to such terms and conditions as the board may impose, the board may issue a limited license to practice registered or practical nursing:

(a) To a graduate of an accredited nursing education program at the appropriate level upon the applicant’s filing for the first examination to be given following the applicant’s graduation. The license issued under this paragraph expires when the results of the examinations are received by the applicant. The board may extend the limited license if the applicant shows to the satisfaction of the board that an emergency situation has prevented the applicant from taking or completing the first examination administered following graduation. The extension expires when the results of the next examination are received by the applicant or on the filing date of the next examination if the applicant has not reapplied.

(b) To an applicant whose license has become void by reason of nonpayment of fees at either level and who otherwise meets the requirements of the board. The board may, in issuing a limited license, require the applicant to demonstrate ability to give safe nursing care by undergoing a supervised experience in nursing practice as shall be designated by the board, or by satisfactorily completing a continuing education program as approved by the board. The license issued under this paragraph expires on the date set in the license by the board. Upon satisfactorily completing the board’s requirements, and payment of the renewal fee and delinquency fee, the board shall issue to the applicant a license to practice nursing.

(c) To an applicant who has not practiced nursing in any state for a period of five years, but has maintained a current license by the payment of fees. Such applicant shall not practice nursing in Oregon unless an application is made to the board for a limited license and it is issued to the applicant. The board, in issuing such limited license, may require the applicant to demonstrate ability to give safe nursing care by undergoing a supervised experience in nursing practice as shall be designated by the board, or by satisfactorily completing a continuing education program approved or designated by the board. No person shall be issued a license if, in the judgment of the board, the person’s conduct has been such, during absence from practice, that the applicant would be denied a license if applying for an initial license to practice nursing in this state.

(d) To a licensee who has been placed on probation or has been otherwise subjected to disciplinary action by the board.

(e) To any of the following persons if the person is affiliated with a planned program of study in Oregon consistent with the standards and requirements established by the board:

(A) A foreign nurse;

(B) A foreign student nurse; or

(C) A nurse licensed in another jurisdiction.

(5) The board may adopt by rule requirements and procedures for placing a license or certificate in inactive status.

(6)(a) Retired status may be granted to a person licensed or certified as a registered nurse, licensed practical nurse, nurse practitioner, certified registered nurse anesthetist or clinical nurse specialist and who surrenders the person’s license or certificate while in good standing with the issuing authority if the person is not subject to any
pending disciplinary investigation or action. The board may adopt by rule requirements, procedures and fees for placing a license or certificate in retired status.

(b) A person granted retired status by the Oregon State Board of Nursing under the provisions of paragraph (a) of this subsection:

(A) Shall pay a fee in an amount to be determined by the board for retired status.

(B) May not practice nursing or offer to practice nursing in this state.

(C) May use the title or abbreviation with the retired license or certificate only if the designation “retired” appears after the title or abbreviation. [Amended by 1953 c.254 §16; 1957 c.316 §10; 1969 c.71 §1; 1973 c.584 §5; 1975 c.205 §2; 1981 c.369 §3; 1983 c.221 §1; 1989 c.673 §1; 1999 c.420 §1; 2001 c.275 §1; 2005 c.380 §1; 2009 c.37 §1]

678.060 [Amended by 1953 c.254 §16; repealed by 1957 c.316 §11 (678.061 enacted in lieu of 678.060)]

678.061 [1957 c.316 §12 (enacted in lieu of 678.060); 1963 c.50 §2; 1969 c.71 §2; repealed by 1973 c.584 §24]

678.070 [Repealed by 1953 c.254 §16]

678.080 Evidence of licensure. Any person to whom a license is issued under ORS 678.010 to 678.445, whenever requested to do so in relation to employment as a registered or practical nurse or in relation to enforcement of ORS 678.010 to 678.445, shall provide evidence of current licensure. [Amended by 1953 c.254 §16; 1957 c.316 §13; 1973 c.584 §6; 1981 c.369 §4; 2009 c.37 §2]

678.085 [1953 c.254 §14; 1957 c.316 §14; repealed by 1973 c.584 §24]

678.090 [Repealed by 1953 c.254 §16]

678.100 [Amended by 1953 c.254 §16; repealed by 1957 c.316 §15 (678.101 enacted in lieu of 678.100)]

678.101 Renewal of license; fee; certificate and privilege. (1) Every person licensed to practice nursing shall apply for renewal of the license other than a limited license in every second year before 12:01 a.m. on the anniversary of the birthdate of the person in the odd-numbered year for persons whose birth occurred in an odd-numbered year and in the even-numbered year for persons whose birth occurred in an even-numbered year. Persons whose birthdate anniversary falls on February 29 shall be treated as if the anniversary were March 1.

(2) Each application shall be accompanied by a nonrefundable renewal fee payable to the Oregon State Board of Nursing.

(3) The board may not renew the license of a person licensed to practice nursing unless:

(a) The requirements of subsections (1) and (2) of this section are met; and

(b) Prior to payment of the renewal fee described in subsection (2) of this section the applicant completes, or provides documentation of previous completion of:

(A) A pain management education program approved by the board and developed in conjunction with the Pain Management Commission established under ORS 409.500; or

(B) An equivalent pain management education program, as determined by the board.

(4) The license of any person not renewed for failure to comply with subsections (1) to (3) of this section is
expired and the person shall be considered delinquent and is subject to the delinquent fee specified in ORS 678.410.

(5) A registered nurse who has been issued a certificate as a nurse practitioner shall apply, personally or by appropriately postmarked letter, for renewal of the certificate and for renewal of the prescriptive privileges in every second year before 12:01 a.m. on the anniversary of the birthdate, as determined for the person’s license to practice nursing. [1957 c.316 §16 (enacted in lieu of 678.100); 1965 c.158 §1; 1969 c.71 §3; 1973 c.584 §7; 1975 c.205 §3; 1981 c.369 §5; 1987 c.79 §5; 1999 c.420 §2; 2001 c.987 §15]

678.110 [Repealed by 1957 c.316 §17 (678.111 enacted in lieu of 678.110)]

(Discipline of Nurses)

678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(a) Conviction of the licensee of crime where such crime bears demonstrable relationship to the practice of nursing. A copy of the record of such conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of the conviction.

(b) Gross incompetence or gross negligence of the licensee in the practice of nursing at the level for which the licensee is licensed.

(c) Any willful fraud or misrepresentation in applying for or procuring a license or renewal thereof.

(d) Fraud or deceit of the licensee in the practice of nursing or in admission to such practice.

(e) Impairment as defined in ORS 676.303.

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder.

(h) Revocation or suspension of a license to practice nursing by any state or territory of the United States, or any foreign jurisdiction authorized to issue nursing credentials whether or not that license or credential was relied upon in issuing that license in this state. A certified copy of the order of revocation or suspension shall be conclusive evidence of such revocation or suspension.

(i) Physical condition that makes the licensee unable to conduct safely the practice for which the licensee is licensed.

(j) Violation of any condition imposed by the board when issuing a limited license.

(2) A certificate of special competence may be denied or suspended or revoked for the reasons stated in subsection (1) of this section.

(3) A license or certificate in inactive status may be denied or suspended or revoked for the reasons stated in subsection (1) of this section.

(4) A license or certificate in retired status may be denied or suspended or revoked for any cause stated in subsection (1) of this section. [1957 c.316 §18 (enacted in lieu of 678.110); 1973 c.584 §11; 1975 c.205 §4; 1979 c.744 §51; 1981 c.369 §7; 1983 c.221 §2; 1985 c.23 §7; 2001 c.275 §2; 2009 c.756 §31]

678.112 Impaired health professional program. Persons licensed to practice nursing who elect not to participate in the impaired health professional program established under ORS 676.190 or who fail to comply
with the terms of participation shall be reported to the Oregon State Board of Nursing for formal disciplinary action under ORS 678.111. [1991 c.193 §2; 2007 c.335 §1; 2009 c.697 §7; 2009 c.756 §§32,94]


678.112. (1) When a person licensed to practice nursing voluntarily seeks treatment for an impairment or physical problem that otherwise may lead to formal disciplinary action under ORS 678.111, the Oregon State Board of Nursing may abstain from taking such formal disciplinary action if the board finds that the licensee can be treated effectively and that there is no danger to the public health, safety or welfare.

(2) If the board abstains from taking such formal disciplinary action, it may require the licensee to be subject to the voluntary monitoring program as established by the board.

(3) All records of the voluntary monitoring program are confidential and shall not be subject to public disclosure, nor shall the records be admissible as evidence in any judicial proceedings.

(4) A licensee voluntarily participating in the voluntary monitoring program shall not be subject to investigation or disciplinary action by the board for the same offense, if the licensee complies with the terms and conditions of the monitoring program.

(5) The board shall establish by rule criteria for eligibility to participate in the voluntary monitoring program and criteria for successful completion of the program.

(6) Licensees who elect not to participate in the voluntary monitoring program or who fail to comply with the terms of participation shall be reported to the board for formal disciplinary action under ORS 678.111.

678.113 When evaluation of mental or physical condition, demonstration of competency or evidence of continuing education may be required; rules. (1) During the course of an investigation into the performance or conduct of an applicant, certificate holder or licensee, the Oregon State Board of Nursing may order mental health, physical condition or chemical dependency evaluations of the applicant, certificate holder or licensee upon reasonable belief that the applicant, certificate holder or licensee is unable to practice nursing with reasonable skill and safety to patients.

(2) When the board has reasonable cause to believe that an applicant, certificate holder or licensee is or may be unable to practice nursing with reasonable skill and safety to patients, the board may order a competency examination of the applicant, certificate holder or licensee for the purpose of determining the fitness of the applicant, certificate holder or licensee to practice nursing with reasonable skill and safety to patients.

(3) A licensee or certificate holder by practicing nursing, or an applicant by applying to practice nursing in Oregon, gives consent to submit to mental health, physical condition or chemical dependency evaluations when ordered by the board and waives any objection on the grounds of privileged communication to the admissibility of information derived from evaluations ordered by the board.

(4) By rule, the board may require evidence of continuing education in an accredited program as a prerequisite for renewal of registered or practical nursing licenses, or both, or may require continuing education for persons whose license has lapsed for nonpayment of fees, who have not practiced nursing for five years, or who have their licenses suspended or revoked as a condition to relicensure. [1973 c.584 §9; 1975 c.205 §5; 1995 c.79 §341; 1999 c.375 §1]

678.115 [1957 c.316 §20 (enacted in lieu of 678.120); 1971 c.734 §121; repealed by 1973 c.584 §24]
678.117 Procedure for imposing civil penalty; amount; rules. (1) The Oregon State Board of Nursing shall adopt by rule a schedule establishing the amount of civil penalty that may be imposed for any violation of ORS 678.010 to 678.445 or any rule of the board. No civil penalty shall exceed $5,000.

(2) In imposing a penalty pursuant to this section, the board shall consider the following factors:

(a) The past history of the person incurring the penalty in observing the provisions of ORS 678.010 to 678.445 and the rules adopted pursuant thereto.

(b) The economic and financial conditions of the person incurring the penalty.

(3) Any penalty imposed under this section may be remitted or mitigated upon such terms and conditions as the board considers proper and consistent with the public health and safety.

(4) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(5) All penalties recovered under this section shall be credited to the special account described in ORS 678.170. [1973 c.584 §22; 1981 c.369 §8; 1985 c.23 §3; 1991 c.734 §72; 1999 c.375 §2]

678.120 [Repealed by 1957 c.316 §19 (678.115 enacted in lieu of 678.120)]

678.121 [1957 c.316 §22; repealed by 1971 c.734 §21]

678.123 Prohibited acts. It shall be unlawful for any person:

(1) To sell or fraudulently obtain or furnish any diploma or license or record thereof for any person not graduated from an accredited nursing program or is not licensed under ORS 678.010 to 678.410 or to sell or fraudulently obtain or furnish any certificate to a person not certified as a nursing assistant.

(2) To practice nursing under authority of a diploma or license or record thereof illegally or fraudulently obtained or issued unlawfully.

(3) To employ unlicensed persons to practice practical or registered nursing. [1973 c.584 §10; 1989 c.800 §4]

678.125 [1957 c.316 §24; repealed by 1973 c.584 §24]

678.126 Confidentiality of information; duty to investigate complaints; immunity. (1) Any information that the Oregon State Board of Nursing obtains pursuant to ORS 678.021, 678.111, 678.113, 678.123, 678.135 or 678.442 is confidential as provided under ORS 676.175.

(2) Upon receipt of a complaint under ORS 678.010 to 678.410 or 678.442, the Oregon State Board of Nursing shall conduct an investigation as described under ORS 676.165.

(3) Any person, facility, licensee or association that reports or provides information to the board under ORS 678.021, 678.111, 678.113, 678.123, 678.135 or 678.442 in good faith shall not be subject to an action for civil damages as a result thereof. [1981 c.369 §14; 1985 c.23 §6; 1997 c.791 §22]

678.128 Liability of complainants, witnesses, investigators, counsel and board members in disciplinary proceedings. (1) Members of the Oregon State Board of Nursing, members of its administrative and investigative staff and its attorneys acting as prosecutors or counsel shall have the same privileges and immunities from civil and criminal proceedings arising by reason of official actions as prosecuting and judicial officers of the state.

(2) No person who has made a complaint as to the conduct of a licensee of the board or who has given information or testimony relative to a proposed or pending proceeding for misconduct against the licensee of the board, shall be answerable for any such act in any proceeding except for perjury. [1981 c.369 §13]
678.130 [Amended by 1953 c.254 §16; 1957 c.316 §25; 1963 c.50 §3; repealed by 1969 c.71 §9]

678.135 Duty to report violations. (1) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, any health care facility licensed as required by ORS 441.015, or any person licensed by the Oregon State Board of Nursing, shall report to the board any suspected violation of ORS 678.010 to 678.410 or any rule adopted by the board.

(2) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, the Oregon Nurses Association or any other organization representing registered or licensed practical nurses shall report to the board any suspected violation of ORS 678.010 to 678.410 or any rule adopted by the board.

(3) Any person may report to the board any suspected violation of ORS 678.010 to 678.410 or any rule adopted by the board, association or other organization representing registered or licensed practical nurses.

(4) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, a person licensed by the board who has reasonable cause to believe that a licensee of another board has engaged in prohibited conduct as defined in ORS 676.150 shall report the prohibited conduct in the manner provided in ORS 676.150. [1985 c.23 §5; 2009 c.536 §14]

(State Board)

678.140 Oregon State Board of Nursing. (1) There is created an Oregon State Board of Nursing composed of nine members appointed by the Governor and subject to confirmation by the Senate in the manner provided in ORS 171.562 and 171.565. All members of the board must be residents of this state. Of the members of the board:

(a) Five must be registered nurses;
(b) One must be a licensed practical nurse;
(c) One must be a certified nursing assistant; and
(d) Two must be members of the public who are otherwise not eligible for appointment to the board.

(2)(a) Board members required to be nurse members may be selected by the Governor from a list of three to five nominees for each vacancy, submitted two months before the expiration of the term of office of a nurse member by:

(A) The Oregon Nurses Association or any other professional organization representing registered nurses, if the vacancy is in a registered nurse position;
(B) The Oregon Licensed Practical Nurses Association or any other professional organization representing licensed practical nurses, if the vacancy is in a licensed practical nurse position; or
(C) A professional organization representing certified nursing assistants, if the vacancy is in a certified nursing assistant position.

(b) Each nurse or certified nursing assistant member must:

(A) Be currently licensed and not under disciplinary status with the board in the category for which the member is appointed; and
(B) Have at least five years’ experience in the category in which the member is appointed, three of which were immediately prior to appointment.

(c) The public members and any person who is a spouse, domestic partner, child, parent or sibling of a public member may not be licensed by the board.

(d) In making appointments of registered nurses, the Governor shall ensure that the following areas of practice are represented on the board:
(A) One nursing educator;
(B) One nursing administrator;
(C) Two nonsupervisory nurses involved in direct patient care; and
(D) One nurse practitioner.

(e) In selecting the members of the board, the Governor shall strive to balance the representation on the board according to:
(A) Geographic areas of this state; and
(B) Ethnic group.

(3)(a) The members of the board shall be appointed by the Governor for terms of three years, beginning on January 1. A member serves at the pleasure of the Governor. The terms must be staggered so that no more than three terms end each year. A member is eligible for reappointment. An unexpired term of a board member shall be filled in the same manner as an original appointment is made. The appointment shall be for the remainder of the unexpired term.

(b) A board member shall be removed immediately from the board if, during the member’s term, the member:
(A) Is not a resident of this state;
(B) Has been absent from three consecutive board meetings, unless at least one absence is excused; or
(C) Is not a registered nurse or licensed practical nurse or a retired registered nurse or licensed practical nurse who was a registered nurse in good standing or licensed practical nurse in good standing at the time of retirement, if the board member was appointed to serve on the board as a nurse member.

(4) Members of the board are entitled to compensation and expenses as provided in ORS 292.495. The board may provide by rule for compensation to board members for the performance of official duties at a rate that is greater than the rate provided in ORS 292.495. [Amended by 1953 c.254 §16; 1957 c.316 §26; 1971 c.650 §27; 1973 c.584 §12; 1973 c.792 §34; 1981 c.206 §1; 1983 c.113 §1; 1995 c.79 §342; 1997 c.141 §1; 2009 c.535 §9]

Note: Sections 36 and 37, chapter 535, Oregon Laws 2009, provide:

Sec. 36. (1) A member serving on the Oregon State Board of Nursing created in ORS 678.140 on the effective date of this 2009 Act [June 25, 2009] continues to serve until the term of office for which the member was appointed terminates by expiration of time, resignation from the board by the member or removal of the member from office.

(2) When a member’s term of service on the board terminates, a member who is otherwise eligible for reappointment to the board may be reappointed, unless the appointment exceeds the total appointments authorized for members within the member’s classification. [2009 c.535 §36]

Sec. 37. Section 36 of this 2009 Act is repealed on June 30, 2014. [2009 c.535 §37]

678.150 Powers, functions and duties of board, officers and executive director; rules; subpoena powers. (1) The Oregon State Board of Nursing shall elect annually from its number a president, a president-elect and a secretary, each of whom shall serve until a successor is elected and qualified. The board shall meet on the call of the president or as the board may require. Special meetings of the board may be called by the secretary upon the request of any three members. Five members shall constitute a quorum.

(2) The board shall adopt a seal which shall be in the care of the executive director.

(3) The board shall keep a record of all its proceedings and of all persons licensed and schools or programs accredited or approved under ORS 678.010 to 678.445. The records shall at all reasonable times be open to public scrutiny.
(4) The executive director of the board may hire and define the duties of employees as necessary to carry into effect the provisions of ORS 678.010 to 678.445. The executive director, with approval of the board, may employ special consultants. All salaries, compensation and expenses incurred or allowed shall be paid out of funds received by the board.

(5) The board shall determine the qualifications of applicants for a license to practice nursing in this state and establish educational and professional standards for such applicants subject to laws of this state.

(6) The board shall:
   (a) Exercise general supervision over the practice of nursing in this state.
   (b) Prescribe standards and approve curricula for nursing education programs preparing persons for licensing under ORS 678.010 to 678.445.
   (c) Provide for surveys of nursing education programs at such times as may be necessary.
   (d) Accredit such nursing education programs as meet the requirements of ORS 678.010 to 678.445 and of the board.
   (e) Deny or withdraw accreditation from nursing education programs for failure to meet prescribed standards.
   (f) Examine, license and renew the licenses of duly qualified applicants and administer examinations for other states where requested to do so by the other state.
   (g) Issue subpoenas for any records relevant to a board investigation, including patient and other medical records, personnel records applicable to nurses and nursing assistants, records of schools of nursing and nursing assistant training records and any other relevant records; issue subpoenas to persons for personal interviews relating to board investigations; compel the attendance of witnesses; and administer oaths or affirmations to persons giving testimony during an investigation or at hearings. In any proceeding under this subsection, when a subpoena is issued to an applicant, certificate holder or licensee of the board, a claim of nurse-patient privilege under ORS 40.240 or of psychotherapist-patient privilege under ORS 40.230 is not grounds for quashing the subpoena or for refusing to produce the material that is subject to the subpoena.
   (h) Enforce the provisions of ORS 678.010 to 678.445, and incur necessary expenses therefor.
   (i) Prescribe standards for the delegation of special tasks of patient care to nursing assistants and for the supervision of nursing assistants. The standards must include rules governing the delegation of administration of noninjectable medication by nursing assistants and must include rules prescribing the types of noninjectable medication that can be administered by nursing assistants, and the circumstances, if any, and level of supervision under which nursing assistants can administer noninjectable medication. In formulating the rules governing the administration of noninjectable medication by nursing assistants, the board shall consult with nurses, physicians, gerontologists and pharmacologists. Notwithstanding any other provision of this paragraph, however, determination of the appropriateness of the delegation of a special task of patient care shall remain with the registered nurse issuing the order.
   (j) Notify licensees at least annually of changes in legislative or board rules that affect the licensees. Notice may be by newsletter or other appropriate means.

(7) The board shall determine the scope of practice as delineated by the knowledge acquired through approved courses of education or through experience.

(8) For local correctional facilities, lockups and juvenile detention facilities, as defined in ORS 169.005, youth correction facilities as defined in ORS 420.005, for facilities operated by a public agency for detoxification of persons who use alcohol excessively, for homes or facilities licensed under ORS 443.705 to 443.825 for adult foster care, and for facilities licensed under ORS 443.400 to 443.455 for residential care, training or treatment, the board shall adopt rules pertaining to the provision of nursing care, and to the various tasks relating to the administration of noninjectable medication including administration of controlled substances. The rules must provide for delegation of nursing care and tasks relating to the administration of medication to other than licensed
nursing personnel by a physician licensed by the Oregon Medical Board or by a registered nurse, designated by
the facility. Such delegation must occur under the procedural guidance, initial direction and periodic inspection
and evaluation of the physician or registered nurse. However, the provision of nursing care may be delegated
only by a registered nurse.

(9) The Oregon State Board of Nursing may require applicants, licensees and certificate holders under ORS
678.010 to 678.445 to provide to the board data concerning the individual’s nursing employment and education.

(10) For the purpose of requesting a state or nationwide criminal records check under ORS 181.534, the
board may require the fingerprints of a person who is:
(a) Applying for a license or certificate that is issued by the board;
(b) Applying for renewal of a license or certificate that is issued by the board; or
(c) Under investigation by the board.

(11) Pursuant to ORS chapter 183, the board shall adopt rules necessary to carry out the provisions of ORS
678.010 to 678.445. [Amended by 1953 c.254 §16; 1957 c.316 §28; subsections (5) to (9) enacted as 1957
c.316 §30; 1973 c.584 §14; 1975 c.659 §2; 1977 c.309 §2; 1979 c.771 §1; 1981 c.369 §9; 1983 c.511 §1;
1983 c.598 §2; 1987 c.369 §1; 1993 c.114 §1; 1999 c.375 §3; 2001 c.275 §3; 2001 c.763 §1; 2003 c.297
§1; 2005 c.730 §48; 2009 c.535 §10; 2009 c.756 §35]

678.153 Interagency agreement to share results of nationwide criminal records check. The
Department of Human Services, the Oregon Health Authority and the Oregon State Board of Nursing shall enter
into an interagency agreement to share the results of nationwide criminal records checks conducted under ORS
181.534 on subject individuals who are subject to criminal records checks by the department, the authority and
the board. [2005 c.730 §67; 2009 c.595 §1058]

Note: 678.153 was enacted into law by the Legislative Assembly but was not added to or made a part of
ORS chapter 678 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further
explanation.

678.155 Restrictions on certain standards prescribed by board. (1) In carrying out its duties under
ORS 678.150 (5), (6) and (7), the Oregon State Board of Nursing shall not make changes in entry level nursing
education or licensure requirements unless such changes are enacted by the Legislative Assembly.

(2) In carrying out its duties under ORS 678.150 (6)(i), the Oregon State Board of Nursing shall not
prescribe any standard that would substantially alter the practices followed prior to July 1, 1979, in long term
care facilities relating to the administration of noninjectable medication by nursing assistants, except for the
training requirements in ORS 678.440. [1979 c.770 §17; 1985 c.208 §2; 1985 c.565 §92a; 1987 c.158 §141;
2009 c.535 §11]

Note: 678.155 was enacted into law by the Legislative Assembly but was not added to or made a part of
ORS chapter 678 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further
explanation.

678.157 Limitation on authority of board over nurse delegation of authority. Nothing in ORS
678.150 and this section affects the limitation on the authority of the board imposed by ORS 678.155 and
678.445 in carrying out its duties under ORS 678.150 (6)(i). [1979 c.771 §4; 1985 c.565 §92b; 2009 c.535
§12]
Note: 678.157 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 678 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

678.158 Continuing authority of board upon lapse, suspension, revocation or voluntary surrender of license or certificate. The lapse, suspension or revocation of a license or certificate by the operation of law or by order of the Oregon State Board of Nursing or by the decision of a court of law, or the voluntary surrender of a license by a licensee or of a certificate by a certificate holder, shall not deprive the board of jurisdiction to proceed with any investigation of or any action or disciplinary proceeding against the licensee or certificate holder or to revise or render null and void an order of disciplinary action against the licensee or certificate holder. [2001 c.275 §6]

Note: 678.158 was added to and made a part of 678.010 to 678.445 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

678.160 [Amended by 1953 c.254 §16; 1957 c.316 §31; 1967 c.559 §2; 1969 c.314 §79; repealed by 1973 c.584 §24]

678.162 [1953 c.254 §9; repealed by 1973 c.584 §24]

678.164 Enjoining violations or threatened violations. (1) Upon suit by the Oregon State Board of Nursing for which no bond shall be required, the circuit courts have jurisdiction to restrain or enjoin any violation or threatened violation of ORS 678.010 to 678.410. Such suit may be brought against a person who practices nursing without a current license or who practices registered nursing when licensed as a practical nurse or who has failed to become licensed or whose license has been suspended, revoked or declared void.

(2) The remedies provided for in this section are in addition to, and not in lieu of, criminal penalties provided for in ORS 678.990. [1953 c.254 §11; 1957 c.316 §32; 1973 c.584 §15]

678.166 [1953 c.254 §10; repealed by 1973 c.584 §24]

678.168 Disposition of fines. All fines imposed and collected under ORS 678.990 (1) shall be paid into the treasury of the county in which such suits, actions or proceedings were commenced. All moneys thus paid into the treasury, over and above the amount necessary to reimburse the county for any expense incurred by the county in any suit, action or proceeding shall be paid before January 1 of each year into the General Fund in the State Treasury and placed to the credit of the Criminal Fine and Assessment Account. [1953 c.254 §12; 1973 c.584 §16; 1981 c.369 §11; 1991 c.460 §7]

678.170 Disposition of receipts. (1) All money received by the Oregon State Board of Nursing under ORS 678.010 to 678.445 shall be paid into the General Fund in the State Treasury and placed to the credit of the Oregon State Board of Nursing Account. Such moneys are appropriated continuously and shall be used only for the administration and enforcement of ORS 678.010 to 678.445.

(2) The board shall keep a record of all moneys deposited in the Oregon State Board of Nursing Account. This record shall indicate by separate cumulative accounts the source from which the moneys are derived and the individual activity or program against which each withdrawal is charged.

(3) The board may maintain a petty cash fund in compliance with ORS 293.180 in the amount of $1,000. [Amended by 1973 c.584 §16a; 1981 c.101 §1]
678.210 [Amended by 1959 c.49 §1; repealed by 1973 c.584 §24]

678.220 [Repealed by 1973 c.584 §24]

678.230 [Repealed by 1973 c.584 §24]

678.235 [1959 c.49 §3; 1967 c.559 §3; repealed by 1973 c.584 §24]

678.237 [1967 c.559 §5; repealed by 1973 c.584 §24]

678.240 [Amended by 1959 c.49 §5; repealed by 1973 c.584 §24]

(Nurse Anesthetists)

678.245 Definitions for ORS 678.245 to 678.285. As used in ORS 678.245 to 678.285:

1. “Anesthesiologist” means a physician who has completed a residency program in anesthesiology that meets or exceeds the standards adopted by the Oregon Medical Board.

2. “Certified registered nurse anesthetist” means a registered nurse licensed by the Oregon State Board of Nursing as a certified registered nurse anesthetist.

3. “Medical collaboration” means approval of the anesthesia plan by an anesthesiologist and an anesthesiologist being readily available during the administration of anesthetic agents until the patient’s post-anesthesia condition is satisfactory and stable.

4. “Physician” means a doctor of medicine or osteopathy licensed in Oregon under ORS chapter 677.

5. “Procedure” means surgery, labor and delivery or other medical services in a hospital or ambulatory surgical center, as defined in ORS 442.015, rendered by a physician or other health care provider qualified by appropriate state license and hospital or center privileges or hospital or center written authorization to render such services. [1997 c.575 §1]

Note: 678.245 to 678.285 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 678 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

678.250 [Amended by 1973 c.584 §17; renumbered 678.045]

678.255 Provision of nurse anesthetist services in ambulatory surgical centers. (1) Except as provided in subsection (2) of this section, anesthesia care in an ambulatory surgical center shall be delivered by an anesthesiologist or by a certified registered nurse anesthetist acting with the medical collaboration of an anesthesiologist.

(2) When no anesthesiologist is readily available for medical collaboration on anesthesia services for a procedure performed in an ambulatory surgical center, a certified registered nurse anesthetist may deliver the following services without medical collaboration:

(a) Assessment of the health status of the patient as that status relates to the relative risks associated with anesthetic management of the patient;

(b) Determination and administration of an appropriate anesthesia plan, including but not limited to selection,
ordering and administration of anesthetic agents, airway management and monitoring and recording of vital signs, life support functions, mechanical support use, fluid management and electrolyte and blood component balance; 
(3) When no anesthesiologist is readily available for medical collaboration on anesthesia services in an 
ambulatory surgical center, a certified registered nurse anesthetist shall review the patient’s pertinent medical 
records, including the medical evaluation of the patient, prior to determining an appropriate anesthesia plan. 
(4) This section does not prohibit any other licensed health care professional from rendering or supervising 
anesthesia services if such services are within the scope of the professional’s license. [1997 c.575 §2]

Note: See note under 678.245.

678.260 [Repealed by 1973 c.584 §24]

678.265 Ambulatory surgical center oversight of nurse anesthetists. Ambulatory surgical center 
bylaws, rules and regulations may establish requirements for ready availability of an anesthesiologist for medical 
collaboration consistent with ORS 678.255 and provide for credentialing, supervision, monitoring, education and 
professional liability insurance for a certified registered nurse anesthetist consistent with ORS 678.255 and the 
scope of practice established by the Oregon State Board of Nursing pursuant to ORS 678.285. [1997 c.575 
§3]

Note: See note under 678.245.

678.270 [Repealed by 1973 c.584 §24]

678.275 Provision of nurse anesthetist services in hospitals. (1) A certified registered nurse anesthetist 
may deliver the following services without medical collaboration in connection with a procedure performed in a 
hospital:
(a) Assessment of the health status of the patient as that status relates to the relative risks associated with 
anesthetic management of the patient;
(b) Determination and administration of an appropriate anesthesia plan, including but not limited to selection, 
ordering and administration of anesthetic agents, airway management and monitoring and recording of vital signs, 
life support functions, mechanical support use, fluid management and electrolyte and blood component balance; 
(c) Action necessary to counteract problems that may develop during implementation of the anesthesia plan; and 
(d) Necessary or routine post-anesthesia care.
(2) Consistent with the provisions of ORS 678.245 to 678.285 and the scope of practice established by the 
Oregon State Board of Nursing pursuant to ORS 678.285, hospital rules and regulations and medical staff 
bylaws may define whether the delivery of anesthesia services in connection with a procedure in a hospital by a 
certified registered nurse anesthetist shall be:
(a) Deemed practice by an independent health care provider;
(b) Subject to a requirement of supervision or medical collaboration by an anesthesiologist; or
(c) Subject to any other requirement that may be applied with due regard for patient health and safety. [1997 
c.575 §4]

Note: See note under 678.245.
678.280 [Amended by 1969 c.71 §4; repealed by 1973 c.584 §24]
678.285 Board regulation of nurse anesthetists; rules. Consistent with the provisions ORS 678.245 to 678.285, the Oregon State Board of Nursing shall adopt rules necessary to establish:
(1) The scope of practice of a certified registered nurse anesthetist;
(2) Procedures for issuing certification of special competency for a certified registered nurse anesthetist;
(3) Educational and competency requirements required for certification; and
(4) Procedures for the maintenance of certification as a certified registered nurse anesthetist, including but not limited to fees necessary for original or renewal certification. [1997 c.575 §5]

Note: See note under 678.245.

678.290 [Amended by 1957 c.293 §2; 1959 c.49 §6; 1969 c.71 §5; repealed by 1973 c.584 §24]
678.300 [Repealed by 1973 c.584 §24]
678.310 [Amended by 1971 c.734 §122; repealed by 1973 c.584 §24]
678.320 [Repealed by 1971 c.734 §21]
678.325 [1985 c.208 §1; repealed by 1993 c.18 §147]
678.330 [Amended by 1959 c.49 §7; 1967 c.559 §6; 1969 c.314 §80; repealed by 1973 c.584 §24]
678.335 [1967 c.559 §8; repealed by 1973 c.584 §24]

(Nursing Education Programs)

678.340 Requirements for institutions desiring to establish nursing education programs. (1) Any institution desiring to establish a nursing education program leading to licensing or a continuing education program that may be recognized or required by the Oregon State Board of Nursing to supplement such program shall apply to the board and submit satisfactory evidence that it is prepared to meet the curricula and standards prescribed by the board.
(2) In considering applications under subsection (1) of this section the board shall review statewide needs for nursing education programs or supplementary programs, financial resources of the institution making application, its clinical resources and its ability to retain qualified faculty.
(3) No institution or program shall represent itself as qualified or accredited to prepare nurses for licensing unless it is accredited by the board. [Amended by 1973 c.584 §18]

678.350 [Repealed by 1973 c.584 §24]

678.360 Survey to evaluate facilities; ensuring compliance with requirements. (1) From time to time as considered necessary by the Oregon State Board of Nursing, it shall cause a survey of the institutions accredited to provide nursing education programs to be made. A report in writing shall be submitted to the board. The report is to include an evaluation of physical facilities and clinical resources, courses of study and
qualifications of instructors. If, in the opinion of the board, the requirements for accredited programs are not being met by any institution, notice thereof shall be given to the institution in writing specifying the defect and prescribing the time within which the defect must be corrected.

(2) The board shall withdraw accreditation from an institution which fails to correct the defect reported to it under subsection (1) of this section within the period of time prescribed in the report. The institution may request and if requested shall be granted a hearing before the board in the manner required for contested cases under ORS chapter 183. [Amended by 1973 c.584 §19]

(Circulating Nurses)

678.362 Circulating nurses; duties. (1) As used in this section:

(a) “Circulating nurse” means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of operating room team members during surgery.

(b) “Type I ambulatory surgical center” means a licensed health care facility for the performance of outpatient surgical procedures including, but not limited to, choleystectomies, tonsillectomies or urological procedures, involving general anesthesia or a relatively high infection control consideration.

(2)(a) The duties of a circulating nurse performed in an operating room of a Type I ambulatory surgical center or a hospital shall be performed by a registered nurse licensed under ORS 678.010 to 678.410.

(b) In any case requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient or procedure.

(c) Nothing in this section precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.

(3) At the request of a Type I ambulatory surgical center or a hospital, the Oregon Health Authority may grant a variance from the requirements of this section based on patient care needs or the nursing practices of the surgical center or hospital. [2005 c.665 §3; 2009 c.595 §1059]

Note: 678.362 was added to and made a part of 678.010 to 678.445 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

(Registered Nurse First Assistants)

678.366 Registered nurse first assistants; rules. The Oregon State Board of Nursing shall adopt rules establishing procedures for the recognition of registered nurses who become registered nurse first assistants by receiving additional certification through nationally recognized professional organizations. [2005 c.628 §5]

(Clinical Nurse Specialists)

678.370 Clinical nurse specialists; certificates. (1) The Oregon State Board of Nursing shall issue a certification to act as a clinical nurse specialist to any nurse who meets the requirements established by the board pursuant to ORS 678.372.

(2) A person may not act as a clinical nurse specialist, use the name, title, designation, initial or abbreviation of clinical nurse specialist or otherwise hold oneself out as a clinical nurse specialist unless the person is certified as a clinical nurse specialist pursuant to subsection (1) of this section.
(3) A certified clinical nurse specialist is authorized to prescribe drugs for the use of and administration to other persons if approval has been given under ORS 678.390. The authority to prescribe and dispense prescription drugs shall be included within the scope of practice of certified clinical nurse specialists as defined by rules of the board. [1999 c.498 §2; 2005 c.462 §4; 2008 c.4 §1]

678.372 Rules for clinical nurse specialists. The Oregon State Board of Nursing shall adopt rules to implement ORS 678.370, including but not limited to rules establishing:
(1) Procedures and requirements for initial issuance and continuation of certification to act as a clinical nurse specialist, including but not limited to educational requirements;
(2) The scope of practice of clinical nurse specialists, including the authority to prescribe and dispense prescription drugs after approval of an application to do so by the board;
(3) Educational requirements for clinical nurse specialists applying for prescriptive authority that include but are not limited to:
   (a) At least 45 contact hours in pharmacology; and
   (b) Clinical education in patient management, including pharmacotherapeutics, that is comparable to the requirements for completion of a nurse practitioner program;
(4) The amount of any fees necessary for issuance of the initial certification, renewal of certification, initial application for prescriptive authority and renewal of application for prescriptive authority; and
(5) Such other rules as may be necessary to implement and administer ORS 678.370. [1999 c.498 §3; 2005 c.462 §5]

(Nurse Practitioners)

678.375 Nurse practitioners; certificates; prohibitions; authority to sign death certificates; drug prescriptions. (1) The Oregon State Board of Nursing is authorized to issue certificates of special competency to licensed registered nurses to practice as nurse practitioners if they meet the requirements of the board pursuant to ORS 678.380.
(2) No person shall practice as a nurse practitioner or hold oneself out to the public or to an employer, or use the initials, name, title, designation or abbreviation as a nurse practitioner until and unless such person is certified by the board.
(3) A registered nurse, certified as a nurse practitioner, is authorized to complete and sign death certificates. Death certificates signed by a certified nurse practitioner shall be accepted as fulfilling all the requirements of the laws dealing with death certificates. A certified nurse practitioner who signs a death certificate must comply with all provisions of ORS 432.307.
(4) A registered nurse, certified as a nurse practitioner, is authorized to prescribe drugs for the use of and administration to other persons if approval has been given under ORS 678.390. The drugs which the nurse practitioner is authorized to prescribe shall be included within the certified nurse practitioner’s scope of practice as defined by rules of the board.
(5) A licensed pharmacist may fill and a licensed pharmacist or an employee of the licensed pharmacist may dispense medications prescribed by a nurse practitioner in accordance with the terms of the prescription. The filling of such a prescription does not constitute evidence of negligence on the part of the pharmacist if the prescription was dispensed within the reasonable and prudent practice of pharmacy.
(6) As used in this section:
   (a) “Drug” means:
   (A) Articles recognized as drugs in the official United States Pharmacopoeia, official National Formulary,
official Homeopathic Pharmacopoeia, other drug compendium or any supplement to any of them;

(B) Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in human beings;

(C) Articles other than food that are intended to affect the structure or any function of the body of human beings; and

(D) Articles intended for use as a component of any articles specified in subparagraph (A), (B) or (C) of this paragraph.

(b) “Prescribe” means to direct, order or designate the preparation, use of or manner of using by spoken or written words or other means. [1975 c.205 §8; 1979 c.785 §1; 1993 c.469 §9; 1993 c.571 §28; 2001 c.357 §1; 2001 c.623 §5; 2008 c.4 §2]

678.380 Rules for nurse practitioners; scope. The Oregon State Board of Nursing may adopt rules applicable to nurse practitioners:

(1) Which establish their education, training and qualifications necessary for certification.

(2) Which limit or restrict practice.

(3) Which establish categories of nurse practitioner practice and define the scope of such practice.

(4) Which establish procedures for maintaining certification, including continuing education and procedures for the reinstatement of certificates rendered void by reason of nonpayment of fees. [1975 c.205 §9]

678.385 [1979 c.785 §16; 1987 c.79 §1; 1989 c.1006 §4; 1991 c.295 §1; 1993 c.742 §4; 1999 c.536 §1; 2005 c.462 §7; repealed by 2008 c.4 §5]

(Prescriptive Authority)

678.390 Authority of nurse practitioner and clinical nurse specialist to write prescriptions or dispense drugs; notice; requirements; revocation; rules. (1) The Oregon State Board of Nursing may grant to a certified nurse practitioner or certified clinical nurse specialist the privilege of writing prescriptions, including prescriptions for controlled substances listed in schedules II, III, III N, IV and V.

(2) A certified nurse practitioner or certified clinical nurse specialist may submit an application to the Oregon State Board of Nursing to dispense prescription drugs. The Oregon State Board of Nursing shall provide immediate notice to the State Board of Pharmacy upon receipt and upon approval of an application from a certified nurse practitioner or certified clinical nurse specialist for authority to dispense prescription drugs to the patients of the applicant.

(3) An application for the authority to dispense prescription drugs as authorized under subsection (1) of this section must include:

(a) Evidence of completion of a prescription drug dispensing training program jointly developed and adopted by rule by the Oregon State Board of Nursing and the State Board of Pharmacy.

(b) Except when a certified nurse practitioner is seeking authority to dispense prescription drugs at a qualified institution of higher education as defined in ORS 399.245, demonstration of a lack of readily available access to pharmacy services in the practice area of the applicant and that the lack of access would be corrected by granting authority to dispense prescription drugs by the applicant. Lack of readily available access to pharmacy services for patients may be established by evidence:

(A) That the patients of the applicant are located:

(i) Outside the boundaries of a metropolitan statistical area;

(ii) Thirty or more highway miles from the closest hospital within the major population center in a metropolitan statistical area; or
(iii) In a county with a population of less than 75,000; or

(B) Of financial barrier to access, including but not limited to receiving services from a health care safety net clinic or eligibility for participation in a patient assistance program of a pharmaceutical company.

(c) Any other information required by the Oregon State Board of Nursing.

(4) Prescription drugs dispensed by a certified nurse practitioner or certified clinical nurse specialist shall be personally dispensed by the certified nurse practitioner or certified clinical nurse specialist, except that nonjudgmental dispensing functions may be delegated to staff assistants when:

(a) The accuracy and completeness of the prescription is verified by the certified nurse practitioner or certified clinical nurse specialist; and

(b) The prescription drug is labeled with the name of the patient to whom it is being dispensed.

(5) The Oregon State Board of Nursing shall adopt rules requiring:

(a) Drugs dispensed by certified nurse practitioners and certified clinical nurse specialists to be either prepackaged by a manufacturer registered with the State Board of Pharmacy or repackaged by a pharmacist licensed by the State Board of Pharmacy under ORS chapter 689;

(b) Labeling requirements for drugs dispensed by certified nurse practitioners and certified clinical nurse specialists that are the same as labeling requirements required of pharmacies licensed under ORS chapter 689;

(c) Record keeping requirements for prescriptions and drug dispensing by a certified nurse practitioner and a certified clinical nurse specialist that are the same as the record keeping requirements required of pharmacies licensed under ORS chapter 689;

(d) A dispensing certified nurse practitioner and a dispensing certified clinical nurse specialist to have available at the dispensing site a hard copy or electronic version of prescription drug reference works commonly used by professionals authorized to dispense prescription medications; and

(e) A dispensing certified nurse practitioner and a dispensing certified clinical nurse specialist to allow representatives of the State Board of Pharmacy, upon receipt of a complaint, to inspect a dispensing site after prior notice to the Oregon State Board of Nursing.

(6) The Oregon State Board of Nursing has sole disciplinary authority regarding certified nurse practitioners and certified clinical nurse specialists who have drug dispensing authority.

(7) The privilege of writing prescriptions and dispensing drugs may be denied, suspended or revoked by the Oregon State Board of Nursing upon proof that the privilege has been abused. The procedure shall be a contested case under ORS chapter 183. Disciplinary action under this subsection is grounds for discipline of the certified nurse practitioner or certified clinical nurse specialist in the same manner as a licensee may be disciplined under ORS 678.111. [1979 c.785 §17; 1981 c.693 §29; 1983 c.486 §58; 1985 c.747 §53; 1987 c.79 §2; 1993 c.742 §5; 2003 c.617 §1; 2005 c.462 §6; 2005 c.471 §13; 2008 c.4 §3; 2009 c.456 §1]

678.395 [1995 c.627 §3; repealed by 1996 c.21 §1]

(Fees)

678.410 Fees; how determined. (1) The Oregon State Board of Nursing may impose fees for the following:

(a) License renewal.

(b) Examination.

(c) License by indorsement.

(d) Limited license.

(e) Examination proctor service.
(f) Duplicate license.
(g) Extension of limited license.
(h) Nurse practitioner certificate.
(i) Reexamination for licensure.
(j) Delinquent fee.
(k) Renewal fee nurse practitioner.
(L) Verification of a license of a nurse applying for license by indorsement in another state.
(m) Certified nurse practitioner’s initial application and registration for writing prescriptions.
(n) Renewal of certified nurse practitioner’s application for writing prescriptions.
(o) Approval of training program for nursing assistants.
(p) Issuance, renewal and delinquency of a nursing assistant certificate.
(q) Clinical nurse specialist certification established pursuant to ORS 678.370.
(r) Clinical nurse specialist’s initial application for prescriptive authority.
(s) Renewal of clinical nurse specialist’s application for prescriptive authority.
(t) Inactive license or certificate.
(u) Retired license or certificate.
(v) Nationwide criminal records check.
(2) Fees are nonrefundable.

(3) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting the fees and charges, the fees and charges established under this section shall not exceed the cost of administering the regulatory program of the board pertaining to the purpose for which the fee or charge is established, as authorized by the Legislative Assembly within the board’s budget, as the budget may be modified by the Emergency Board. If federal or other funds are available to offset costs of administering the program, fees shall be established based on net costs to the state but not to exceed $75 per biennium for the certification fee under subsection (1)(p) of this section. [1969 c.71 §7; 1973 c.584 §20; 1975 c.205 §6; 1983 c.221 §4; 1987 c.79 §3; 1989 c.800 §5; 1991 c.193 §3; 1991 c.536 §2; 1991 c.703 §24; 1999 c.420 §3; 1999 c.498 §5; 2001 c.275 §4; 2005 c.380 §3; 2005 c.462 §10; 2007 c.532 §1; 2009 c.697 §8 ]

**Note:** The amendments to 678.410 by section 8, chapter 697, Oregon Laws 2009, become operative July 1, 2010. See section 22, chapter 697, Oregon Laws 2009, as amended by section 76, chapter 828, Oregon Laws 2009. The text that is operative until July 1, 2010, is set forth for the user’s convenience.

**678.410.** (1) The Oregon State Board of Nursing may impose fees for the following:
(a) License renewal.
(b) Examination.
(c) License by indorsement.
(d) Limited license.
(e) Examination proctor service.
(f) Duplicate license.
(g) Extension of limited license.
(h) Nurse practitioner certificate.
(i) Reexamination for licensure.
(j) Delinquent fee.
(k) Renewal fee nurse practitioner.
(L) Verification of a license of a nurse applying for license by indorsement in another state.
(m) Certified nurse practitioner’s initial application and registration for writing prescriptions.
(n) Renewal of certified nurse practitioner’s application for writing prescriptions.
(o) Approval of training program for nursing assistants.
(p) Issuance, renewal and delinquency of a nursing assistant certificate.
(q) Voluntary monitoring program for chemical dependency or an emotional or physical problem.
(r) Clinical nurse specialist certification established pursuant to ORS 678.370.
(s) Clinical nurse specialist’s initial application for prescriptive authority.
(t) Renewal of clinical nurse specialist’s application for prescriptive authority.
(u) Inactive license or certificate.
(v) Retired license or certificate.
(w) Nationwide criminal records check.
(2) Fees are nonrefundable.
(3) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting the fees and charges, the fees and charges established under this section shall not exceed the cost of administering the regulatory program of the board pertaining to the purpose for which the fee or charge is established, as authorized by the Legislative Assembly within the board’s budget, as the budget may be modified by the Emergency Board. If federal or other funds are available to offset costs of administering the program, fees shall be established based on net costs to the state but not to exceed $75 per biennium for the certification fee under subsection (1)(p) of this section.

(Miscellaneous)

678.420 Declaration of nursing workforce and faculty shortage. There is declared a nursing workforce and nursing faculty shortage in Oregon. The declaration of the nursing workforce shortage shall remain in effect until the Governor suspends the declaration by executive action. [2007 c.789 §1]

Note: 678.420 and 678.425 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 678 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

678.425 Advisory organizations. The Oregon Center for Nursing and the Oregon Healthcare Workforce Institute may serve in advisory capacities to the State Workforce Investment Board, the Joint Boards of Education and other related entities. The Oregon Center for Nursing may advise on education and workforce development issues affecting nursing. The Oregon Healthcare Workforce Institute may advise on education and workforce development issues affecting doctors, dentists and other allied health professionals. The Oregon Center for Nursing and the Oregon Healthcare Workforce Institute may work together to develop comprehensive solutions to the healthcare workforce shortages in Oregon. [2007 c.789 §2]

Note: See note under 678.420.

(Nursing Assistants)

678.440 Nursing assistants; training; effect of employing untrained assistant; civil penalties. (1) It is the intent of the Legislative Assembly to require that nursing assistants be adequately trained.
(2) The Oregon State Board of Nursing shall prepare curricula and standards for training programs for nursing assistants. Such curricula and standards shall provide for additional training for nursing assistants to administer noninjectable medications.
3. The Department of Human Services may impose civil penalties or revoke the license of any long term care facility that employs any untrained nursing assistant for a period of more than eight weeks without providing for the training prescribed by the board. Any license which is revoked shall be revoked as provided in ORS 441.030.

4. The Oregon Health Authority may impose civil penalties or revoke the license of any health care facility that employs any untrained nursing assistant for a period of more than eight weeks without providing for the training prescribed by the board. Any license which is revoked shall be revoked as provided in ORS 441.030.

5. As used in this section, “nursing assistant” means a person who assists licensed nursing personnel in the provision of nursing care. [1977 c.309 §1; 2009 c.595 §1060]

678.442 Certification of nursing assistants; rules. (1) The Oregon State Board of Nursing shall establish standards for certifying and shall certify as a nursing assistant any person who applies therefor, shows completion of an approved training program for nursing assistants and passes a board approved examination.

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

   (a) Conviction of the certificate holder of a crime where such crime bears demonstrable relationship to the duties of a nursing assistant. A copy of the record of such conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of the conviction.

   (b) Any willful fraud or misrepresentation in applying for or procuring a certificate or renewal thereof.

   (c) Impairment as defined in ORS 676.303.

   (d) Violation of any provisions of ORS 678.010 to 678.445 or rules adopted thereunder.

   (e) Physical condition that makes the certificate holder unable to perform safely the duties of a nursing assistant.

   (f) Conduct unbecoming a nursing assistant in the performance of duties.

(3) The board shall establish by rule a procedure for the biennial renewal of nursing assistant certificates. The certificate renewal procedure shall be substantially like the procedure established for the licensing of nurses under ORS 678.101. [1989 c.800 §3; 1991 c.536 §1; 2009 c.756 §36]

678.444 Standards for training programs for nursing assistants. The Oregon State Board of Nursing shall establish standards for training programs for nursing assistants. Upon application therefor, the board shall review and approve programs that meet board standards. The board by means of a contested case proceeding under ORS chapter 183 may revoke approval of any training program that ceases to meet board standards. [1989 c.800 §2]

678.445 Authority of nursing assistants to administer noninjectable medication; authority of nurse to report questions about continuation of medication. (1) It is the intent of the Legislative Assembly that the Oregon State Board of Nursing not adopt any standard the practical effect of which is to prohibit a nursing assistant in a long term care facility from administering noninjectable medication except under direct supervision of a registered nurse.

(2) Where a nurse employed by the long term care facility questions the efficacy, need or safety of continuation of medications being dispensed by that nurse or by another employee of the facility to a patient therein, the nurse shall report that question to the physician or a nurse practitioner, if authorized to do so, ordering or authorizing the medication and shall seek further instructions concerning the continuation of the medication. [1979 c.770 §18]

678.505 [1977 c.635 §2; 1981 c.469 §2; renumbered 342.455]
678.510 [1955 c.489 §1(1),(3),(4),(5); 1957 c.579 §1; repealed by 1971 c.663 §17]

678.515 [1977 c.635 §§3,4; 1981 c.469 §3; renumbered 342.475]

678.520 [1955 c.489 §11; 1957 c.579 §2; repealed by 1971 c.663 §17]

678.525 [1977 c.635 §5; 1981 c.469 §4; renumbered 342.465]

678.530 [1955 c.489 §1(2); 1957 c.579 §3; repealed by 1971 c.663 §17]

678.540 [1955 c.489 §5; 1957 c.579 §4; 1961 c.371 §1; repealed by 1971 c.663 §17]

678.550 [1955 c.489 §6; 1957 c.579 §5; 1967 c.487 §1; repealed by 1971 c.663 §17]

678.560 [1955 c.489 §§7,8; 1957 c.579 §6; repealed by 1971 c.663 §17]

678.570 [1955 c.489 §4; 1957 c.579 §7; repealed by 1971 c.663 §17]

678.575 [1957 c.579 §17; repealed by 1971 c.663 §17]

678.580 [1955 c.489 §9; repealed by 1957 c.579 §8 (678.581 enacted in lieu of 678.580)]

678.581 [1957 c.579 §9 (678.581 enacted in lieu of 678.580); repealed by 1971 c.663 §17]

678.590 [1955 c.489 §10; repealed by 1957 c.579 §10 (678.591 enacted in lieu of 678.590)]

678.591 [1957 c.579 §11 (678.591 enacted in lieu of 678.590); repealed by 1971 c.663 §17 and 1971 c.734 §21]

678.593 [1957 c.579 §13; repealed by 1971 c.663 §17 and 1971 c.734 §21]

678.596 [1957 c.579 §15; repealed by 1971 c.663 §17]

678.600 [1955 c.489 §2; 1957 c.579 §18; repealed by 1971 c.663 §17]

678.610 [1955 c.489 §3; 1957 c.579 §19; 1969 c.314 §81; repealed by 1971 c.663 §17]

678.620 [1955 c.489 §13; repealed by 1971 c.663 §17]

LICENSED NURSING HOME ADMINISTRATORS

(Generally)

678.710 Definitions for ORS 678.710 to 678.820. As used in ORS 678.710 to 678.820, unless the
context requires otherwise:

(1) “Dual facility” means a facility that operates both a hospital and a long term care facility on the same campus.

(2) “Nursing home” means any institution or facility defined as a long term care facility for licensing purposes under state statute or the rules of the Department of Human Services, including a long term care facility operated as part of a dual facility.

(3) “Nursing home administrator” means an individual responsible for planning, organizing and managing the operation of a nursing home, whether or not such individual has an ownership interest in such home and whether or not such functions are shared by one or more other individuals, if:

(a) Final responsibility and authority are retained in the nursing home administrator; and

(b) In the case of a dual facility, the nursing home administrator may be subject to the authority of the administrator of the dual facility or the dual facility administrator may administer the nursing home if the administrator is licensed or otherwise qualified by statute to administer a nursing home.

(4) “Provisional license” means a temporary license issued to a provisional nursing home administrator under the rules of the Oregon Health Licensing Agency. [1971 c.663 §1; 1973 c.829 §57; 1989 c.495 §1; 1995 c.643 §1; 2009 c.768 §14]

678.720 Prohibited acts relating to administration of nursing homes. (1) Unless an individual holds a valid license issued under the provisions of ORS 678.710 to 678.820, an individual may not:

(a) Practice or offer to practice as a nursing home administrator; or

(b) Use in connection with the name of the individual the words or letters “nursing home administrator,” “NHA” or any other words, letters or abbreviations or insignia tending to indicate that the individual is a licensed nursing home administrator.

(2) A nursing home shall be conducted or operated under the supervision of a nursing home administrator who holds a valid license issued under the provisions of ORS 678.710 to 678.820. [1971 c.663 §2; 2009 c.768 §15]

678.725 Reporting unlawful or unsatisfactory nursing home conditions and prohibited conduct; confidentiality of information; limitation of liability. (1)(a) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, any health care facility licensed under ORS 441.015, any licensee licensed by the Oregon Health Licensing Agency, any physician licensed by the Oregon Medical Board, any licensed professional nurse and any licensed pharmacist shall report to the agency suspected violations of ORS 678.710 to 678.820 and unsanitary or other unsatisfactory conditions in a nursing home.

(b) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, a licensee licensed under ORS 678.710 to 678.820 who has reasonable cause to believe that a licensee of any board as defined in ORS 676.150 has engaged in prohibited conduct as defined in ORS 676.150 shall report the prohibited conduct in the manner provided in ORS 676.150.

(c) Any person may report to the agency suspected violations of ORS 678.710 to 678.820 or unsanitary or other unsatisfactory conditions in a nursing home.

(2) Information acquired by the agency pursuant to subsection (1) of this section is confidential and is not subject to public disclosure.

(3) Any person who reports or provides information to the agency under subsection (1) of this section and who provides information in good faith may not be subject to an action for civil damages as a result of making the report or providing the information. [1985 c.47 §7; 1995 c.643 §2; 2009 c.768 §§16,16a]
**678.730 Licensing qualifications of administrator; rules.** (1) An individual qualifies for licensure as a nursing home administrator if the individual:

(a) Meets the education, training and other standards established by rules of the Nursing Home Administrators Board. The board shall establish standards that accept one year of experience as an administrator serving a dual facility in lieu of any residency or intern requirement that may be established by the board; and

(b) Has passed an examination as provided in ORS 678.740.

(2) A license holder may renew a license as provided by ORS 678.760. The board may require up to 50 hours of continuing education in any one-year period for a renewed license.

(3) In establishing educational standards pursuant to subsection (1)(a) of this section, the board shall require a baccalaureate degree from an accredited school of higher education. However, the educational requirement does not apply to any person who:

(a) Was a licensed administrator in any jurisdiction of the United States prior to January 1, 1983; or

(b) Was an administrator of a dual facility meeting the experience requirements pursuant to subsection (1)(a) of this section.

(4) Notwithstanding the requirements established under subsection (1) of this section, upon the request of the governing body of a hospital, as defined in ORS 442.015, the board shall adopt standards by rule that deem a health care administrator to have met the requirements for licensure as a nursing home administrator if the health care administrator possesses an advanced degree in management and has at least 10 years of experience in health care management. [1971 c.663 §6; 1973 c.827 §68; 1973 c.829 §58a; 1985 c.47 §3; 1987 c.544 §1; 1989 c.495 §2; 1995 c.667 §5; 2001 c.104 §260; 2009 c.595 §1061; 2009 c.768 §17; 2009 c.792 §47]

**678.740 Examination for license.** (1) Examinations for licensure as a nursing home administrator shall be conducted at such times and places as the Nursing Home Administrators Board designates, but not less than once a year. The fee for examination or reexamination shall be determined by the Oregon Health Licensing Agency under ORS 678.775.

(2) The board shall, consistent with the purposes for which the examination is given, determine the subjects, scope, content and the minimum passing grade for examinations. [1971 c.663 §7; 1973 c.829 §59; 1979 c.127 §1; 1993 c.572 §1; 2009 c.768 §18]

**678.750 Applicability of licensing requirements to administrators of organizations that rely on spiritual care and treatment.** (1) Nothing in ORS 678.710 to 678.820 or the rules adopted under ORS 678.710 to 678.820 may be construed to require an individual, who is employed to administer an institution exempted under ORS 441.065 as an institution that is operated by and for persons who rely on spiritual means alone for the care and treatment of the sick, to demonstrate proficiency in any medical techniques or to meet any medical educational qualifications or medical standards not in accord with the remedial care and treatment provided in the institution. Any license issued under ORS 678.710 to 678.820 to an individual described in this subsection shall indicate the limited extent of the authority of the individual to act as an administrator.

(2) Subsection (1) of this section does not limit or prohibit the operator of an institution from enforcing any religious affiliation requirements imposed as a bona fide occupational qualification or business necessity or as otherwise permitted by section 703(e) of Title VII of the Civil Rights Act of 1964 or other provision of federal law. [1971 c.663 §8; 1997 c.574 §1; 2009 c.768 §19]

**678.760 License; application; renewal; reactivation; provisional licenses; rules.** (1) Subject to ORS
676.612 and subsection (2) of this section, the Oregon Health Licensing Agency shall:

(a) Issue a license as a nursing home administrator to a qualified applicant upon satisfactory evidence of meeting the requirements of ORS 678.730 and other qualifications adopted by the Nursing Home Administrators Board by rule.

(b) Renew a license as a nursing home administrator if, by a date specified by the agency by rule, the license holder submits to the agency a completed renewal application, required renewal fees and satisfactory evidence of completion of any required continuing education credits.

(2) For up to one year from the date of a denial, suspension, revocation or expiration of a nursing home administrator license, the agency may refuse to grant or renew the license of a nursing home administrator whose license has expired or been denied, suspended or revoked.

(3)(a) Except as provided by paragraph (b) of this subsection, a nursing home administrator license expires on the last day of the month, one year from the date of issuance.

(b) The agency may adopt by rule an expiration date that is different than the date provided by paragraph (a) of this subsection if the license holder is provided written notice of the different renewal date and the renewal fee is prorated.

(4) The agency may adopt rules for the reactivation of an expired license, including additional requirements for a license that has been expired for three years or more.

(5) The agency may establish requirements for the issuance of a temporary provisional license. The fee for a provisional license is established by rules of the agency under ORS 678.775. [1971 c.663 §9; 1973 c.829 §60; 1979 c.127 §2; 1979 c.696 §17; 1993 c.572 §2; 1995 c.643 §3; 2007 c.768 §44; 2009 c.768 §20]

678.770 Licensing reciprocity. (1) The Nursing Home Administrators Board may establish by rule standards for the issuance of a license by endorsement, without examination, to an applicant who:

(a) Meets the requirements as established by the board; and

(b) On the date of making application, is a nursing home administrator licensed under the laws of any other state or territory of the United States if the requirements for licensing of nursing home administrators in the state or territory in which the applicant is licensed are not less than those required by ORS 678.710 to 678.820.

(2) Each applicant under this section shall pay to the Oregon Health Licensing Agency at the time of filing the application a fee determined by the agency under ORS 678.775. [1971 c.663 §11; 1973 c.829 §61; 1993 c.572 §3; 2009 c.768 §22]

678.775 Fees; disposition of moneys. (1) The Oregon Health Licensing Agency shall establish by rule and collect fees and charges for the following under ORS 678.710 to 678.820:

(a) Application;
(b) Examination or reexamination;
(c) Original license;
(d) License renewal;
(e) Provisional or temporary license;
(f) Licensure by reciprocity or endorsement;
(g) License reactivation;
(h) Issuance of a replacement license;
(i) Delinquency fee;
(j) License verification; and
(k) Costs of providing copies of official documents or records and for recovering administrative costs associated with compiling, copying or preparing and delivering the records.

(2) All moneys received by the agency under subsection (1) of this section shall be paid into the General
Fund of the State Treasury and credited to the Oregon Health Licensing Agency Account, and are appropriated continuously to and shall be used by the agency as authorized by ORS 676.625. [1993 c.572 §4; 2009 c.768 §23]

(Discipline of Administrators)

678.780 Grounds for discipline. (1) In the manner prescribed in ORS chapter 183 for contested cases, the Oregon Health Licensing Agency may impose a form of discipline as specified in ORS 676.612 against any person practicing as a nursing home administrator for any of the grounds listed in ORS 676.612 and for any violation of the provisions of ORS 678.710 to 678.820, or the rules adopted under ORS 678.710 to 678.820.

(2) In addition to any discipline that may be imposed as provided by subsection (1) of this section, the agency may impose disciplinary sanctions against a person practicing as a nursing home administrator for any of the following causes:
   (a) Violation of or noncompliance with any applicable provisions of ORS 678.710 to 678.820 or of any rule or order of the agency;
   (b) Any continuous or substantial violation of the rules adopted under ORS 441.025; or
   (c) Discipline imposed by any other licensing body in this or any other state based on conduct that would be grounds for discipline under this section or rules adopted by the agency. [1971 c.663 §14; 1973 c.58 §1; 1979 c.744 §52; 1985 c.47 §4; 1995 c.643 §4; 1997 c.791 §23; 1999 c.849 §§160,161; 2003 c.75 §58; 2009 c.768 §24; 2009 c.792 §74]

678.790 Procedure; review of orders. (1) When the Oregon Health Licensing Agency proposes to refuse to issue or renew a license, or proposes to revoke or suspend a license under ORS 678.710 to 678.820, opportunity for hearing shall be accorded as provided in ORS chapter 183.

(2) Judicial review of orders under subsection (1) of this section shall be in accordance with ORS chapter 183.

(3) If the final order of the court on review reverses the agency’s order of suspension, revocation or refusal to renew, the agency shall issue the license and reinstate the appellant not later than the 30th day after the decision of the court. [1971 c.734 §124; 2009 c.768 §26]

(Board)

678.800 Nursing Home Administrators Board. (1) The Nursing Home Administrators Board is established within the Oregon Health Licensing Agency.

(2) The board consists of nine members appointed by the Governor and subject to confirmation by the Senate in the manner provided in ORS 171.562 and 171.565. All members of the board must be concerned with the care and treatment of the chronically ill or infirm elderly patients and must be residents of this state. Of the members of the board:
   (a) Three must be nursing home administrators licensed under ORS 678.710 to 678.820;
   (b) One must be a medical doctor licensed by the Oregon Medical Board actively engaged in private practice and conversant with the care and treatment of the long-term patient;
   (c) One must be a licensed professional nurse actively engaged in caring for chronically ill and infirm patients and licensed by the Oregon State Board of Nursing;
   (d) One must be a pharmacist licensed by the State Board of Pharmacy; and
   (e) Three must be members of the public who are not:
(A) Otherwise eligible for appointment to the board; or
(B) A spouse, domestic partner, child, parent or sibling of a nursing home administrator.

(3)(a) Board members required to be nursing home administrators may be selected by the Governor from a list of three to five nominees submitted by any professional organization representing nursing home administrators.

(b) Except for those persons described in paragraph (a) of this subsection, no member of the board may have a direct financial interest in a nursing home.

(c) No more than two of the members of the board may be officials or full-time employees of state or local governments.

(d) At least one public member must be at least 62 years of age.

(e) No public members of the board may hold any pecuniary interest in, or have any employment contract with, a long term care facility.

(f) In selecting the members of the board, the Governor shall strive to balance the representation on the board according to:

(A) Geographic areas of this state; and
(B) Ethnic group.

(4)(a) The term of office of each member is three years but a member serves at the pleasure of the Governor. The terms must be staggered so that no more than three terms end each year. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause the Governor shall make an appointment to become immediately effective for the unexpired term.

(b) A board member shall be removed immediately from the board if, during the member’s term, the member:

(A) Is not a resident of this state;
(B) Has been absent from three consecutive board meetings, unless at least one absence is excused; or
(C) Is not a licensed nursing home administrator or a retired nursing home administrator whose license as a nursing home administrator was in good standing at the time of retirement, if the member was appointed to serve on the board as a nursing home administrator.

(5) The members of the board are entitled to compensation and expenses as provided in ORS 292.495. The board may provide by rule for compensation to board members for the performance of official duties at a rate that is greater than the rate provided in ORS 292.495. [1971 c.663 §3; 1973 c.58 §2; 1973 c.792 §35; 1975 c.234 §1; 1979 c.500 §1; 2009 c.535 §13; 2009 c.768 §3a]

678.810 Board meetings; officers. (1) The Nursing Home Administrators Board shall hold at least one meeting each year. A majority of the members of the board constitutes a quorum for the transaction of business.

(2) The board shall select one of its members as chairperson and another as vice chairperson, for a one-year term and with such duties and powers necessary for the performance of the functions of the offices as the board determines. [1971 c.663 §4; 2005 c.726 §8; 2009 c.768 §12]

678.820 Duties and powers of board and Oregon Health Licensing Agency; rules. (1) The Nursing Home Administrators Board is responsible for advising the Oregon Health Licensing Agency in all matters relating to the administration of ORS 678.710 to 678.820, including:

(a) Developing standards for education and training;
(b) Developing standards of practice and professional conduct;
(c) Establishing standards related to the issuance, denial, revocation, suspension or renewal of licenses to practice as a nursing home administrator;
(d) Preparing or approving the examinations required under ORS 678.710 to 678.820, in accordance with
standards provided by the agency; and

(e) Assisting the agency in administering the provisions of ORS 678.710 to 678.820.

(2) The Oregon Health Licensing Agency shall administer ORS 678.710 to 678.820 by:

(a) Determining the qualifications and fitness of applicants for licenses, renewed licenses, reciprocal licenses and provisional licenses under ORS 678.710 to 678.820.

(b) Examining, approving, issuing, denying, revoking, suspending and renewing licenses to practice as a nursing home administrator.

(c) Providing for waivers of examinations or provisional licenses.

(d) Establishing and carrying out procedures to ensure compliance with professional standards adopted by the board.

(e) Pursuant to ORS 676.608, receiving and investigating complaints filed regarding nursing home administrators.

(f) Establishing and collecting fees and charges to carry out the agency’s duties under ORS 678.710 to 678.820.

(g) In accordance with ORS 183.330 and 676.615, adopting, amending and repealing rules that are necessary to carry out the administration of ORS 678.710 to 678.820.

(h) Maintaining a register of all licensed nursing home administrators.

(3) The agency shall consider and be guided by the recommendations of the board in all matters relating to the administration of ORS 678.710 to 678.820. [1971 c.663 §5; 1985 c.47 §5; 1995 c.79 §343; 2009 c.768 §13]