Residential Care And Assisted Living Facilities
Chapter 411
Division 54
QUESTIONS AND ANSWERS

NEW QUESTIONS FROM RULE REVISION JULY 1, 2010

1. ***The licensee must check all potential employees against the Oregon State Board of Nursing and inquire whether the person is licensed or certified by the Board and check for any disciplinary action against the individual.***
Does this mean all employees (cooks, housekeepers, receptionists, etc..) or just those that would be listed with the OSBN, such as RN's, LPN, CNA's etc...

A. Yes, this means all employees should be checked under these registry's.

2. ***Licensees must complete form number 301 criminal background check every two years.***
I'm assuming this means RN's, LPN's, CNA's, etc... Is that correct? If so, do they complete the 301 form with us, or, is that something the employee would do on their own and submit to OSBN when they are renewing their license? I

A. No, RN's, LPN's, CNA's do not have to be checked every two years. The Licensee is referring to the owner/operator of the assisted living or residential care facility.

3. ***Criminal records checks are required: Prior to job changes, promotion, demotion, transfer and and re-employment employment***
I'm assuming this is for **all** positions - is that correct? I understand the re-employment piece but confused on the job change, promotion and transfer. Is it as literal as it sounds; if someone moves from the laundry department to the housekeeping department then we are required to do a new criminal check, or, if someone is promoted from a waitstaff position to a head waitstaff position - that too would trigger a new criminal check - am I understanding this correctly?

A. Yes, this means any job change such as the example you gave, from waitstaff to head waitstaff, or from care giver to lead care giver, etc.

Q & A's from 2007, 2008

1. What is an acceptable procedure for sending medications out of the facility with family, friend or if a resident leaves for the day on his own and needs medications?

A: The rules state that medications administered by the facility must be set-up or poured and documented by the same person who administers the medications and that the staff person who administers the medication must visually observe the resident take (e.g., ingest, inhale, apply, etc.) the medication unless the prescriber's order for that specific medication states otherwise. The intention of this rule is that residents receive their medication(s) in a safe manner. However, all residents have the right to short-term leaves from the facility. To balance safety and rights, it may be prudent for the facility to develop policies and procedures for this issue. These procedures might address processes such as how to document medications given to a responsible party and methods by which to educate that party, as applicable, regarding proper administration, times, and potential side effects which may need monitoring.

2. When a resident moves out of the facility to go to another setting can the 'old' facility give the resident his/her medications to take with them? Can the 'old' facility allow the resident to take narcotics with them to their new residence?

A: All medications that belong to the resident should either be sent with the resident or sent directly to the receiving facility. If the resident is going home or going to live with family, the medications should be given to the resident to take with him/her. A good practice would be to make a list of the medications being sent, with a copy of the list kept by the transferring facility. If the resident was given narcotics, it would be prudent to have two staff persons carefully document how many, and to whom, these medications were released.

3. Can the initial evaluation and initial service plan be the same document or do they need to be separate and distinct documents?

A: The initial evaluation must clearly be separate from the service plan because the evaluation information must be obtained before the service plan is developed. Also, the rule states, “after the initial 30-day move-in period, the initial evaluation must be retained in the resident’s file for 24 months. Future evaluations must be separate and distinct from the initial evaluation.”

4. Can the 30-day and quarterly evaluation review/update be the same document as the service plan?

A: Evaluations and Service Plans fulfill different purposes. However, beginning with the first quarterly review, the evaluation elements could be contained on the same document as the service plan *as long as all of the rule requirements are met*. The evaluation may be dated and initialed to show changes on an on-going basis, rather than starting a new evaluation for each quarterly review.
Resident evaluations must be reviewed and updates documented each time a resident has a significant change of condition; the evaluation must be done in person; evaluations must be documented, dated and indicate who was involved in the process; the most recent evaluation must be in the resident’s current record and available to staff; if the evaluation is revised and updated at the quarterly review, changes must be dated and initialed and prior historical information must be maintained.
Service plans must reflect resident’s needs as identified in the evaluation; must be readily available to staff and provide clear direction regarding the delivery of services; must include a written description of who will provide services, what, when, how and how often the services will be provided; changes must be dated and initialed; a copy of the service plan must be offered to the resident or to the resident’s legal representative.

5. The Medications and Treatments section of the rules state that “resident specific parameters and instructions for p.r.n. medications” need to be included in the medication record. Can

a facility write these on a document different from the Medication Administration Record (MAR) and have that included with the medication sheets?

A: The rule does not state that parameters need to be written on a specific document, but it would be considered good practice to include this information on the MAR. If parameters and instructions are not on the MAR, then they should be close, accessible, and known to all caregivers who administer medications.

6. Medications and Treatments 411-054-0055(2)(b)(C) - The medication record for each resident the facility administers medication to must include any medication specific instructions, if applicable (e.g., significant side effects, time sensitive dosage, when to call the prescriber or nurse). Please provide more clarification about what "if applicable" and "significant side effects" mean. There is limited room on the MARs so we want to make sure the pertinent information is clear and easy for the caregiver to follow.

A: The required information can be kept on a separate page in the medication record book as long as it is easily accessible by staff. Resident- and medication-specific information (e.g., significant side effects, time sensitive dosage, when to call the prescriber or nurse) would best be defined on an individual basis by the facility or other nurse and/or other involved health care provider(s).

7. For providers that work exclusively with CMA's or LPN's passing medications, do their MARS need to list significant side effects and when to call the nurse pursuant to new OAR 411-054-0055?

A. Medication specific instructions (e.g., significant side effects, time sensitive dosage, when to call the prescriber or nurse) must be documented as required, regardless of the qualifications of the person administering the medications.

8. Can treatments be written on the Medication Administration Record (MAR) or do they need to have a specific treatment record?

A: The rules do not specify a Treatment Administration Record (TAR) document, and they do specify a MAR document. Therefore, a facility can document treatments wherever they want, either on the MAR or on a separate document. What is most important is that there is an accurate record of the treatments administered.

9. Does an Administrator who has been absent from an administrator's position less than 5 years but who HAS NOT kept up with their CEUs need to re-take the Administrator Training Course?

A: The intent of OAR 411-054-0065 (3)(c) is that an individual must keep up their CEUs during their absence from an administrator position. The individual would be required to retake the administrator-training course if this requirement is not met.

10. The Administrator must appoint a designee in their absence. Does the designee need specific qualifications (i.e., Administrator Training) if the Administrator is going to be absent for an extended period of time (i.e., 1 plus months)?

A: The intent of the rule is that there is a designated person in charge at all times. The designee must be capable of making decisions in the absence of the administrator.
If an administrator is expected to have a long-term absence (greater than a month), contact the State Office of Licensing and Quality of Care and discuss the specific situation with a CBC Program Coordinator.

11. The Staffing Requirements and Training section of the rule states that if a facility employs universal workers whose duties include other tasks (e.g., housekeeping, laundry, food service, etc.), in addition to direct resident care, staffing must be increased to maintain adequate resident care and services. How is this going to be measured/surveyed?

A: If the facility uses universal workers, those workers, by definition, are not spending all their time providing direct care; so more of them would be needed to provide the same amount of care than if there were only direct caregivers. The facility must develop a staffing plan

based on acuity and facility structural design. Surveyors will ask for the plan at the time of survey. Based on investigative techniques outlined in the Survey Protocol for Staffing, surveyors will evaluate whether or not residents are receiving the care and services they need and that their needs are met.

12. Will written acuity plans be reviewed only if there are issues such as poor care outcomes, complaints from residents, families and staff of inadequate staffing or will this be a routine ask at survey?

A: Staffing plans will routinely be asked for at the time of survey, as with other new policies and procedures. Based on investigative techniques outlined in the Survey Protocol for Staffing, surveyors will evaluate whether or not residents are receiving the care and services they need and that their needs are met.

13. Does a facility that has one license but several "houses" need 2 staff in each house if they have residents who need 2 person transfers?

A: Not necessarily. Should there be a situation where a resident only occasionally needs the assistance of 2 people, and there is an extra, trained, staff person who can "float" across settings to meet the transfer needs of residents, it may be acceptable to have a minimum of one staff in each area (plus one "floater"). Whether or not this practice is acceptable, and whether it would be cited on a survey report, is dependent on how many residents need the assistance of 2 staff, how frequently, and whether the staffing pattern meets the needs of all residents. In no case can a house or section be without at least one caregiver, and residents cannot be left unattended.

14. Please clarify "segregated areas."

A: Segregated areas are separated by locked doors or are separate buildings. Regardless of whether a facility has "segregated areas" or not, there need to be sufficient staff to meet resident needs.

15. Can facilities share or "float" staff between an ALF and an RCF at any time?

A: The rules currently do not allow sharing staff across license types. If a facility wishes to explore an exception, they should contact the State Office of Licensing and Quality of Care and discuss the specific situation with a CBC Program Coordinator.

16. Several facilities do not have call systems. Are they going to be required to provide one?

A: Yes. Call systems are vital to residents' health and safety. With currently available technology (e.g., wireless systems) call systems are not dependent on hard wiring in older facilities.

17. The previous rule had a grandfather clause for some structural requirements. Are any structural changes "grandfathered" in this rule?

A: OAR 411-054-0200 (1) and 411-054-0300 (1) states, " BUILDING CODES. Each residential care (assisted living) facility must meet the requirements of the facility standards set forth in these rules, the Oregon Structural Specialty Code (OSSC) and the Oregon Fire Code (OFC) in effect at the time of original licensure. Structural requirements at the time of building construction do not have to be modified. However, call systems are required in all licensed facilities since this is a resident safety issue and structural changes to the building are not required. Lockable storage is also required to be phased in *(see question number 39)* since this is not a structural change to the building.

18. What is considered a reasonable amount of time for residents to wait for call light responses?

A: The answer to this varies. Facility/resident expectations may vary, resident needs are different, and facility policies may be different. The rule requires that resident needs be met. In detectable emergency situations, very little time should elapse before the resident receives assistance. Caregivers should also be aware of and alert to residents' special needs (e.g., urinary urgency or pain management). If residents, families, or others familiar with the facility complain that response times are too long, they are probably too long.

19. Please clarify the dates for which Food Handler Cards must be acquired for current staff and incoming staff. The Office of Environmental Public Health allows 30 days for food service workers to obtain the card. Will this be the standard for non-direct care food service staff as well?

A: The reason for requiring Food Handlers Cards is to assure that anyone who is involved with food or food sanitation issues (cooks, dishwashers, bus persons, etc.) have a basic understanding of food safety and can prepare and serve food safely. If an employee works in the kitchen or handles food, it would be prudent for them to have a food handler's card.
From DHS Website:
http://www.oregon.gov/DHS/ph/foodsafety/cert.shtml
Food Handler Cards
Food service workers are required to obtain a food handler card within 30 days of beginning work. The cost of the card is $10.00 and the card is valid for three years. Food handler cards issued in any county are valid throughout Oregon. If you have a valid food manager training certificate, it is accepted in lieu of a food handler card. Food handler cards issued in other states are not valid in Oregon.
Food service workers, including non-direct care food service workers, must have a card within 30 days, but the facility is required to have staff who are knowledgeable about safe food handling procedures at all times.

20. When the rule says that a nurse has to sign off on the service plan after a significant change of condition within 48 hours, does the nurse have to do a physical exam or in-person assessment? Is chart review or some other method possible?

A: There are two separate issues here – assessment and service planning. Regarding assessment, the rules state, "the RN must assess all residents with a significant change of condition. The assessment may be a full or problem focused assessment as determined by the RN. A chart review or phone consultation may be performed as part of this assessment. The RN must document findings, resident status, and interventions made as a result of this assessment. The assessment must be timely, but is not required prior to emergency response in acute situations." So, the RN determines

whether their assessment requires a physical exam, in-person assessment or other methods. Regarding licensed nurse participation on the Service Plan Team, the rules state that “if the resident experiences a significant change of condition and the service plan is updated, the licensed nurse must participate on the Service Planning Team, or must review the service plan with date and signature within 48 hours.” It would be reasonable to conclude that after the RN has done whatever level of assessment is deemed necessary, the service plan would be reviewed to determine if anything needs changing, based on that assessment and other available information. The 48-hour time frame is for licensed nurse review of the service plan. It is not for assessment.

21. How will the application of “timely” in Resident Health Services 411-054-0045 (1)(f)(A) be applied as far as RN assessment? If a phone consultation is part of that assessment, is that sufficient until the nurse makes their next visit? For example, if a nurse assesses via information provided over the phone that they want the resident to be seen by physician, is that timely and sufficient?

A: The rule states that there must be a Registered nurse (RN) assessment in accordance with facility policy and resident condition. At minimum the RN must assess all residents with a significant change of condition. The assessment may be a full or problem focused assessment as determined by the RN. A chart review or phone consultation may be performed as part of this assessment. The RN must document findings, resident status, and interventions made as a result of this assessment. The assessment must be timely, but is not required prior to emergency response in acute situations. If the RN assessment made with information provided over the phone is done within a reasonable time frame, given accepted medical standards of practice, after the change of condition or need for assessment, then that would be sufficient. Specific examples and timeframes are difficult to define as individual situations and resident needs vary greatly. Some medical conditions such as newly identified pressure ulcers or uncontrolled pain may dictate very short time frames. Other situations may not be quite as time sensitive. A significant change of condition is defined as imposing a “significant

risk to the resident" therefore, that risk must be assessed so that residents' health needs are adequately met.
If a facility has a resident monitoring and reporting system in place such that an RN is aware enough of a situation sufficient to make an informed judgment, the RN can make a determination about the level of and timelines for an assessment.

22. (a) Please clarify the exit door alarms. Do we have to have them on all the time? We have no residents who are at risk for wandering and only turn our door alarms on at night for the protection of residents and staff.
(b) Please clarify the difference between exit door alarms for security purposes versus to alert staff when residents exit the building. I have read the administrator alert but this is confusing. The old ALF rule did not mention "alert staff when residents exit the building," and the old RCF rule specified "alert staff when residents wander from the building." The way this is written it now sounds like facilities must monitor all residents' comings and goings.

A: Exit door alarms have been required in rule for Assisted Living since 1990 and for Residential Care since 1994. The intent of the exit door alarms is to alert staff when a person is entering or exiting the building.
When, and for how long, alarms are activated would depend on the needs of residents, acuity, and the purposes for which an alarm system is used. If no residents in a facility have been evaluated or are potentially at risk for wandering/elopement or other unsafe behavior, it may be acceptable to have an alarm system that is only activated at night, for security and safety purposes. If any resident has been evaluated or is at risk, interventions must be put in place to protect the resident and this may include activating the alarm system at all times. It would seem prudent to have an alarm system activated on all exit doors at night, for security purposes.

23. Does a facility have to perform criminal history checks on "private duty" caregivers who are hired by residents?

A: The facility is required to maintain a safe environment. It would be best practice to have a policy requiring criminal history checks for caregivers not employed by the facility.

24. Do facilities have a responsibility to conduct criminal history checks on outside service providers who are not facility employees? What about other non-employees who have regular one-to-one contact with residents?

A: The licensee is responsible for the operation of the facility and the quality of care rendered in the facility. Reasonable precautions must be exercised against any condition that could threaten the health, safety or welfare of residents. It would be prudent for the facility to have a policy addressing criminal history checks.
If an outside provider, such as a home health or hospice agency, conducts criminal history checks on their staff, it would be duplicative for the facility to also process a criminal history check.
Facilities must follow the Criminal History Check Rules, OAR chapter 407, division 007. Facilities can contact the Criminal Records Unit at 1-888-272-5545 or (503) 378-5470 with specific questions.

25. Will additional trainings be conducted by the state?

A: Additional trainings on these rules may be conducted from time to time in the future, as needs dictate, but no specific dates or venues have been set. There are several resources and materials available on the DHS website: http://www.oregon.gov/DHS/spd/provtools/ including PowerPoint and other handouts that were distributed during provider trainings conducted in the fall of 2007. Additional materials and Administrator Alerts will be posted as they become available. You can also call the State Office of Licensing and Quality of Care in Salem, at 503-945-5832 for additional information or to request materials.

26. Will a list of Community Based Care communities that were not able to attend the training be made available for follow up support by associations?

A: A list of facilities represented at the trainings is available at this time.

27. At a provider training, it was mentioned that if providers had a working process/system in place that there was not an expectation that they should change the system. Is there more clarification on this? One example might be a facility's service planning system where they combine their evaluation and service plan. It works for them, they have an excellent survey history, and the case manager really likes it.

A: As long as a facility's system meets the rule requirements of having all of the components of both the evaluation and service plan, and updates are conducted as required, the facility should not have to change the system it is currently using. The same rationale would apply to other system(s) a facility may currently have in place. If the system works, rule requirements are met, and resident needs are met, there should be no overriding need to change the system.

28. Is December 1, 2007 still the anticipated date for the Uniform Disclosure Statement to be available?

A: The estimated date for the UDS to be available is January 15, 2008.

29. When must facilities start using the new one? Can you use the old one until the new one is out?

A: Facilities should begin using the new UDS once it is posted on the website, estimated January 15, 2008.

30. What is the expected date for a revised CBC Survey Process Guide to be available?

A: The Survey Process Guide will be available January 1, 2008.

31. It is our understanding that medication times will be defined broadly. For example, morning passes could all be set up at the same time for 8:00, 9:00, and 10:00 am passes. Noon passes would be another distinct time period, as would afternoon/evening passes. We are advising that these are the broad time frames and that all individual times could be set up in the block as long as the same person who sets up medications administers them.

A: The process of setting up all “morning” medications at once is acceptable if the person who sets up the medications is the same person who will administer the medications.

32. Some people understand Health Services to mean the nurse must be on call 24/7. Those that think there is leeway are not sure what the surveyors will consider sufficient availability.

A: The nurse does not have to be on call 24/7. The nurse has to be available enough to deliver required nursing services and meet the needs of residents.

33. Do reports of suspected abuse and neglect need to be called in on weekends or can they wait until the next business day unless it is a situation that requires law enforcement?

A: Some offices have 24-hour reporting lines; however, the majority does not. Reporting the next business day is sufficient, provided that the safety of the resident victim is ensured. If a crime is suspected, law enforcement must be called immediately.

34. If a medication error results in a facility sending a resident to a physician or E/R for evaluation, would that be considered abuse?

A: If the resident’s baseline functional status has changed such that the resident requires medical attention, then the resident has suffered a negative outcome. Therefore, this situation does constitute abuse under the definition of failure to provide basic care or services to a resident that results in physical harm or unreasonable discomfort. For further definitions and interpretive guidance, refer to the Oregon Residential Care And Assisted Living Facilities Abuse Reporting And Investigation Guide For Providers available on the DHS website at: http://www.oregon.gov/DHS/spd/provtools/

35. Will DHS allow an online or CBC specific alternative to Red Cross (First Aid) training based upon an agreed upon criteria? Do first aid trainers need to be certified?

A: Online training is acceptable, but must offer American Health & Safety Institute (ASHI), American Heart Association (AHA), or American Red Cross (ARC) certification.
A comparable CBC specific alternative training is acceptable as long as the trainer is certified.

36. Please clarify direct sight supervision.

A: The individual requiring supervision must be in direct line of sight of another qualified, trained employee at all times.
The intent is that when a supervised person is performing any kind of resident care, they will be directly supervised. Therefore, the individual requiring supervision must be visible to a qualified, trained employee at all times. "Visible to" means in person; in other words, the visual supervision may not be done electronically. The qualified employee providing direct supervision will be able to intervene quickly if needed.

37. At a provider training session, a presenter stated that the servers in the dining room were also considered to be caregivers. Another provider at another community interpreted the rules to say that the servers would only be considered a caregiver if they were assigned other duties outside of the kitchen/dining room. So, which is it?

A: Employees who serve in the dining room are considered caregivers if they have received the required training for caregivers and they are functioning in the capacity of providing care and services to residents.

38. Does the state have any guideline for training competencies or do we just make this up ourselves?

A: The rule does not prescribe how facilities must determine a person’s competency as a result of training. Demonstration of physical tasks is evidence of a person’s capability to perform the task. However, competency in other required areas of training may need to be done by a question and answer method. Additional assistance may be obtained through Better Jobs Better Care or from the associations.

39. Will an alternative of offering lockable storage to residents via disclosure information be an alternative to lockable storage for all units including Alzheimer's units?

A: The intent of this rule is to provide all residents with a lockable storage area in their room/unit where they can store small valuable items. It is acceptable to ask residents if they would like to have a lockable storage unit in the room/unit and install those that request storage first. As rooms become vacant, a lockable storage compartment must be installed prior to a new resident moving in. This clarification applies to Alzheimer's Indorsed Units as well as residential care and assisted living units.
NEW QUESTIONS FROM 12/19/07

40. Are pool staff expected to have the same training as employees - i.e., orientation to individualized care, facility orientation?

A: We would not expect pool staff to have the same training that you provide employees. However, we do expect that pool staff are oriented to the facility, policies & procedures and the individual clients that they are to care for.

41. Does each required policy have to be stand-alone or can it be part of a resident handbook or contract?
A: The intent is informed consent. So, the information can be part of other documents, but they need to be pointed out to residents & families so they can make good decisions about their services and placement.

42. When will surveyors be looking at the staffing plan methodology?

A: Surveyors will be asking for your staffing plan and methodology at the time of entrance to insure that you have one. They will further investigate the adequacy of the plan if triggered and as outlined in the staffing survey protocol.

43. Does the evaluation and service plan have to be on separate documents?

A. The format is up to the provider. They both have to be done, service plan has to be available to and useable by staff, and available to surveyors when asked.

44. When is the first quarterly review due—90 days after ADMISSION (which may be 60 days after the initial evaluation) or 90 days after the initial evaluation (which may be 4 months after admission)?

A. The rule states that "Service plans must be completed quarterly after the resident moves into the facility." This means quarterly from the date of move in.

45. Clarify the 48-hour requirement for RN to sign the service plan Q&A #20. The rule says the RN should participate in the service planning process OR sign the services plan within 48 hours. Interpreted to mean that the RN can participate in the service planning process (perhaps by phone) then sign or initial the service plan when s/he is in the facility again (which may be longer than 48 hours). The 48 hour review & sign requirement is only if the nurse does not participate in the service planning process. Is this correct?

A. The rule states, "…the licensed nurse must participate on the Service Planning Team, ***OR*** (emphasis mine) must review the service plan with date and signature within 48 hours." This review and signature of the service plan could be done via fax if the nurse is not in the facility within that 48-hour time frame.

46. Who needs to be certified for first aid? Do we want every direct caregiver to be certified in first aid or trained in first aid?
A. Our intent is that the trainer be certified. The direct care staff must be trained in first aid by a certified trainer.
NEW QUESTIONS FROM 1/24/08

47. When surveyors are conducting surveys post January 1, 2008 is that the starting point in time for compliance with the new rules?

A. January 1 is the starting date of the new rule implementation, but surveyors will be looking at events and issues prior to that date in relation to health and safety of residents.

48. Do new employees hired on or after January 1, 2008 need to meet new orientation and training procedures?

A. Yes.

50. Do current employees have to be trained according to the new rule requirements?

A. Employees hired before January 1 must obtain first aid training, food handlers cards, if they prepare food and be subject to new in-service requirements.

51. Do residents who have moved in on or after January 1 need to have the evaluation elements and meet new timelines for service planning development and review?

A. Residents who move in on or after January 1, 2008 must have a full evaluation and the facility must meet all timelines in the new rules. Residents living in the facility prior to January 1 must have the evaluation elements completed at their quarterly update.