Rule Advisory Committee Meeting
January 14, 2019, 9:00 am till noon
Agenda

Meeting Location:	**Keizer Self-Sufficiency** **3420 Cherry Avenue, Main Conference Room** **Salem, OR 97303**
Call-in Information:	1 (503) 934-1400, Conference ID: 766850#

1. Introductions

2. Background information on HB 3262 and need for rule revisions

3. Rule Revisions
   a. Definitions: Primary Care Provider – Page 12
      Psychotropic Medication – Page 12
      Resident Evaluation – Page 13

   b. Revisions to Resident Evaluation – Pages 18 – 23

   c. Revisions to Psychotropic Medications – Page 24

4. Meeting Adjournment

Enrolled
House Bill 3262

Sponsored by Representative NATHANSON; Representatives ALONSO LEON, BYNUM, EVANS, FAHEY, MCKEOWN, MEEK, Senators MONNES ANDERSON, STEINER HAYWARD

CHAPTER .....

AN ACT

Relating to psychotropic medication; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) As used in this section:

(a) "Elderly person" means a person who is 65 years of age or older;

(b) "Person with a disability" has the meaning given that term in ORS 410.040; and

(c) "Psychotropic medication" has the meaning given that term in ORS 418.517.

(2) The Department of Human Services, in collaboration with the State Board of Pharmacy, the Oregon Medical Board, the Oregon State Board of Nursing and the Long Term Care Ombudsman, shall adopt rules related to the prescription of a psychotropic medication to an elderly person or a person with a disability who resides in:

(a) An adult foster home, as defined in ORS 443.705;

(b) A residential care facility, as defined in ORS 443.400; or

(c) A long term care facility, as defined in ORS 442.015.

(3) The requirements of this section do not apply to an elderly person or person with a disability in a hospice program, as defined in ORS 443.850.

(4) The rules adopted under subsection (2) of this section must include, but are not limited to, requirements that:

(a) If a prescription of psychotropic medication is written by a licensed health care practitioner other than the primary care provider or mental health care provider, or other licensed health care practitioner designated by the department, of the elderly person or person with a disability, the prescription must be reviewed by the primary care provider or mental health care provider, or other licensed health care practitioner designated by the department, of the elderly person or person with a disability to:

(A) Limit the adverse side effects of the psychotropic medication; and

(B) Ensure that the psychotropic medication is prescribed in the lowest possible effective dosage;

(b) A licensed health care practitioner other than the primary care provider or mental health care provider, or other licensed health care practitioner designated by the department, of the elderly person or person with a disability who prescribes a psychotropic medication notify the primary care provider or mental health care provider, or other licensed health care practitioner designated by the department, of the elderly person or person with a disability of the prescription not later than 24 hours after issuing the prescription;

(c) Psychotropic medication prescribed by a licensed health care practitioner other than the primary care provider or mental health care provider, or other licensed health care practitioner designated by the department, of the elderly person or person with a disability may be in an amount sufficient for a seven-day supply; and

(d) The facility or home in which the elderly person or person with a disability resides demonstrates that:

(A) A person-centered assessment has been performed for the elderly person or person with a disability; and

(B) Based on the findings of the assessment, the best course of treatment, including the use of nonpharmacological interventions, psychotropic medication or a combination of nonpharmacological interventions and psychotropic medication, is followed.

(5) The department may adopt other rules necessary to carry out the provisions of this section.

SECTION 2. The Department of Human Services shall convene an advisory committee of stakeholders and of representatives from the department, the State Board of Pharmacy, the Oregon Medical Board, the Oregon State Board of Nursing and the Long Term Care Ombudsman to study and make recommendations for best practices related to the implementation of section 1 of this 2017 Act. The department shall submit the findings and recommendations from the study to an interim committee of the Legislative Assembly related to human services not later than December 31, 2017.

SECTION 3. Section 1 of this 2017 Act applies to prescriptions for psychotropic medication issued on or after the effective date of this 2017 Act by a licensed health care practitioner other than the primary care provider or mental health care provider, or other licensed health care practitioner designated by the Department of Human Services, of an elderly person or person with a disability.

SECTION 4. (1) Section 1 of this 2017 Act becomes operative on January 1, 2018.

(2) The Department of Human Services, the State Board of Pharmacy, the Oregon Medical Board, the Oregon State Board of Nursing and the Long Term Care Ombudsman may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the agencies to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the agencies by section 1 of this 2017 Act.

SECTION 5. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.

Notification of Psychotropic Medication Prescriptions and Long-Term Care Facilities

Report to the Legislative Assembly
Senate Human Services Committee
House Human Services and Housing Committee

Recommendations of the HB 3262 Advisory Committee Concerning HB 3262, from the 2017 Legislative Session

December 20, 2017

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1. Summary

The 2017 Oregon legislature recently passed legislation to limit the adverse side effects of psychotropic medications on elderly persons residing in Oregon's long term care settings, and to ensure that psychotropic medication is prescribed in the lowest possible effective dose. Psychotropic medications include any medications that affect mental processes and behavior.

HB 3262 was designed to ensure primary care providers (PCPs) are aware of any psychotropic medications prescribed to residents in their care. The bill outlines a process for informing a PCP if another medical provider prescribes a psychotropic medication to a resident under the PCP's care.

The bill required the Department of Human Services (DHS) to convene an advisory committee comprised of stakeholders, and representatives of DHS, the State Board of Pharmacy, the Oregon Medical Board, the Oregon State Board of Nursing, and the Long Term Care Ombudsman. This committee was directed to review the bill, and make recommendations to the Legislative Assembly no later than December 31, 2017. This committee met four times, and determined that the bill language presents significant challenges to implement as written. The committee then developed this report to describe their analysis of the issues raised by HB 3262, and to recommend changes to the language in order to meet the legislation's intended purpose and allow for implementation.

Recommendations developed by the advisory committee include:

- Redefine the bill's purpose: Promote coordination of care by notifying the primary care provider of any prescriptions, with special attention to psychotropic medications
- Define "psychotropic medication" consistently across long term care settings.
- Develop a consistent definition for "Primary Care Provider (PCP)."
- Clarify which entity is expected to have responsibility for notifying the PCP.
- Require that notification to the PCP be documented in writing.
- Provide Oregon Medical Board (OMB) and Oregon State Board of Nursing (OSBN) with the authority to adopt rules necessary to implement bill.
- Delete statement that prescriptions may be in amount sufficient for a seven-day supply.
- Recommend training on use and effects of psychotropic medications for all primary care providers, ensuring that training is provided to nursing staff.

2. Acronyms Used in Report:

- Adult Foster Home – AFH
- Assisted Living Facility – ALF
- Centers for Medicare and Medicaid - CMS
- Department of Human Services – DHS
- Long Term Care Settings – LTC settings

  (Used generically to encompass all long term care settings licensed by Department of Human Services, Aging and People with Disabilities, Safety, Oversight and Quality. These licensed settings include adult foster homes, residential care facilities, assisted living facilities and nursing facilities. Note: according to state statute, "long term care" facilities include nursing facilities and intermediate care facilities, but do not include residential care facilities, assisted living facilities, or adult foster homes. See ORS 442.015(18).)

- Nursing Facility – NF
- Nurse Practitioner – NP
- Endorsed Memory Care Community - MCC
- Oregon Board of Pharmacy – OBOP
- Oregon Medical Board – OMB
- Oregon State Board of Nursing – OSBN
- Primary Care Provider – PCP
- Physicians Order for Life Sustaining Treatment – POLST
- Residential Care Facility - RCF

3. Introduction

HB 3262 was passed by the Legislative Assembly during the 2017 Legislative Session. This bill required the Department of Human Services to convene an advisory committee to review the bill and make recommendations concerning best practices. The advisory committee was comprised of stakeholders, and representatives of the Department of Human Services, Oregon Board of Pharmacy, the Oregon Medical Board, Oregon State Board of Nursing and the Long Term Care Ombudsman. The committee members are listed in Section 3 of this report.

After identifying key issues, DHS worked with the committee to develop recommendations for the legislature for potential amendments that would clarify and fully implement the goals of HB 3262. Committee members were highly knowledgeable subject matter experts from diverse perspectives. They shared their knowledge through raising critical questions and professionally discussing the bill. Over the course of four meetings the committee had identified and agreed on several key issues. This report provides an overview of the deliberations of the committee, and the committee's recommendations to the Legislative Assembly.

The following report summarizes concerns and questions raised by committee members and includes their recommendations as to how best to implement HB 3262 to support best practices. The advisory committee was directed to present recommendations to the 2018 Legislative Assembly by December 31, 2017.

The committee thanks the legislature for their interest in the well-being of the individuals who reside in Oregon's LTC settings and for the opportunity to discuss this important topic with the many partners who participate in their care.

4. Advisory Committee Members

- Dave Allm, Program Manager, Nursing Facility (NF), DHS/Aging and People with Disabilities (DHS/APD)
- Chris Angel, HCBS Project Manager, DHS/APD
- Lynn Beaton, JD, Policy Analyst, DHS/APD
- Lynette Caldwell, Adult Foster Home (AFH) Program Manager, DHS/APD
- Becky Callicrate, RN, Policy Analyst, DHS/APD
- Deborah Cateora, RN, Policy Analyst, DHS/APD

- Debbie Concidine, Policy Analyst, Community Based Care (CBC) Program, DHS/APD
- Gwen Dayton, JD, Executive Vice President & General Counsel, Oregon Health Care Association (OHCA)
- Emily Dazy, Administrator/Executive Director, Providence Benedictine Nursing Center, Mt. Angel, OR
- Nirmala Dhar, LCSW, Coordinator, Oregon Health Authority, Older Behavioral Health Program
- Petronella Donovan, AFH Owner, Independent Adult Foster Home Association
- Joshua Free, R-PH, representing Oregon Board of Pharmacy
- Eleni Gialoyrakes, Policy Analyst, Adult Foster Home Program, DHS/APD
- Patrick Gillette, MD, Internal Medicine, Medford, OR
- Page Griffen, MD, Family Medicine, Woodburn, OR
- Ruth Gulyas, Executive Director, LeadingAge Oregon
- David Hibbs, ARNP, representing Oregon Geriatrics Society (OGS)
- Sarah Holland, Program Director, Alzheimer's Association, Oregon Chapter
- Ileana Ivan, RN, AFH Owner, Independent Adult Foster Home Association
- Jan Karlen, Policy Analyst, DHS/APD, Safety, Oversight and Quality
- Linda Kirshbaum, Senior Vice President Quality Services, Oregon Health Care Association (OHCA)
- Gretchen Koch, MSN, RN, Policy Analyst, Oregon State Board of Nursing (OSBN)
- Sara Kofman, Policy Director, Alzheimer's Association, Oregon Chapter
- Nicole Krishnaswami, JD, Policy Analyst, Oregon Medical Board
- Annie Lupei, RN, AFH Owner, Independent Adult Foster Home Association
- Mike McCormick, Deputy Director, DHS, Aging & People with Disabilities
- Allison McKenzie, Policy Analyst, DHS, Office of Adult Protections, Prevention and Investigations
- Ann McQueen, Administrator, DHS/APD, Safety, Oversight & Quality
- Ruth Medak, MD, representing Oregon Hospice and Palliative Care Association
- Lisa Miura, MD, Associate Professor of Medicine, OHSU/VA representing Oregon Geriatrics Society (OGS)
- Maureen Nash, MD, Medical Director, Providence ElderPlace
- Margaret Njonjo, MD, representing Oregon Geriatrics Society
- Ana Potter, Program Manager, CBC Program, DHS/APD

- Sylvia Rieger, Policy Analyst, AFH Program, DHS/APD
- Fred Steele, JD, Oregon Long Term Care Ombudsman
- Liz VonWellsheim, GNP, RCF/MCC owner, representing OGS
- Bob Weir, Policy Analyst, Medicaid HCBS, DHS/APD
- Diana White, PhD, Senior Research Associate, Portland State University
- Sarah Wickenhagen, DNP, FNP-C, Policy Analyst, OSBN

5. Purpose of Bill

The key purpose of the bill, as written, is to limit the adverse side effects of psychotropic medications on elderly persons living in Oregon's LTC settings and to ensure that psychotropic medication is prescribed in the lowest possible effective dose. Many of the committee members did not agree with focusing on "the lowest possible effective dose." They argued that when a new medication is first prescribed, it is generally first prescribed at a very low dose, and then slowly increased until the therapeutic dosage is reached. It was also stated that, in certain cases, it can be dangerous to the individual to focus primarily on prescribing as low a dose as possible. Instead, these committee members argued that it is best to focus on prescribing an "appropriate" dose.

HB 3262, passed by the Oregon Legislative Assembly in 2017, is focused primarily on situations in which the resident's PCP is not the medical professional who prescribes the psychotropic medication. For example, a resident living in a LTC setting, may have been rushed to a hospital emergency room, and an emergency room physician may have prescribed a psychotropic. It is essential that the PCP be made aware of this psychotropic medication as soon as possible. Knowledge of an emergency room visit and all medications prescribed can be a matter of life and death.

The bill specifically addressed the long-term care settings licensed by DHS and the residents who live in them. HB 3262 outlined a process for notifying PCPs of prescriptions for psychotropic medications, and for encouraging the most appropriate dosage and side effects of these medications by improving coordination with medical professionals who are not the PCP for a given resident.

The purpose of the bill was discussed during each of the four meetings of the committee. Ultimately, there was general agreement that it was best to propose a new purpose for the bill. All committee members agreed that "coordination of

care" is essential if individuals are to receive excellent care and if medications are to be prescribed in the most appropriate manner. However, it should be noted some committee members were concerned this amended new purpose might "dilute" the original focus on psychotropic medications. For that reason, the committee agreed to maintain special attention to psychotropic medications to not lose that focus.

Recommendation #1: Redefine the purpose of the bill: "Promote coordination of care by notifying the primary care provider of any prescriptions, with special attention to psychotropic medications."

6. Positive Topics of Consensus

Collaboration with licensing boards, LTC Ombudsman and stakeholders

The use of psychotropic medications, especially the use of antipsychotics, has been a focus of DHS and the long-term care industry for several years. However, HB 3262's requirement to bring such broad representatives to collaborate and review current and best practices concerning the use of these medications is new and valuable. Even though DHS staff works with these entities on other committees and workgroups, this was the first time we were provided the opportunity to collectively address and align our efforts regarding the best practices in addressing psychotropic medication use in Oregon's LTC settings.

Psychotropic versus psychoactive definition

Current regulations for RCFs, ALFs and AFHs use the term "psychoactive" instead of "psychotropic." The definition of "psychoactive" is also somewhat different between these two facility types. In addition, the federal regulations for NFs use the term "psychotropic," rather than "psychoactive" medications.

It is noted that the definition of "psychotropic medication" referenced in HB 3262 is the definition used by the Child Welfare program of DHS. After discussion, the group recommended that a separate definition for "psychotropic medication" should be used for residents of long-term care facilities. This is a different audience, with different needs and challenges.

The suggestion was made to adopt the definition of "psychotropic medications" used by the federal Centers for Medicare & Medicaid Services (CMS). The committee also supported applying this definition to <u>all</u> of the long-term care settings regulated by the DHS.

Recommendation #2: Define "psychotropic medication" consistently across all long-term care facility types, including RCFs, AFHs, and NFs.

Define "psychotropic medication" to mean any drug that affects the brain activities associated with mental processes and behavior. These drugs include, but are not limited to drugs in the following categories:

(a) Antipsychotic.
(b) Antidepressant.
(c) Antianxiety.
(d) Hypnotic.

Person-Centered Assessment

HB 3262 also added a new element – the bill requires all LTC settings to perform "person-centered assessments." The bill focuses on the concept of person-centered care. In the context of HB 3262, a person-centered assessment encourages staff who work in Oregon's LTC settings to focus on the person (resident) to determine if there is an underlying reason for their behavior and to attempt interventions other than psychotropic medications.

A reason for a "challenging" behavior could be something as simple as a change in the resident's daily routine, pain or discomfort, potential illness, or even something in the resident's environment that is causing distress or uneasiness. Any of these, coupled with the resident being unable to verbalize feelings, often result in the resident expressing discomfort through behavior. As described earlier, if a person is unable to verbalize, then that person will likely express needs through behavior. If caregiving staff do not understand behavior is a form of communication, or staff don't understand the potential that other interventions offer, the resident will be more at risk of receiving a psychotropic medication that might not be needed.

Gathering as much information about the person as possible, being aware of the person's unique needs and preferences, trying to understand the person's routines, and recognizing any health conditions that may impact behavior are key to providing the most effective care. Understanding what a person enjoys or positively responds to can also help prevent the use of psychotropic medications and enhance quality of life. When another intervention is appropriate and works effectively, inappropriate pain medications are less likely to be used.

7. Issues Raised by Committee Members Concerning Notification

Which population(s) is this bill meant to address?

This bill focuses on residents who live in Oregon's LTC settings regulated by the Safety, Oversight & Quality Unit, an office within the Aging and People with Disabilities Program of the DHS. These residents are elderly or disabled persons living in residential care facilities (RCFs), assisted living facilities (ALFs), nursing facilities (NFs), or adult foster homes (AFHs). The bill specifically excludes people who are enrolled in a hospice program. For hospice residents, who are at the end of life, the standard of practice includes the ability to prescribe psychotropic medications to control symptoms such as nausea, vomiting, anxiety, etc. However, individuals in LTC settings are also prescribed psychotropic medications for symptom management for the same purpose as hospice patients.

The bill also does not address those who are receiving palliative care services at end of life and are not enrolled in a formal hospice program. It was suggested that people receiving palliative care in long term care settings be excluded from the requirements of HB 3262, as are those in hospice. Also, it should be noted that federal requirements for nursing facilities do not make a distinction when a resident is receiving palliative or hospice care. In addition, CMS requires states to have policies on end of life care. Some individuals are in a terminal delirium and cannot be managed without these medications.

In addition, there are individuals who reside in Oregon's long term care settings who live with mental health conditions such as schizophrenia or bi-polar disorder. The prescribing of psychotropic medications, especially antipsychotics, are a standard of practice for these individuals. During the legislative hearings on HB 3262, it was made clear that the bill was not intended to be applied to these individuals. However, the bill itself does not make this distinction.

Individuals who live in Oregon's RCFs, ALFs, NFs, or AFHs who could most likely benefit from this legislation are those who live with dementia or other developmental or neurological conditions or disabilities that make it difficult to verbally communicate needs or feelings. If a person is unable to verbalize, then that person will likely express their needs through behavior. If caregiving staff do not understand these behaviors are a form of communication, or staff don't understand the potential for other interventions, the resident will be at a higher risk for receiving a psychotropic medication that may not be needed.

What is a "Primary Care Provider?"

The committee agreed that the person who has provided medical care and prescriptions over time should be the person designated as the "primary care provider" or PCP. This person was described as the "longitudinal" care provider – meaning the provider serving the resident over time.

Nurse Practitioners (NPs) are also considered PCPs, as are naturopathic physicians, given that they can now sign POLSTs and prescribe medications.

The committee recommends using the definition in the Oregon Medical Practice Act (ORS 677.137(3) (b)), but adapting it so it includes all PCPs, that incorporates the "longitudinal" concept, and allows for medical directors of facilities to serve as PCP when appropriate.

Recommendation #3: A "Primary Care Provider" means the health care provider primarily responsible for the on-going diagnosis or treatment of the resident in the setting where they currently reside.

Who has the duty to ensure the Primary Care Provider is notified?

The committee generally understood the initial intent of the bill drafters was to require LTC settings to notify primary care providers when psychotropic medications have been ordered by other licensed health care practitioners. However, the bill states:

> "A licensed health care practitioner other than the primary care provider or mental health provider, or other licensed health care practitioner designated by the department, of the elderly person ... who prescribes a psychotropic medication [must] **notify** the primary care provider or mental health care provider ... no later than 24 hours after issuing the prescription." *(HB 3262, Section 1(4)(b))(edit added)*

Some argued that clearly the LTC settings were intended to notify, given that only these settings are explicitly named in the bill. Others supported this argument by noting that the bill was assigned to DHS, and the only entities DHS is authorized to regulate are LTC settings.

There was general consensus among the committee members that staff of the LTC setting are better positioned than the licensed health care prescriber to notify the primary care provider. Often, a "licensed health care practitioner" may see the resident briefly and may not know who the PCP is, let alone have the contact information for the PCP. The prescribing provider may not know the patient's residency status and may not know the patient's current PCP.

It was suggested that perhaps the "service/care planning team" should be responsible for notifying the PCP in writing of any newly prescribed psychotropic medications. However, others maintain that the bill does not propose adding this responsibility onto the LTC setting, given the bill clearly states the licensed health care practitioner who prescribed the medication has the responsibility for notifying the PCP. The group was unable to reach any consensus on this issue.

Recommendation #4: Amend the language of HB 3262 to clarify which entity is expected to have responsibility for notifying the PCP when a psychotropic medication is prescribed.

What Constitutes Sufficient Notification?

HB 3262 requires the prescribing practitioner "who prescribes a psychotropic medication notify the primary care provider or mental health care provider ...not later than 24 hours after issuing the prescription."

(HB 3262, Section 1(4)(b))

The bill does not include any other instruction regarding the method of notification. Does this include faxing? Phoning? Electronic submission?

The committee determined it is necessary to document the notification in writing, but the form of this writing does not matter – notification can be faxed or electronically submitted, as long as the PCP is sent written notice of the prescription. In addition, there was discussion concerning whether 24 hours was a reasonable amount of time in which to notify the primary care provider. Some suggested that this should be changed to three business days in order to allow for weekends and holidays when a primary care provider may not be available.

Recommendation #5: Whichever entity has responsibility for notifying the PCP should be required to send notifications in writing.

What is the responsibility of the PCP?
The current language requires the prescription to be reviewed by the PCP in order to limit the adverse side effects and to ensure that the prescription is written for the lowest possible effective dose. Must the PCP document an analysis of side effects and dosage? Or is the bill language meant to provide the rationale for requiring the PCP's review and provide the PCP complete information and the opportunity to better manage the resident's treatment?

Although the issue of the PCP's responsibility was discussed, the committee did not reach a final decision regarding what that responsibility should be. Clearly, the entire purpose of this bill is to ensure that the PCP has more complete information concerning the medications being prescribed to the resident of a LTC setting and can therefore treat the resident more effectively.

Some members stated that the bill would ideally require the PCP to read the notice and then contact the prescriber, if necessary. However, the committee acknowledged it would be extremely difficult to monitor or enforce this action. Instead, the bill was an effort at ensuring that PCPs have better information, and can, accordingly, hopefully provide more appropriate care.

What if a resident does not have a PCP?
It is relatively uncommon for a resident not to have a PCP, but it does occur. NF regulations requires residents to have a PCP, in order to be admitted. However, RCF, ALF and AFH rules do not require a resident to have a primary care provider.

It was suggested that the initial assessment/evaluation and/or the care plan must include the PCP name and contact information. Then, if there is no PCP, the assessment/evaluation should indicate "none" and be updated if and when the patient establishes care with a PCP. No one proposed that we require all residents of every facility type to have a PCP.

How will this law be enforced?
Questions were raised regarding how the OMB is expected to enforce the requirements of this bill. An OMB representative stated the board commonly receives complaints concerning prescribing issues, and that the board carefully considers the individual circumstances before taking action against a physician's license. The OMB and other boards enforce the "standard of care."

For example, if the board were to receive a complaint about a physician prescribing of antipsychotic medications in a LTC facility, they would consider

what a reasonably prudent physician in the same or similar circumstances in the community would do. This is known as the "community standard of care." The standard of care is almost never prescribed or specified in statute or rule.

Since the bill states DHS must adopt rules, this indicated to OMB and OSBN that DHS has primary responsibility for writing rules and the other licensing boards would write rules to support. However, DHS does not have legal authority to write rules regulating health care practitioners. Instead, DHS only has authority to regulate LTC settings.

Recommendation #6: Provide the Oregon Medical Board (OMB) and the Oregon State Board of Nursing (OSBN) with the explicit authority to adopt rules necessary to carry out the provisions of this bill, if the bill places new responsibilities or regulations on primary care providers beyond the "standard of care," which is the measure currently used to evaluate a provider's practice.

8. Person-Centered Assessment versus Evaluation

As mentioned earlier, HB 3262 required a "person-centered assessment" be performed for elderly persons or persons with a disability. Current administrative rules governing all facility types mentioned in HB 3262 do not use the term "person-centered assessment." However, all four settings are required to conduct an extensive screening, assessment or evaluation of potential residents before admission. A re-evaluation must occur every 90 days in NFs, RCFs and ALFs, and every six months in AFHs, under current law. In addition, when a resident has a change of condition, all four facility types are required to re-assess or re-evaluate the resident. The assessment or evaluation provides the basis for the individualized written care or service plan.

"Assessment" is a word that has different meanings in other related contexts, and committee members noted this could cause confusion. For example, within Oregon's Intellectual and Developmental Disability Program, "assessment" involves a measurement of a person's functions, while that term is not used when appraising the person's desires and supports. Likewise, "assessment" could easily be confused with "comprehensive nursing assessment," which has a very specific medical meaning and can only be completed by a registered nurse.

Discussions with the OSBN several years ago brought this concern to the attention of the DHS and RCF/ALF providers. To avoid confusion with a nursing assessment, administrative rules for RCFs and ALFs use the term "evaluation" rather than "assessment." Because most RCFs and ALFs designate a non-licensed staff person to obtain the required information about the resident, it was decided this information gathering would be considered an "evaluation." Of course, if the resident has nursing needs, a "nursing assessment" must be performed.

It should be noted that adult foster homes use non-licensed staff to evaluate potential residents for admission. Typically, they do not have a nurse on staff and use the services of the Community Nurse Program when one of their Medicaid residents has nursing needs. If a resident is private pay and has nursing needs, the adult foster home must obtain the services of a registered nurse.

9. Prescribing Medications – Seven-Day Supply Issue

HB 3262 states that,

> "Psychotropic medication prescribed by a licensed health care practitioner other the primary care provider or mental health care provider ... <u>may be in an amount sufficient for a seven-day supply</u>."
>
> (HB 3262, Section 1(4)(c))(emphasis added)

Many advisory committee members who are licensed health care practitioners queried the intent of this language, since it doesn't seem to represent current standard of practice. Also, it is unclear if this requirement is directed to LTC facilities or to licensed health care practitioners. If the intent was to require the facilities to direct care in determining the best course of treatment, that is not appropriate, since directing care in the responsibility of a health care provider.

Questions and concerns that advisory committee members expressed include:

- What would the LTC setting do if the prescription for a psychotropic medication is written for a longer period of time than seven days? Would they have to limit it to seven days or would they continue to administer the medication pursuant to a provider's order?

- By putting a limit on the number of days a resident in a LTC setting can receive a psychotropic medication, the practice of a licensed health care practitioner is restricted.

- A prescribing provider may not fully understand the patient's living arrangements, particularly if those living arrangements are in flux. It will be difficult to require the prescribing provider to limit a new psychotropic medication to a seven-day supply for this specific group of patients. How would this be enforced?

Furthermore, discussions during Advisory Committee meetings noted that DHS does not have authority to regulate the prescribing of medications. This requirement would therefore need to be addressed by the OMB and the OSBN.

Recommendation #7: Remove language from the bill stating that the prescription "may be in an amount sufficient for a seven-day supply."

10. Long Term Care Settings Cannot Direct Medical Care

Conflation (or Blending) of responsibilities of long term care settings with medical practices

Section 1 (d) (A) requires the facility or home to perform a person-centered assessment and, based on the findings of the assessment, determine the best course of treatment, including the use of nonpharmacological interventions, psychotropic medications or a combination of both.

Advisory committee members mostly agree with the concept of a person-centered assessment to determine if there is an underlying cause of behavior that could be managed or treated with other interventions. However, in review of this requirement, it was acknowledged this requires the facility to direct the resident's care in determining the best course of treatment, which is actually the practice of medicine (and nursing) and is the responsibility of licensed health care providers.

There was also a question regarding the timing of the assessment. Does the assessment need to be completed before a psychotropic medication can be requested? There was a suggestion that after the person-centered assessment is completed that the course of treatment should be determined in collaboration or consultation with the resident (and/or their representative) and the primary care provider.

As noted earlier in this report, all three settings mentioned in the bill are currently required to conduct extensive screenings, assessments or evaluations at the time of admission: every 90 days for NFs and RCFs/ALFs, every six months for AFHs, and whenever there is a change of condition for any of these types. In addition, there are rules in place for all the settings that state psychotropic medications shall only be used to treat specific conditions, and only after other interventions have been tried, and in consultation with a licensed health care practitioner or mental health professional.

11. Description of LTC Settings and Explanation of their Differences

How care is coordinated in each setting

Not all facilities discussed in this bill are the same, yet they all serve residents who require care and services, whether under the Medicaid program or paying privately. All three settings mentioned in HB 3262 have different care coordination processes. The three different types of facilities mentioned in the bill are as follows:

- Adult foster homes serve five or fewer residents in a home setting. The AFH provider is usually the main caregiver and hires caregiving staff. Most of the time, these are lay caregivers. There is not a requirement for awake staff at night, as this is a home with a primary caregiver who lives in the home with the residents. Typically, AFHs do not have shift caregivers. If any of the Medicaid residents require nursing assessment and intervention related to a chronic care need(s), a contracted community RN will be referred by the client's case manager to come into the home to assess the client and develop a nursing plan of care. The community RN will evaluate the client's medications during each visit, may delegate the performance of a client's chronically-needed nursing procedure to a care provider to perform, and will provide ongoing assessment and planning for the client's chronic care needs. If a resident pays privately and has nursing needs, the AFH provider must obtain the services of a registered nurse.

- Community-Based Care Facilities which include RCFs, ALFs and MCCs that are licensed as either a RCF or ALF. These settings require 24-hour awake caregiving staff, staffing based on resident acuity, and an RN available for consultation 24/7. There are no rules regarding how many hours an RN must be present in the facility. The facility RN and the resident care coordinator

(RCC), who is typically a non-licensed staff person, coordinate with the PCP regarding resident care. Direct care staff do not have to have a CNA license however many of these settings do hire them. There are requirements for training direct care staff and determining their competency to provide care.

- Nursing Facilities: NFs are considered the highest level of care. There are licensed nurses on duty 24/7 in the facility. There is also a Medical Director who may also be the resident's PCP. Direct care staff must be certified nursing assistants (CNAs).

12. Training

All PCPs need to be well-educated concerning the effects, use, and prescribing of psychotropic medications. Offering training for providers is an essential step in ensuring that psychotropic medications are prescribed in the most appropriate dosages. As mentioned in Section 12 below, HB 3359 passed during the 2017 Legislative Session requires dementia training for all direct care staff who work in RCFs, ALFs and AFHs.

This required training for direct care staff includes a general discussion of many aspects of dementia, including the progression of the disease, techniques for understanding and managing symptoms, and strategies for addressing the needs of persons with dementia. This same bill also requires that all physicians be encouraged to complete training in the treatment of Alzheimer's disease. As mentioned by HB 3262 committee members, dementia training for physicians should ideally include a more complete training on treating dementia beyond just Alzheimer's disease, since Alzheimer's is just one form of dementia.

Concern was expressed that licensed nurses are often excluded from receiving training, given their significant daily responsibilities, which include conducting nursing assessments, involvement in plans of care, interpreting orders, and training caregivers. Facilities may have policies in place regarding training for nurses. MCCs are required to provide dementia care training to all staff, but training is not a requirement for all nurses working with elderly persons or people with disabilities. Committee members mentioned that it would be good to have a mandatory dementia care training designed for nurses who work in LTC settings.

Training for all PCPs concerning psychotropic medications fits well with the training being required by HB 3359. There should be an effort to include nurses in these trainings, since nurses are frequently not able to attend other training courses.

Recommendation #8: Provide training on the effects and use of psychotropic medications to all PCPs, with an emphasis on including training for nursing staff who work with LTC settings.

13. Dementia Training and the Connection to HB 3359

Connection to dementia training for RCF direct care staff and physicians

HB 3359 was passed by the 2017 Legislature. This is an omnibus bill that has several facets. It focuses primarily on RCFs, ALFs and AFHs. There are requirements around licensing and corrective action, but the sections that are mostly related to HB 3262 include:

- Section 16 - Establishes the Residential Care Quality Measurement Council Under this program there will be Quality Measurement Council which will consist of eight members representing various disciplines and stakeholders. One of the quality measures that will be reviewed is the use of antipsychotics for non-standard purposes.

- Section 24 – Addresses the appropriate staffing to meet the scheduled and unscheduled needs of residents who reside in RCFs and ALFs. Many residents in these settings have cognitive impairment and are in need of oversight.

- Sections 25 & 30 - Which requires dementia training of employees prior to providing direct care to residents. This requirement applies to direct care staff who work in RCFs, ALFs, and AFHs. In addition to this pre-service training, direct care staff who work in RCFs and ALFs will be required to complete six hours training in dementia care annually. A key topic of this training is the use of the person-centered approach in working with these residents.

- Section 34 requires that Alzheimer's disease and other related dementia training be offered to physicians for detection and early diagnosis and appropriate prescribing of antipsychotic drugs to treat people with Alzheimer's disease.

As noted in these bullet points, there is a concerted effort in Oregon to address the needs of people with dementia. The goal is to apply tactics such as those outlined above, while also implementing a person-centered approach. Using a more comprehensive method will hopefully provide residents living in Oregon's long-term care settings with an enhanced quality of life that includes the administration of appropriate medications.

DEPARTMENT OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 54

RESIDENTIAL CARE AND ASSISTED LIVING FACILITIES

411-054-0000 Purpose *(Amended 06/28/2016)*

(1) The purpose of these rules is to establish standards for assisted living and residential care facilities that promote the availability of a wide range of individualized services for elderly and persons with disabilities, in a homelike environment. The standards are designed to enhance the dignity, independence, individuality, and decision--making ability of the resident in a safe and secure environment while addressing the needs of the resident in a manner that supports and enables the individual to maximize abilities to function at the highest level possible.

(2) Residential care and assisted living facilities are also required to adhere to Home and Community-Based Services, OAR 411-004. For purposes of these rules, all residential care and assisted living facilities are considered home and community-based care settings and therefore shall be referred to as "facility".

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

411-054-0005 Definitions *(Amended 6/29/2018)*
For the purpose of these rules, the following definitions apply:

(1) "Abuse" means abuse as defined in OAR 411-020-0002 (Adult Protective Services).

(2)"Activities of Daily Living (ADL)" mean those personal functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include eating, dressing and grooming, bathing and personal hygiene, mobility, elimination, and cognition.

(3) "Acute Sexual Assault" means any non-consensual or unwanted sexual contact that warrants medical treatment or forensic collection.

(4) "Administrator" means the person who is designated by the licensee that is responsible for the daily operation and maintenance of the facility as described in OAR 411-054-0065.

(5) "Advance Directive" means a document that contains a health care instruction or a power of attorney for health care.

(6) "Aging and People with Disabilities (APD)" means the program area of Aging and People with Disabilities, within the Department of Human Services.

(7) "Applicant" means the individual, individuals, or entity, required to complete a facility application for license.

(a) Except as set forth in OAR 411-054-0013(1)(b), applicant includes a sole proprietor, each partner in a partnership, and each member with a 10 percent or more ownership interest in a limited liability company, corporation, or entity that:

(A) Owns the residential care or assisted living facility business; or

(B) Operates the residential care or assisted living facility on behalf of the facility business owner.

(b) Except as set forth in OAR 411-054-0013(1)(b), for those who serve the Medicaid population, applicant includes a sole proprietor, each partner in a partnership, and each member with a five percent or more ownership interest in a limited liability company, corporation, or entity that:

(A) Owns the residential care or assisted living facility business; or

(B) Operates the residential care or assisted living facility on behalf of the facility business owner.

(8) "Approved Dementia Training" means a dementia training curriculum approved by an entity selected by the Department to be an approving entity pursuant to a Request for Application (RFA) process.

(9) "Area Agency on Aging (AAA)" as defined in ORS 410.040 means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors or 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 B Area Agencies on Aging that contract with the Department to perform specific activities in relation to residential care and assisted living facilities including:

(a) Conducting inspections and investigations regarding protective service, abuse, and neglect.

(b) Monitoring.

(c) Making recommendations to the Department regarding facility license approval, denial, revocation, suspension, non-renewal, and civil penalties.

(10) "Assisted Living Facility (ALF)" means a building, complex, or distinct part thereof, consisting of fully, self-contained, individual living units where six or more seniors and adult individuals with disabilities may reside in homelike surroundings. The assisted living facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, and independence.

(11) "Building Codes" are comprised of the set of specialty codes, including the Oregon Structural Specialty Code (OSSC), Oregon Mechanical Specialty Code (OMSC), Oregon Electrical Specialty Code (OESC), Oregon Plumbing Specialty Code (OPSC), and their reference codes and standards.

(12) "Caregiver" means a facility employee who is either direct care staff or a universal worker, who is trained in accordance with OAR 411-054-0070 to provide personal care services to residents.

(13) "Change in Use" means altering the purpose of an existing room, within the facility, that requires structural changes.

(14) "Change of Condition - Short-Term" means a change in the resident's health or functioning, that is expected to resolve or be reversed with minimal intervention, or is an established, predictable, cyclical pattern associated with a previously diagnosed condition.

(15) "Change of Condition - Significant" means a major deviation from the most recent evaluation, that may affect multiple areas of functioning or health, that is not expected to be short-term, and imposes significant risk to the resident. Examples of significant change of condition include, but are not limited to:

(a) Broken bones.

(b) Stroke, heart attack, or other acute illness or condition onset.

(c) Unmanaged high blood sugar levels.

(d) Uncontrolled pain.

(e) Fast decline in activities of daily living.

(f) Significant unplanned weight loss.

(g) Pattern of refusing to eat.

(h) Level of consciousness change.

(i) Pressure ulcers (stage 2 or greater).

(16) "Choice" means a resident has viable options that enable the resident to exercise greater control over their life. Choice is supported by the provision of sufficient private and common space within the facility that

allows residents to select where and how to spend time and receive personal assistance.

(17) "CMS" means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

(18) "Competency" means to possess specific knowledge, technical skill, and the ability to perform tasks related to the role and responsibilities of direct care staff.

(19) "Competency Assessment" means an evaluation of knowledge, technical skill and ability to carry out care pursuant to the requirements in OAR 411-054-0070. Evaluation shall include verification and documentation of direct care staff competency through observation, written testing or verbal testing.

(20) "Condition" means a provision attached to a new or existing license that limits or restricts the scope of the license or imposes additional requirements on the licensee.

(21) "Conversion Facility (CF)" means a nursing facility that has followed the requirements in these rules to become a residential care facility through the conversion facility process.

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

(23) "Designated Representative" means:

(a) Any adult, such as a parent, family member, guardian, advocate, or other person, who is:

(A) Chosen by the individual or, as applicable, the legal representative;

(B) Not a paid provider for the individual; and

(C) Authorized by the individual, or as applicable the legal representative, to serve as the representative of the individual, or as applicable the legal representative, in connection with the provision of funded supports.

(D) The power to act as a designated representative is valid until the individual modifies the authorization or notifies the agency that the designated representative is no longer authorized to act on his or her behalf.

(b) An individual or the legal representative of the individual is not required to appoint a designated representative.

(24) "Dignity" means providing support in such a way as to validate the self-worth of the individual. Dignity is supported by creating an environment that allows personal assistance to be provided in privacy and by delivering services in a manner that shows courtesy and respect.

(25) "Direct Care Staff" means a facility employee whose primary responsibility is to provide personal care services to residents. These personal care services may include:

(a) Medication administration.

(b) Resident-focused activities.

(c) Assistance with activities of daily living.

(d) Supervision and support of residents.

(e) Serving meals, but not meal preparation.

(26) "Directly Supervised" means a qualified staff member maintains visual contact with the supervised staff.

(27) "Director" means the Director of the Department or that individual's designee.

(28) "Disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or man-made, that renders the licensee unable to operate the facility or makes the facility uninhabitable.

(29) "Disclosure" means the written information the facility is required to provide to consumers to enhance the understanding of facility costs, services, and operations.

(30) "Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation of a state.

(31) "Exception" means a written variance granted by the Department from a regulation or provision of these rules.

(32) "Facility" means the residential care or assisted living facility licensee and the operations, policies, procedures, and employees of the residential care or assisted living facility. For purposes of HCBS, "facility" can also mean "provider".

(33) "FPS" means the Facilities, Planning, and Safety Program within the Public Health Division of the Oregon Health Authority (OHA).

(34) "HCB" means "Home and Community-Based".

(35) "HCBS" means "Home and Community-Based Services." HCBS are services provided in the home or community of an individual. DHS, Office of Licensing and Regulatory Oversight and OHA provide oversight and license, certify, and endorse programs, settings, or settings designated as HCB.

(36) "Homelike Environment" means a living environment that creates an atmosphere supportive of the resident's preferred lifestyle. Homelike environment is also supported by the use of residential building materials and furnishings.

(37) "Immediate Jeopardy" means a situation where the failure of a residential care facility to comply with a Department rule has caused, or is likely to cause, a resident:

(a) Serious injury;

(b) Serious harm;

(c) Serious impairment; or

(d) Death.

(38) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interests.

(39) "Independence" means supporting resident capabilities and facilitating the use of those abilities. Creating barrier free structures and careful use of assistive devices supports independence.

(40) "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.

(41) "Individual" means a person enrolled in or utilizing HCBS.

(42) "Individually-Based Limitation" means any limitation to the qualities outlined in OAR 411-004-0020 (1)(d) and (2)(d) to (2)(j), due to health and safety risks. An individually-based limitation is based on specific assessed need and only implemented with the informed consent of the individual, or as applicable the legal representative, as described in OAR 411-004-0040.

(43) "Informed Consent" means options, risks, and benefits have been explained to an individual, and, as applicable, the legal representative of the individual, in a manner that the individual, and, as applicable, the legal representative, comprehends.

(44) "Individuality" means recognizing variability in residents' needs and preferences and having flexibility to organize services in response to different needs and preferences.

(45) "Intensive Intervention Community (IIC)" means an RCF endorsed to house fewer than six socially dependent individuals or individuals with physical disabilities. The purpose of the IIC is to serve individuals with co-

occurring mental, emotional, or behavioral disturbances who are more appropriately served in smaller settings.

(46) "Licensed Nurse" means an Oregon licensed practical or registered nurse.

(47) "Licensee" means the entity that owns the residential care or assisted living facility business, and to whom an assisted living or residential care facility license has been issued.

(48) "Legal Representative" means a person who has the legal authority to act for an individual.

(a) The legal representative only has authority to act within the scope and limits of his or her authority as designated by the court or other agreement. Legal representatives acting outside of his or her authority or scope must meet the definition of designated representative.

(b) For an individual 18 years of age and older, a guardian appointed by a court order or an agent legally designated as the health care representative, where the court order or the written designation provide authority for the appointed or designated person to make the decisions indicated where the term "legal representative" is used in this rule.

(49) "Major Alteration":

(a) Means:

(A) Any structural change to the foundation, floor, roof, exterior, or load bearing wall of a building;

(B) The addition of floor area to an existing building; or

(C) The modification of an existing building that results in a change in use where such modification affects resident services or safety.

(b) Does not include, cosmetic upgrades to the interior or exterior of an existing building (for example: changes to wall finishes, floorings, or casework).

(50) "Management" or "Operator" means possessing the right to exercise operational or management control over, or directly or indirectly conduct, the day-to-day operation of a facility.

(51) "Modified Special Diet" means a diet ordered by a physician or other licensed health care professional that may be required to treat a medical condition (for example: heart disease or diabetes).

(a) Modified special diets include, but are not limited to:

(A) Small frequent meals;

(B) No added salt;

(C) Reduced or no added sugar; and

(D) Simple textural modifications.

(b) Medically complex diets are not included.

(52) "New Construction" means:

(a) A new building.

(b) An existing building or part of a building that is not currently licensed.

(c) A major alteration to an existing building.

(d) Additions, conversions, renovations, or remodeling of existing buildings.

(53) "Nursing Care" means the practice of nursing as governed by ORS chapter 678 and OAR chapter 851.

(54) "OHA" means the Oregon Health Authority.

(55) "Owner" means an individual with an ownership interest.

(56) "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of an entity.

(57) "Person-Centered Service Plan" means the details of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety, as described in OAR 411-004-0030.

(a) FOR INDIVIDUALS RECEIVING MEDICAID. The person-centered service plan coordinator completes the person-centered service plan.

(b) FOR NON-MEDICAID INDIVIDUALS. The person-centered service plan may be completed by the resident, and as applicable, the representative of the individual, and others as chosen by the individual. The licensee may assist non-Medicaid individuals in developing person-centered service plans when no alternative resources are available. The elements of the individual's person-centered service plan may be incorporated into the resident's care plan.

(58) "Person-Centered Service Plan Coordinator" means a:

(a) Resident's AAA or APD case manager assigned to provide case management services or person-centered service planning for and with individuals; or

(b) Person of the individual's choice for individuals who pay privately.

(59) "Personal Incidental Funds (PIF)" means the monthly amount allowed each Medicaid resident for personal incidental needs. For purposes of this definition, personal incidental funds include monthly payments, as allowed, and previously accumulated resident savings.

(60) "Pre-Service Training" means training that must be completed before direct care staff provide care to residents.

(61) "Primary Care Provider" means the health care provider primarily responsible for the on-going diagnosis and treatment of the resident where they currently reside.

~~(61)~~(62) "Privacy" means a specific area or time over which the resident maintains a large degree of control. Privacy is supported with services that are delivered with respect for the resident's civil rights.

~~(62)~~(63) "Provider" means any person or entity providing HCBS.

~~(63)~~(64) "P.R.N." means those medications and treatments that have been ordered by a qualified practitioner to be administered as needed.

~~(64) "Psychoactive Medications" mean medications used to alter mood, level of anxiety, behavior, or cognitive processes. Psychoactive medications include antidepressants, anti-psychotics, sedatives, hypnotics, and anti-anxiety medications.~~

(65) Psychotropic Medications" means any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to drugs in the following categories:

(a) Anti-psychotic.

(b) Anti-depressant.

(c) Anti-anxiety.

(d) Hypnotic

~~(65)~~(66) "Quality Measurement Program" means the quality metrics program, as described in OAR 411-054-0320.

~~(66)~~(67) "Quality Measurement Council" means a group of individuals appointed by the Governor to develop and oversee the Quality Metric Reporting Program as described in OAR 411-054-0320.

~~(67)~~(68) "Remodel" means a renovation or conversion of a building that requires a building permit and meets the criteria for review by the Facilities Planning and Safety Program as described in OAR 333-675-0000.

~~(68)~~(69) "Renovate" means to restore to good condition or to repair.

~~(69)~~(70) "Residency Agreement" means the written, legally enforceable agreement between a facility and an individual, or legal representative receiving services in a residential setting.

~~(70)~~(71) "Resident" means any individual who is receiving room, board, care, and services on a 24-hour basis in a residential care or assisted living facility for compensation.

~~(71)~~(72) "Residential Care Facility (RCF)" means a building, complex, or distinct part thereof, consisting of shared or individual living units in a homelike surrounding, where six or more seniors and adult individuals with disabilities may reside. The residential care facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, individuality, and independence.

(73) "Resident Evaluation" means an evaluation that uses the information obtained when addressing the elements required in OAR 411-054-0034 (5). The evaluation identifies the resident's preferences, strengths, relationships and activities that are meaningful to them as well as their physical health status and environmental factors that help them function at their optimal level. The resident evaluation provides the foundation of the resident's service plan.

~~(72)~~(74) "Restraint" means:

(a) Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the individual's body that the individual cannot remove easily, which

restricts freedom of movement or normal access of the individual to the individual's body. Any manual method includes physically restraining someone by manually holding someone in place.

(c) Chemical restraints are any substance or drug used for the purpose of discipline or convenience that has the effect of restricting the individual's freedom of movement or behavior and is not used to treat the individual's medical or psychiatric condition.

~~(73)~~(75) "Retaliation" means to threaten, intimidate, or take an action that is detrimental to an individual (for example, harassment, abuse, or coercion).

~~(74)~~(76) "Risk Agreement" means a process where a resident's high-risk behavior or choices are reviewed with the resident. Alternatives to and consequences of the behavior or choices are explained to the resident and the resident's decision to modify behavior or accept the consequences is documented.

~~(75)~~(77) "Service Plan" means a written, individualized plan for services, developed by a service planning team and the resident or the resident's legal representative, that reflects the resident's capabilities, choices, and if applicable, measurable goals, and managed risk issues. The service plan defines the division of responsibility in the implementation of the services.

~~(76)~~(78) "Service Planning Team" means two or more individuals, as set forth in OAR 411-054-0036, that assist the resident in determining what services and care are needed, preferred, and may be provided to the resident. For IICs, the term "interdisciplinary team" is synonymous with "service planning team."

~~(77)~~(79) "Services" mean supervision or assistance provided in support of a resident's needs, preferences, and comfort, including health care and activities of daily living, that help develop, increase, maintain, or maximize the resident's level of independent, psychosocial, and physical functioning.

~~(78)~~(80) "Subject Individual" means any individual 16 years of age or older on whom the Department may conduct a background check as defined in OAR 407-007-0210 and from whom the Department may require fingerprints for the purpose of conducting a national background check.

(a) For the purpose of these rules, subject individual includes:

(A) All applicants, licensees and operators of a residential care or assisted living facility.

(B) All individuals employed or receiving training in an assisted living or residential care facility.

(C) Volunteers, if allowed unsupervised access to residents.

(b) For the purpose of these rules, subject individual does not apply to:

(A) Residents and visitors of residents.

(C) Individuals that provide services to residents who are employed by a private business not regulated by the Department.

~~(79)~~(81) "Substantial Compliance" means a level of compliance with state law and rules of the Department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents of a facility.

~~(80)~~(82) "Supportive Device" means a device that may have restraining qualities that supports and improves a resident's physical functioning.

~~(81)~~(83) "These Rules" mean the rules in OAR chapter 411, division 054.

~~(82)~~(84) "Underserved" means services are significantly unavailable within the service area in a comparable setting for:

(a) The general public.

(b) A specific population, for example, residents with dementia or traumatic brain injury.

~~(83)~~(85) "Unit" means the personal and sleeping space of an individual receiving services in a RCF or ALF setting, as agreed to in the Residency Agreement.

~~(84)~~(86) "Universal Worker" means a facility employee whose assignments include other tasks (for example, housekeeping, laundry, or food service) in addition to providing direct resident services. Universal worker does not include administrators, clerical or administrative staff, building maintenance staff, or licensed nurses who provide services as specified in OAR 411-054-0034.

Stat. Auth.: ORS 410.070, 443.450, 443.738
Stats. Implemented: ORS 443.400 - 443.455, 443.738, 443.991

411-054-0034 Resident Move-In and Evaluation *(Amended 06/28/2016)*

(1) INITIAL SCREENING AND MOVE-IN.

(a) The facility must determine whether a potential resident meets the facility's admission requirements.

(b) Before the resident moving in, the facility must conduct an initial screening to determine the prospective resident's service needs and preferences. The screening must determine the ability of the facility to meet the potential resident's needs and preferences, while considering the needs of the other residents and the facility's overall service capability.

(c) Each resident record must, before move-in and when updated, include the following information:

(A) Prior living arrangements;

(B) Emergency contacts;

(C) Service plan involvement - resident, family, and social supports;

(D) Financial and other legal relationships, if applicable, including, but not limited to:

(i) Advance directives;

(ii) Guardianship;

(iii) Conservatorship; and

(iv) Power of attorney.

(E) Primary language;

(F) Community connections; and

(G) Health and social service providers.

(2) RESIDENT EVALUATION - GENERAL. The resident evaluation identifies the resident's preferences, strengths and relationships, as well as activities that are meaningful to the individual. It describes the resident's physical health status, mental status, and the environmental factors that help the individual function at optimal level. The evaluation is the foundation that a facility uses to develop the resident's service plan ~~and reflects the resident's current health and mental status~~. The evaluation information may be collected using tools and protocols established by the facility, but must contain the elements stated in this rule.

(a) Resident evaluations must be:

(A) Performed before the resident moves into the facility, with updates and changes as appropriate within the first 30 days; and

(B) Performed at least quarterly, to correspond with the quarterly service plan updates.

(C) Reviewed and any updates must be documented each time a resident has a significant change in condition.

(D) Done in person and the facility must gather data that is relevant to the needs and current condition of the resident.

(D) Documented, dated, and indicate who was involved in the evaluation process.

(b) 24 months of past evaluations must be kept in the resident's files in an accessible, on-site location.

(c) The facility administrator is responsible for assuring only trained and experienced staff perform resident evaluations.

(3) EVALUATION REQUIREMENTS AT MOVE-IN.

(a) The resident evaluation must be completed before the resident moves into the facility. This evaluation provides baseline information of the resident's physical and mental condition at move-in.

(b) If there is an urgent need and the evaluation is not completed before move-in, the facility must document the reasons and complete the evaluation within eight hours of move-in.

(c) The initial evaluation must contain the elements specified in section (5) of this rule, and address sufficient information to develop an initial service plan to meet the resident's needs.

(d) The initial evaluation must be updated and modified as needed during the 30 days following the resident's move into the facility.

(e) 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) QUARTERLY EVALUATION REQUIREMENTS.

(a) Resident evaluations must be performed quarterly after the resident moves into the facility.

(b) The quarterly evaluation is the basis of the resident's quarterly service plan.

(c) The most recent quarterly evaluation, with documented change of condition updates, must be in the resident's current record and available to staff.

(d) If the evaluation is revised and updated at the quarterly review, changes must be dated and initialed and prior historical information must be maintained.

(5) The resident evaluation must address the following elements:

(a) Resident routines and preferences including:

(A) Customary routines, such as those related to sleeping, eating and bathing~~, dietary,~~;

~~(A)~~(B) Interests, hobbies, social, and leisure activities;

~~(B)~~(C) Spiritual and cultural preferences and traditions; and

~~(C)~~ Additional elements as listed in 411-054-0027(2).

(b) Physical health status including:

(A) List of current diagnoses;

(B) List of medications and PRN use;

(C) Visits to health practitioners, emergency room, hospital, or nursing facility in the past year; and

(D) Vital signs if indicated by diagnoses, health problems, or medications.

~~(b)~~(c) Mental health issues including:

(A) Presence of depression, thought disorders, or behavioral or mood problems;

(B) History of treatment; and

(C) Effective non-drug interventions.

~~(c)~~(d) Cognition, including:

(A) Memory;

(B) Orientation;

(C) Confusion; and

(D) Decision making abilities.

~~(d)~~(e) Personality, including how the person copes with change or challenging situations.

~~(e)~~(f) Communication and sensory abilities including:

(A) Hearing;

(B) Vision;

(C) Speech;

(D) Use of ~~A~~assistive devices; and

(E) Ability to understand and be understood.

~~(f)~~(g) Activities of daily living including:

(A) Toileting, bowel, and bladder management;

(B) Dressing, grooming, bathing, and personal hygiene;

(C) Mobility - ambulation, transfers, and assistive devices; and

(D) Eating, dental status, and assistive devices.

~~(g)~~(h) Independent activities of daily living including:

(A) Ability to manage medications;

(B) Ability to use call system;

(C) Housework and laundry; and

(D) Transportation.

~~(h)~~(i) Pain - pharmaceutical and non-pharmaceutical interventions, including how a person expresses pain or discomfort.

~~(i)~~(j) Skin condition.

~~(j)~~(k) Nutrition habits, fluid preferences, and weight if indicated.

~~(k)~~(l) List of treatments - type, frequency, and level of assistance needed.

~~(l)~~(m) Indicators of nursing needs, including potential for delegated nursing tasks.

~~(m)~~(n) Review of risk indicators including:

(A) Fall risk or history;

(B) ~~(B)~~ Emergency evacuation ability;

(C) Complex medication regimen;

(D) History of dehydration or unexplained weight loss or gain;

(E) Recent losses;

(F) Unsuccessful prior placements;

(G) Elopement risk or history;

(H) Smoking. The resident's ability to smoke without causing burns or injury to themselves or others or damage to property must be evaluated and addressed in the resident's service plan; and

(I) Alcohol and drug use. The resident's use of alcohol or the use of drugs not prescribed by a physician must be evaluated and addressed in the resident's service plan.

(o) Environmental factors that impact the resident's behavior including but not limited to:

(A) Noise.

(B) Lighting.

~~(A)~~(C) Room temperature.

(6) If the information has not changed from the previous evaluation period, the information does not need to be repeated. A dated and initialed notation of no changes is sufficient. The prior evaluation must then be kept in the current resident record for reference.

Stat. Auth.: ORS 410.070, 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991

OAR 411-054-0055 Medications and Treatments

(6) ~~PSYCHOACTIVE~~ PSYCHOTROPIC MEDICATION. ~~Pscyhoactive~~Psychotropic medications may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use.

(a) Facility-administered ~~psychoactive~~psychotropic medications may be used only when required to treat a resident's medical symptoms or to maximize a resident's functioning.

(b) The facility must not request ~~psychoactive~~psychotropic medication to treat a resident's behavioral symptoms without a consultation from a physician, nurse practitioner, registered nurse, or mental health professional. Prior to requesting a psychotropic medication, the facility must demonstrate through the evaluation and service planning process that they have attempted non-pharmacological interventions.

(c) Prior to administering any ~~psychoactive~~ psychotropic medications to treat a resident's behavior, all direct care staff administering medications for the resident must know:

(A) The specific reasons for the use of the ~~psychoactive~~psychotropic medication for that resident.

(B) The common side effects of the medications.

(C) When to contact a health professional regarding side effects.

(d) When a psychotropic medication is ordered by a health care practitioner other than the resident's primary care provider, the facility is responsible for notifying the resident's primary care provider of that medication order within 72 hours of when the order was given. This includes weekends and holidays. Notification may be either by telephone or electronic submission and should be documented by the facility.

(Rest of section will be renumbered accordingly.)