DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 325

24-HOUR RESIDENTIAL PROGRAMS AND SETTINGS FOR CHILDREN AND ADULTS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

EFFECTIVE FEBRUARY 15, 2019

411-325-0010 Statement of Purpose
(Amended 02/15/2019)

(1) The rules in OAR chapter 411, division 325 prescribe standards, responsibilities, and procedures for 24-hour residential programs delivering home and community-based services to individuals with intellectual or developmental disabilities in 24-hour residential settings.

(2) These rules incorporate the provisions for home and community-based services and settings, person-centered service planning, and individually-based limitations, set forth in OAR chapter 411, division 004.

(3) These rules and the rules in OAR chapter 411, division 004 ensure individuals with intellectual or developmental disabilities receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving home and community-based services.

(4) Effective September 1, 2018, each 24-hour residential setting must be in full compliance with the requirements for home and community-based services and settings set forth in OAR chapter 411, division 004. All setting and individually-based limitation requirements of home and community-based settings and services must be fully implemented.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384,

443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0020 Definitions and Acronyms
(Amended 02/15/2019)

In addition to the following definitions, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 325. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

(1) "24-Hour Residential Program" means the distinct method for the delivery of home and community-based services in a 24-hour residential setting by a provider certified and endorsed according to the rules in OAR chapter 411, division 323.

(2) "24-Hour Residential Setting" means a residential home, apartment, or duplex, licensed by the Department under ORS 443.410, where home and community-based services are provided to individuals with intellectual or developmental disabilities. A 24-hour residential setting is considered a provider owned, controlled, or operated residential setting.

(3) "Apartment" means "24-hour residential setting" as defined in this rule.

(4) "Applicant" means a person, agency, corporation, or governmental unit, who applies for a license to deliver home and community-based services in a 24-hour residential setting.

(5) "CDDP" means "Community Developmental Disabilities Program".

(6) "Certificate" means the document issued by the Department to a provider that certifies the provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the delivery of services through an endorsed 24-hour residential setting.

(7) "Denial" means the refusal of the Department to issue a certificate, endorsement, or license to operate a 24-hour residential program or 24-hour residential setting because the Department has determined the provider or the home is not in compliance with these rules or the rules in OAR chapter 411, division 323.

(8) "Duplex" means "24-hour residential setting" as defined in this rule.

(9) "Educational Surrogate" means the person who acts in place of the parent of a child in safeguarding the rights of the child in the public education decision-making process:

(a) When the parent of the child cannot be identified or located after reasonable efforts.

(b) When there is reasonable cause to believe the child has a disability and is a ward of the state.

(c) At the request of the parent of the child or young adult student.

(10) "Endorsement" means the authorization to deliver services in a 24-hour residential setting. An endorsement is issued by the Department to a certified provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(11) "Executive Director" means the person designated by a board of directors or corporate owner responsible for the operation of a 24-hour residential program and the delivery of services in a 24-hour residential setting.

(12) "Home" means "24-hour residential setting" as defined in this rule.

(13) "ISP" means "Individual Support Plan".

(14) "License" means a document granted by the Department to an applicant who is in compliance with the requirements of these rules and the rules in OAR chapter 411, division 323.

(15) "Licensee" means the person or organization to whom a certificate, endorsement, and license is granted.

(16) "Modified Diet" means the texture or consistency of food or drink is altered or limited, such as no hard foods, thickened fluids, mechanical soft, finely chopped, pureed, or bread only soaked in milk.

(17) "Nursing Services" means the provision of individual-specific advice, plans, or interventions by a nurse at a home based on the nursing process as outlined by the Oregon State Board of Nursing. Nursing services differ from administrative nursing services.

(18) "OCCS" means the "Office of Client and Community Services".

(19) "OIS" means "Oregon Intervention System".

(20) "Oregon Core Competencies" means:

(a) The list of skills and knowledge required for newly hired staff in the areas of health, safety, rights, values and personal regard, and the mission of the provider.

(b) The associated timelines in which newly hired staff must demonstrate the competencies.

(21) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(22) "Revocation" means the action taken by the Department to rescind a certificate, endorsement, or license to operate a 24-hour residential program or 24-hour residential setting after the Department determines a provider or home is not in compliance with one or more of these rules or the rules in OAR chapter 411, division 323.

(23) "Special Diets" means the specially prepared food or particular types of food specific to the medical condition or diagnosis of an individual and in support of an evidence-based treatment regimen. Examples of special diets include, but are not limited to, low calorie, high fiber, diabetic, low salt, lactose free, or low fat diets. Special diets do not include a diet where extra or additional food is offered without the order of a physician but may not be eaten, such as offering prunes each morning at breakfast or including fresh fruit with each meal.

(24) "Suspension" means an immediate temporary withdrawal of the approval to operate a 24-hour residential program or 24-hour residential setting after the Department determines a provider or home is not in compliance with one or more of these rules or the rules in OAR chapter 411, division 323.

(25) "These Rules" mean the rules in OAR chapter 411, division 325.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0025 Program Management
(Amended 02/15/2019)

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To operate a 24-hour residential program, a provider must have:

(a) A certificate and an endorsement for a 24-hour residential program as set forth in OAR chapter 411, division 323;

(b) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370; and

(c) For each specific geographic service area where 24-hour residential services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

(2) INSPECTIONS AND INVESTIGATIONS. A provider must allow inspections and investigations as described in OAR 411-323-0040.

(3) MANAGEMENT AND PERSONNEL PRACTICES. A provider must comply with the management and personnel practices as described in OAR 411-323-0050.

(4) STAFFING SURVEY.

(a) A provider must submit annual staffing data to the nationally standardized reporting survey organization specified by the Department.

(b) A provider must ensure completion of the direct support worker staffing survey by the provider’s employees when required by the Department.

(5) COMPETENCY BASED TRAINING PLAN. A provider must have and implement a Competency Based Training Plan that meets, at a minimum, the competencies and timelines set forth in the Department's Oregon Core Competencies. At a minimum, the Competency Based Training Plan must:

(a) Address health, safety, rights, values, personal regard, and the mission of the provider.

(b) Describe competencies, training methods, timelines, how competencies of staff are determined and documented, including steps for remediation, and when a competency may be waived by the provider to accommodate the specific circumstances of a staff member.

(6) GENERAL STAFF QUALIFICATIONS. Each staff member providing direct assistance to individuals must:

(a) Have knowledge of the ISPs for all individuals and all medical, behavioral, and additional supports required by the individuals; and

(b) Have met the basic qualifications in the Competency Based Training Plan. The provider must maintain and keep current written documentation that the staff member has demonstrated competency in areas identified by the Competency Based Training Plan as required by section (5) of this rule, and that is appropriate to their job description.

(7) CONFIDENTIALITY OF RECORDS. A provider must ensure all individuals' records are confidential as described in OAR 411-323-0060.

(8) DOCUMENTATION REQUIREMENTS. Unless stated otherwise, all entries required by these rules must:

(a) Be prepared at the time of, or immediately following, the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than three years.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0030 Issuance of License
(Amended 02/15/2019)

(1) No person, agency, or governmental unit acting individually or jointly with any other person, agency, or governmental unit shall establish, conduct, maintain, manage, or operate a 24-hour residential program without being licensed for each 24-hour residential setting.

(2) A license is not transferable and is only applicable to the location, home, agency, management agent, or ownership indicated on the application and license.

(3) The Department issues a license to an applicant found to be in compliance with these rules and the rules in OAR chapter 411, divisions 004, 304, 318, and 323. A license is in effect for two years from the date issued unless revoked or suspended.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0040 Application for Initial License
(Amended 06/29/2016)

(1) At least 30 days prior to anticipated licensure, an applicant must submit an application and required non-refundable fee. The application is provided by the Department and must include all information requested by the Department.

(2) The application must identify the number of beds the 24-hour residential setting is presently capable of operating at the time of application, considering existing equipment, ancillary service capability, and the physical requirements as specified by these rules. For purposes of license

renewal, the number of beds to be licensed may not exceed the number identified on the license to be renewed unless approved by the Department.

(3) The initial application must include --

(a) A copy of any lease agreements or contracts, management agreements or contracts, and sales agreements or contracts, relative to the operation and ownership of the home;

(b) A floor plan of the home showing the location and size of rooms, exits, smoke alarms, and extinguishers; and

(c) A copy of the Residency Agreement as described in OAR 411-325-0300.

(4) If a scheduled, onsite licensing inspection reveals that an applicant is not in compliance with these rules as attested to on the Licensing Onsite Inspection Checklist, the onsite licensing inspection may be rescheduled at the convenience of the Department.

(5) Applicants may not admit any individual to the home prior to receiving a written confirmation of licensure from the Department.

(6) If an applicant fails to provide complete, accurate, and truthful information during the application and licensing process, the Department may cause initial licensure to be delayed or may deny or revoke the license.

(7) Any applicant or person with a controlling interest in an agency is considered responsible for acts occurring during, and relating to, the operation of such home for the purpose of licensing.

(8) The Department may consider the background and operating history of each applicant and each person with a controlling ownership interest when determining whether to issue a license.

(9) When an application for initial licensure is made by an applicant who owns or operates other licensed homes or facilities in Oregon, the Department may deny the license if the applicant's existing home or facility

is not, or has not been, in substantial compliance with the Oregon Administrative Rules.

(10) Separate licenses are not required for separate buildings located contiguously and operated as an integrated unit by the same management.

(11) A provider may not admit an individual whose service needs exceed the classification on the license of the home without prior written consent of the Department.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400 - 443.455

411-325-0050 License Expiration, Termination of Operations, and License Return
(Amended 12/28/2013)

(1) Unless revoked, suspended, or terminated earlier, each license to operate a residential home expires two years following the date of issuance.

(2) If the operation of a home is discontinued for any reason, the license is considered to have been terminated.

(3) Each license is considered void immediately if the operation of a home is discontinued by voluntary action of the licensee or if there is a change in ownership.

(4) The license must be returned to the Department immediately upon suspension or revocation of the license or when operation is discontinued.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0060 License Conditions
(Amended 02/15/2019)

The Department may attach conditions to a license that limit, restrict, or specify other criteria for operation of a home. The type of condition

attached to a license must directly relate to the risk of harm or potential risk of harm to individuals.

(1) The Department may attach a condition to a license upon a finding that:

(a) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(b) A threat to the health, safety, or welfare of an individual exists;

(c) There is reliable evidence of abuse;

(d) The home is not being operated in compliance with these rules or the rules in OAR chapter 411, divisions 004, 304, 318, and 323; or

(e) A provider is licensed to provide services for a specific individual only and further placements may not be made into the home.

(2) Conditions the Department may impose on a license include, but are not limited to, the following:

(a) Restricting the total number of individuals to whom a provider may deliver services;

(b) Restricting the total number of individuals within a licensed classification level based upon the capability and capacity of a provider and staff to meet the health and safety needs of all individuals;

(c) Restricting the type of support and services within a licensed classification level based upon the capability and capacity of a provider and staff to meet the health and safety needs of all individuals;

(d) Requiring additional staff or staff qualifications;

(e) Requiring additional training;

(f) Restricting a provider from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(g) Requiring additional documentation; or

(h) Restricting entry.

(3) The Department issues a written notice to the provider when the Department imposes conditions to a license. The written notice of conditions includes the conditions imposed by the Department, the reason for the conditions, and the opportunity to request a hearing according to ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation which warranted the condition has been remedied.

(4) A provider may request a hearing in accordance with ORS chapter 183 and this rule upon receipt of written notice of conditions. The request for a hearing must be in writing.

(a) The provider must request a hearing within 21 calendar days from the date of the written notice of conditions.

(b) In addition to, or in lieu of a hearing, the provider may request an administrative review as described in section (5) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish the right of the provider to a hearing.

(5) ADMINISTRATIVE REVIEW.

(a) In addition to the right to a hearing, a provider may request an administrative review by the Director of the Department for imposition of conditions. The request for an administrative review must be in writing.

(b) The Department must receive a written request for an administrative review within 10 business days from the date of the notice of conditions. The provider may submit, along with the written request for an administrative review, any additional written materials

the provider wishes to have considered during the administrative review.

(c) The determination of the administrative review is issued in writing within 10 business days from the date of the written request for an administrative review, or by a later date as agreed to by the provider.

(d) The provider may request a hearing if the decision of the Department is to affirm the condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 calendar days from the date of the original written notice of conditions.

(6) A provider may send a written request to the Department to remove a condition if the provider believes the situation that warranted the condition has been remedied.

(7) Conditions must be posted with the license in a prominent location and be available for inspection at all times.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0070 License Renewal
(Amended 02/15/2019)

(1) A license is renewable upon submission of an application to the Department and the payment of the required non-refundable fee, except that no fee is required of a governmental owned home.

(2) Filing of an application and required fee for renewal prior to the expiration date of a license extends the effective date of the license until the Department acts upon the renewal application. If the renewal application and fee are not submitted prior to the expiration date of a license, the home is unlicensed and subject to the civil penalties described in OAR 411-325-0460.

(3) The Department shall conduct a licensing review of a home prior to the renewal of a license. The licensing review shall be unannounced,

conducted 30-120 calendar days prior to expiration of the license, and review compliance with these rules and the rules in OAR chapter 411, divisions 004, 304, 318, and 323.

(4) The Department may not renew a license if the home is not substantially in compliance with these rules or if the State Fire Marshal or the State Fire Marshal's authorized representative has given notice of noncompliance according to ORS 479.220.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0080 Mid-Cycle Review
(Repealed 01/06/2012)

411-325-0090 Change of Ownership, Legal Entity, Legal Status, and Management Corporation
(Amended 12/28/2013)

(1) The service provider must notify the Department in writing of any pending change in ownership or legal entity, legal status, or management corporation.

(2) A new license is required upon change in ownership, legal entity, or legal status. The service provider must submit a license application and required fee at least 30 days prior to change in ownership, legal entity, or legal status.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0100 Inspections and Investigations
(Repealed 01/06/2012 – See OAR 411-323-0040)

411-325-0110 Variances
(Amended 02/15/2019)

(1) The Department may grant a variance to these rules based upon a provider's demonstration that an alternative method or different approach

provides equal or greater effectiveness and does not violate state or federal laws or adversely impact individuals' welfare, health, safety, or rights.

(2) A provider must submit a variance request to the CDDP. The variance request must be on the applicable Department form and contain the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept, or procedure proposed; and

(d) If the variance applies to the services for an individual, evidence the variance is consistent with the individual's currently authorized ISP.

(3) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the provider, the CDDP, and to all relevant Department programs or offices within 30 calendar days from the date of the variance request.

(4) A provider may request an administrative review of the denial of a variance request. The Department must receive a written request for an administrative review within 10 business days from the date of the denial. The provider must send a copy of the written request for an administrative review to the CDDP. The decision of the Director is the final response from the Department.

(5) The duration of the variance is determined by the Department.

(6) A provider may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0120 Medical Services

(Amended 02/15/2019)

(1) A provider must have and implement written policies and procedures that maintain and protect individuals' physical health. The policies and procedures must address the following:

(a) Individual health care;

(b) Medication administration;

(c) Medication storage;

(d) Response to emergency medical situations;

(e) Nursing services, if provided;

(f) Disposal of medications; and

(g) Early detection and prevention of infectious disease.

(2) INDIVIDUAL HEALTH CARE.

(a) A provider must ensure an individual receives care that promotes the health and well-being of the individual as follows:

(A) The provider must ensure the individual has a primary physician or health care provider whom the individual has chosen from among qualified providers. Provisions must be made for a secondary physician or clinic in the event of an emergency.

(B) The provider must ensure the individual receives a medical evaluation by a qualified health care provider no fewer than every two years or as recommended by a physician.

(C) The provider must monitor the health status and physical conditions of the individual and take action in a timely manner in response to identified changes or conditions that may lead to deterioration or harm.

(b) A written, signed order from a physician or qualified health care provider is required prior to the usage or implementation of all of the following:

(A) Prescription medications;

(B) Non-prescription medications except over the counter topical;

(C) Treatments other than basic first aid;

(D) Modified or special diets;

(E) Adaptive equipment; and

(F) Aids to physical functioning.

(c) A provider must implement the order of a physician or qualified health care provider.

(d) A provider must maintain records on each individual to aid physicians, licensed health professionals, and the provider in understanding the medical history of the individual. The record must include:

(A) A list of known health conditions, medical diagnoses, known allergies, and immunizations;

(B) A record of visits to licensed health professionals that include documentation of the consultation and any therapy provided; and

(C) A record of known hospitalizations and surgeries.

(3) MEDICATION.

(a) All medications must be:

(A) Kept in their original containers;

(B) Labeled by the dispensing pharmacy, product manufacturer, or physician, as specified per the written order of a physician or qualified health care provider; and

(C) Kept in a secured locked container and stored as indicated by the product manufacturer.

(b) All medications and treatments must be recorded on an individualized medication administration record (MAR). The MAR must include:

(A) The name of the individual;

(B) A transcription of the written order of a physician or qualified health care provider, including the brand or generic name of the medication, prescribed dosage, frequency, and method of administration;

(C) For topical medications and treatments without the order of a physician or qualified health care provider, a transcription of the printed instructions from the package;

(D) Times and dates of administration or self-administration of the medication;

(E) Signature of the person administering the medication or the person monitoring the self-administration of the medication;

(F) Method of administration;

(G) An explanation of why a PRN (i.e., as needed) medication was administered;

(H) Documented effectiveness of any PRN (i.e., as needed) medication administration;

(I) An explanation of any medication administration irregularity; and

(J) Documentation of any known allergy or adverse drug reaction.

(c) Self-administration of medication.

(A) The ISP for individuals who independently self-administer medications must include a plan for the periodic monitoring and review of the self-administration of medications.

(B) A provider must ensure that individuals able to self-administer medications keep the medications in a secure locked container unavailable to other individuals residing in the same home and store the medications as recommended by the product manufacturer.

(d) PRN (i.e., as needed) orders are not allowed for psychotropic medication.

(e) Safeguards to prevent adverse effects or medication reactions must be utilized and include:

(A) Whenever possible, obtaining all prescription medication for an individual, except samples provided by a health care provider, from a single pharmacy which maintains a medication profile for the individual;

(B) Maintaining information about the desired effects and side effects of each medication;

(C) Ensuring that medications prescribed for one individual are not administered to, or self-administered by, another individual or staff member; and

(D) Documentation in the record for an individual of the reason all medications are not provided through a single pharmacy.

(f) All expired, discontinued, recalled, or contaminated medications, including over-the-counter medications, may not be kept in a home and must be disposed of within 10 calendar days of expiration, discontinuation, or a provider's knowledge of a recall or

contamination. A provider must dispose of the prescription medications for an individual who has died within 10 calendar days of the individual's death.

(A) A provider must dispose of medications according to the provider's policy. The provider's policy must reflect the medication disposal guidelines issued by the Department of Environmental Quality.

(B) A provider must maintain a written record of the disposal of a medication. The record must include documentation of the following:

(i) Date of disposal;

(ii) Description of the medication, including dosage, strength, and amount being disposed;

(iii) Name of the individual for whom the medication was prescribed;

(iv) Reason for disposal;

(v) Method of disposal;

(vi) Signature of the person disposing of the medication; and

(vii) For controlled medications, the signature of a witness to the disposal.

(4) NURSING SERVICES. When nursing services are provided to an individual, a provider must:

(a) Coordinate with a registered nurse and the individual's ISP team to ensure the nursing services being provided are sufficient to meet the health needs of the individual; and

(b) Implement the Nursing Service Plan, or appropriate portions therein, as agreed upon by the individual's ISP team and the registered nurse.

(5) DELEGATION AND SUPERVISION OF NURSING TASKS. Nursing tasks must be delegated by a registered nurse to a provider in accordance with the rules of the Oregon State Board of Nursing in OAR chapter 851, division 047.

(6) DIRECT NURSING SERVICES. Upon official approval from the Centers for Medicare and Medicaid Services, direct nursing services may be provided to individuals 21 years of age and older in accordance with OAR chapter 411, division 380.

(a) A provider of a 24-hour residential setting may deliver direct nursing services to an individual in the 24-hour residential setting under the following conditions:

(A) The provider must be endorsed to OAR chapter 411, division 380 in accordance with OAR chapter 411, division 323, and the staff delivering the direct nursing services must meet the qualifications described in OAR 411-380-0060;

(B) More than one individual who receives Department-funded services must reside in the 24-hour residential setting;

(C) The provider must be the individual's, or as applicable the individual's legal representative's, provider of choice for direct nursing services;

(D) Direct nursing services are not delivered at the 24-hour residential setting for the convenience of the provider or 24-hour residential program; and

(E) The provider meets the requirements as an enrolled Medicaid Provider as described in OAR 411-380-0060 and has a separate and distinct Medicaid provider number for the provision of direct nursing services.

(b) A Nursing Service Plan must be present when Department funds are used for direct nursing services. The provision of direct nursing services must be authorized by a case manager as identified in an ISP.

(c) When direct nursing services are provided to an eligible individual by a provider, the provider must:

(A) Coordinate with the registered nurse and the individual's ISP team to ensure the direct nursing services being provided are sufficient to meet the individual's health needs;

(B) Implement the Nursing Service Plan, or appropriate portions therein, as agreed upon by the individual's ISP team and the registered nurse; and

(C) While delivering direct nursing services exclusively to the individual, assure the needs of other individuals in the home are met.

(7) A provider must immediately notify an individual's case manager, and document the notification, when the individual's medical, behavioral, or physical needs change to a point that they may not be met by the provider.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0130 Food and Nutrition
(Amended 02/15/2019)

(1) A provider must support an individual's freedom to have access to his or her personal food at any time. A limitation may only be used when there is a health or safety risk and written informed consent is obtained as described in OAR 411-325-0430 and OAR 411-004-0040.

(2) Three nutritious meals and two snacks must be provided daily. Meals must be offered at times consistent with those in the community.

(a) Each meal must include food from the basic food groups according to the United States Department of Agriculture (USDA) and include fresh fruit and vegetables when in season, unless otherwise specified in writing by a health care provider.

(b) Food preparation must include consideration of cultural and ethnic backgrounds, as well as the food preferences of individuals. Special consideration must be given to individuals with chewing difficulties and other eating limitations as described in section (3) of this rule.

(c) If an individual misses or plans to miss a meal at a scheduled time, or requests an alternate mealtime, an alternative meal must be made available. Individuals are not restricted to specific mealtimes and are encouraged to choose when, where, and with whom to eat.

(d) Provision of food beyond the required three meals and two snacks are the responsibility of the individual.

(3) MODIFIED OR SPECIAL DIETS. For an individual with a modified or special diet ordered by a physician or health care provider, a provider must:

(a) Have menus for the current week that provide food and beverages that consider the preferences of the individual and are appropriate to the modified or special diet; and

(b) Maintain documentation that identifies how the modified or special diets is prepared and served to the individual.

(4) Unpasteurized milk and juice and home canned meats and fish may not be served or stored in a home.

(5) A provider must maintain adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days on the premises.

(6) Food must be stored, prepared, and served in a sanitary manner.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384,

443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0140 Physical Environment
(Amended 02/15/2019)

(1) All floors, walls, ceilings, windows, furniture, and fixtures must be kept in good repair, clean, and free from odors. Walls, ceilings, and floors must be of such character to permit frequent washing, cleaning, or painting.

(2) The interior and exterior must be well and safely maintained and accessible according to individuals' needs.

(3) The water supply and sewage disposal must meet the requirements of the current rules of the Oregon Health Authority governing domestic water supply.

(4) A public water supply must be utilized if available. If a non-municipal water source is used, a sample must be collected yearly by a provider, sanitarian, or technician from a certified water-testing laboratory. The water sample must be tested for coliform bacteria and action taken to ensure potability. Test records must be retained for three years.

(5) Septic tanks or other non-municipal sewage disposal systems must be in good working order.

(6) Incontinence garments must be disposed of in closed containers.

(7) A provider must establish and implement a policy for the appropriate disposal of biohazards and medical waste.

(8) All heating and cooling devices and systems must be installed in accordance with current building codes and must be in working order. Areas of a home used by individuals must be maintained at a temperature within a comfort range reasonable for the individuals residing in the home. Minimum temperatures when individuals are in the home may not be less than 60 degrees Fahrenheit.

> (a) During times of extreme summer heat, a provider must make every reasonable effort to make the individuals comfortable and safe

using ventilation, fans, or air conditioners. The temperature in a home may not exceed 85 degrees Fahrenheit.

(b) If an individual's needs require a strictly maintained temperature or temperatures outside of a reasonable comfort range, a provider must maintain the environment according to the individual's needs as identified in the individual's ISP.

(9) Screening for workable fireplaces and heaters with exposed heating elements must be provided.

(10) Handrails must be provided on all stairways.

(11) Yard and exterior steps must be accessible and appropriate to the needs of the individuals.

(12) Swimming pools, hot tubs, saunas, or spas must be equipped with safety barriers or devices designed to prevent accidental injury and unsupervised access.

(13) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards. Proof of current rabies vaccinations and any other vaccinations that are required for the pet by a licensed veterinarian must be maintained on the premises. Pets not confined in enclosures must be under control and may not present a danger or health risk to individuals or guests.

(14) All measures necessary must be taken to prevent the entry of rodents, flies, mosquitoes, and other insects.

(15) The interior and exterior of a home must be kept free of litter, garbage, and refuse.

(16) Any work undertaken at a home including, but not limited to, demolition, construction, remodeling, maintenance, repair, or replacement must comply with all applicable state and local building, electrical, plumbing, and zoning codes.

(17) A provider must comply with all applicable legal zoning ordinances pertaining to the number of individuals receiving services at the home.

(18) TELEPHONE.

(a) A telephone must be provided in the home.

(A) The telephone must be available and accessible for individuals 18 years of age and older.

(B) Individuals less than 18 years of age must have reasonable access to the telephone.

(b) The following emergency telephone numbers must be located in an accessible place within a home:

(A) Local CDDP;

(B) Police, fire, and medical, if not served by 911;

(C) Provider agency on-call or designee;

(D) Emergency physician; and

(E) Additional people to be contacted in the case of an emergency.

(c) Telephone numbers for making complaints or a report of alleged abuse to the Department, the local CDDP, and Disability Rights Oregon must also be posted.

(d) A licensee must notify the Department, individuals, and as applicable the individuals' families, legal representatives, and service coordinators, of any change in the home's telephone number within 24 hours of the change.

(19) A poster for the Residential Facilities Ombudsman Program must be posted in a conspicuous location in accordance with ORS 443.392 no later than July 1, 2019.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384,

443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0150 General Safety
(Amended 06/29/2016)

(1) All toxic materials, including, but not limited to poisons, chemicals, rodenticides, and insecticides must be:

(a) Properly labeled;

(b) Stored in the original container separate from all foods, food preparation utensils, linens, and medications; and

(c) Stored in a locked area unless the Risk Tracking records for all individuals residing in the home document that there is no risk present.

(2) All flammable and combustible materials must be properly labeled, stored, and locked in accordance with state fire code.

(3) For children, knives and sharp kitchen utensils must be locked unless otherwise determined by a documented ISP team decision.

(4) Window shades, curtains, or other covering devices must be provided for all bedroom and bathroom windows to assure privacy.

(5) Hot water in bathtubs and showers may not exceed 120 degrees Fahrenheit. Other water sources, except the dishwasher, may not exceed 140 degrees Fahrenheit.

(6) Bedrooms.

(a) Bedrooms on ground level must have at least one window that opens from the inside without special tools that provides a clear opening of not less than 821 square inches, with the least dimension not less than 22 inches in height or 20 inches in width. Sill height may not be more than 44 inches from the floor level. Exterior sill heights may not be greater than 72 inches from the ground, platform, deck, or landing. There must be stairs or a ramp to ground level. Those homes previously licensed having a minimum window opening of not

less than 720 square inches are acceptable unless through inspection it is deemed that the window opening dimensions present a life safety hazard.

(b) Bedrooms must have 60 square feet per individual with beds located at least three feet apart.

(c) If an individual chooses to share a bedroom with another individual, the individuals must be afforded an opportunity to have a choice of roommates.

(d) Single Action Locks.

(A) A 24-hour residential setting licensed on or after January 1, 2016 must have single action locks on the entrance doors to the bedroom for each individual, lockable by the individual, with only appropriate staff having keys.

(B) A 24-hour residential setting licensed prior to January 1, 2016 must have single action locks on the entrance doors to the bedroom for each individual, lockable by the individual, with only appropriate staff having keys by September 1, 2018.

(C) Limitations may only be used when there is a health or safety risk and when a written informed consent is obtained as described in OAR 411-325-0430 and OAR 411-004-0040.

(7) Operative flashlights, at least one per floor, must be readily available to staff in case of emergency.

(8) First-aid kits and first-aid manuals must be available to staff within each home in a designated location. First aid kits must be locked if, after evaluating any associated risk, items contained in the first aid kit present a hazard to individuals living in the home. First aid kits containing any medication including topical medications must be locked.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400 - 443.455

411-325-0160 Program Management and Personnel Practices

(Repealed 01/06/2012 – See OAR 411-323-0050)

411-325-0170 Staffing Requirements
(Amended 02/15/2019)

(1) A home must have staff appropriate to the number of individuals receiving services as follows:

(a) A home with five or fewer individuals must have at least one staff member on the premises of the home when individuals are present.

(b) A 24-hour residential setting with five or fewer individuals in apartments must have at least one staff member on the premises of the apartment complex when individuals are present.

(c) A home with six or more individuals must have at least one staff member on the premises of the home for every 15 individuals during awake and sleeping hours, except homes licensed prior to January 1, 1990.

(d) A home with any number of children must provide at least one awake night staff member on the premises of the home when children are present.

(2) A home is granted an exception to the staffing requirements in sections (1)(a), (1)(b), and (1)(c) when the following conditions have been met:

(a) No more than two adult individuals are to be left alone in the home at any time without on-site staff supervision.

(b) The amount of time an adult individual may be left alone in the home may not exceed five hours within a 24-hour period and the adult individual may not be responsible for any other adult individual or a child in the home or community.

(c) An adult individual may not be left alone in the home without staff supervision between the hours of 11:00 P.M. and 6:00 A.M.

(d) An adult individual may be left alone in the home if the adult individual has a documented history of being able to perform the

following safety measures or there is a documented ISP team decision agreeing to an equivalent alternative practice:

(A) Independently call 911 in an emergency and give relevant information after calling 911;

(B) Evacuate the premises during emergencies or fire drills without assistance in three minutes or less;

(C) Knows when, where, and how to contact their provider in an emergency;

(D) Before opening the door, checks who is there;

(E) Answer the door appropriately, including not inviting strangers into the home;

(F) Safely use small appliances, sharp knives, kitchen stove, and microwave, or if not used safely, understands not to use without a staff present;

(G) Self-administer medications, if applicable;

(H) Safely adjust water temperature at all faucets; and

(I) Safely take a shower or bathe without falling, or if these activities present a risk to the individual, understands not to shower or bathe without a staff present.

(e) There is a documented ISP team decision annually noting team agreement that the adult individual meets the requirements of subsection (d) of this section.

(3) If at any time an adult individual is unable to meet all of the requirements in section (2)(d)(A)-(I) of this rule, a provider may not leave the individual alone without supervision. In addition, the provider must notify the individual's case manager within one business day and request that the individual's ISP team meet to address the ability of the individual to be left alone without supervision.

(4) Each home must meet all requirements for staff ratios as specified by contract requirements.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0180 Individual Summary Sheets
(Amended 02/15/2019)

A provider must maintain a current one to two page summary sheet for each individual receiving services from the provider. The record must include:

(1) The name of the individual and his or her current address, previous address if the individual has lived in the home less than one year, date of entry into the home, date of birth, gender, marital status (for individuals 18 or older), religious preference, preferred hospital, medical prime number and private insurance number (if applicable), and guardianship status; and

(2) The name, address, and telephone number of the following (if applicable):

(a) The legal or designated representative, family, and people significant to the individual, and for a child, the parent and educational surrogate;

(b) The primary care provider and clinic preferred by the individual;

(c) The dentist preferred by the individual;

(d) The identified pharmacy preferred by the individual;

(e) The school, day program, or employer of the individual;

(f) The case manager of the individual, and for Department direct contracts, the Department representative; and

(g) Other agencies and representatives providing services and supports to the individual.

(3) For a child under the age 18, any court-ordered or contacts or limitations authorized by the child's legal representative must also be included on the individual summary sheet.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0185 Emergency Information
(Amended 12/28/2014)

(1) A provider must maintain emergency information for each individual receiving services from the home in addition to the individual summary sheet described in OAR 411-325-0180.

(2) The emergency information must be kept current and must include:

(a) The name of the individual;

(b) The name, address, and telephone number of the provider;

(c) The address and telephone number of the home where the individual lives;

(d) The physical description of the individual, which may include a picture and the date the picture was taken, and identification of:

(A) The race, gender, height, weight range, hair, and eye color of the individual; and

(B) Any other identifying characteristics that may assist in identifying the individual if the need arises, such as marks or scars, tattoos, or body piercings.

(e) Information on the abilities and characteristics of the individual including:

(A) How the individual communicates;

(B) The language the individual uses or understands;

(C) The ability of the individual to know and take care of bodily functions; and

(D) Any additional information that may assist a person not familiar with the individual to understand what the individual may do for him or herself.

(f) The health support needs of the individual, including:

(A) Diagnosis;

(B) Allergies or adverse drug reactions;

(C) Health issues that a person needs to know when taking care of the individual;

(D) Special dietary or nutritional needs, such as requirements around the textures or consistency of foods and fluids;

(E) Food or fluid limitations due to allergies, diagnosis, or medications the individual is taking that may be an aspiration risk or other risk for the individual;

(F) Additional special requirements the individual has related to eating or drinking, such as special positional needs or a specific way foods or fluids are given to the individual;

(G) Physical limitations that may affect the ability of the individual to communicate, respond to instructions, or follow directions; and

(H) Specialized equipment needed for mobility, positioning, or other health-related needs.

(g) The emotional and behavioral support needs of the individual, including:

(A) Mental health or behavioral diagnosis and the behaviors displayed by the individual; and

(B) Approaches to use when dealing with the individual to minimize emotional and physical outbursts.

(h) Any court ordered or legal representative authorized contacts or limitations;

(i) The supervision requirements of the individual and why; and

(j) Any additional pertinent information the provider has that may assist in the care and support of the individual if a natural or man-made disaster occurs.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400-455

411-325-0190 Abuse and Incident Reporting
(Amended 02/15/2019)

(1) IMMEDIATE NOTIFICATION OF ABUSE.

(a) ABUSE. If an incident falls within the scope of abuse as defined in OAR 411-317-0000, a provider must immediately notify an individual's case management entity. In addition to immediately notifying the case management entity, the provider must also immediately notify the following:

(A) Local law enforcement if there is reason to suspect a crime has occurred.

(B) Child Welfare if the allegation of abuse involves a child under the age of 18 years.

(b) The duty to report suspected abuse, as defined in OAR 411-317-0000, is personal to the staff and is not fulfilled by reporting the abuse to the owner, operator, or any other staff of the provider even if the owner, operator, or other staff reports the abuse to the Department.

(c) A provider must inform staff of the duty to immediately report abuse as defined in OAR 411-317-0000 to the Department or appropriate entity and provide annual training and written materials on abuse reporting requirements.

(d) NOTIFICATION OF A SUBSTANTIATED ALLEGATION OF ABUSE.

(A) When a provider receives notification of a substantiated allegation of abuse, the provider must immediately provide written notification to all of the following:

(i) The person found to have committed abuse.

(ii) Individuals residing in the home.

(iii) Individuals' case managers.

(iv) Individuals' legal representatives.

(B) A provider's written notification of a substantiated allegation of abuse must include all of the following:

(i) The type of abuse.

(ii) When the allegation was substantiated.

(iii) How to request a public record copy of the Abuse Investigation and Protective Services Report.

(C) A provider must have policies and procedures to describe how the provider implements notification of substantiated abuse as listed in this section.

(2) IMMEDIATE NOTIFICATION OF SERIOUS ILLNESS, INJURY, ACCIDENT, DEATH. In the case of a serious illness, injury, accident, or death of an individual, a provider must immediately notify all of the following (as applicable):

(a) The individual's legal or designated representative, parent, next of kin, and designated contact person.

(b) The individual's case management entity.

(c) Any other agency responsible for, or delivering services to, the individual.

(3) IMMEDIATE NOTIFICATION OF UNAUTHORIZED ABSENCE. In the case of an individual who is away from their home without support beyond the time frames established by their ISP team, a provider must immediately notify all of the following (as applicable):

(a) The individual's legal or designated representative and nearest responsible relative.

(b) The local police department.

(c) The individual's case management entity.

(4) INCIDENT REPORTS.

(a) A provider must complete an incident report for all of the following:

(A) Any allegation of abuse as defined in OAR 411-317-0000.

(B) Death or serious illness, injury, or accident, requiring inpatient or emergency hospitalization.

(C) An individual is away from their home without support beyond the time frames established by their ISP team.

(D) Use of an emergency physical restraint.

(E) Use of a safeguarding intervention or safeguarding equipment.

(F) Unusual incident as defined in OAR 411-317-0000.

(b) An incident report must include all of the following information:

(A) Name of the individual who is the subject of the incident.

(B) Date, time, duration, type, and location of the incident.

(C) Conditions prior to, or leading to, the incident.

(D) Detailed description of the incident, including staff response.

(E) Description of injury if injury occurred.

(F) Name of staff, including their position title, and witnesses to the incident.

(G) Follow-up to be taken to prevent a recurrence of the incident. The use of any emergency physical restraint must be reviewed by an agency's executive director, or as applicable their designee, within two hours of application.

(c) INCIDENT REPORTING TIMELINES.

(A) A provider must place an incident report in the individual's record and provide a copy to the individual's case manager, and as applicable their legal representative, in accordance with the following timelines:

(i) ABUSE. An incident report documenting abuse must be provided within five business days from the date of the incident.

(ii) DEATH, SERIOUS ILLNESS, INJURY, OR ACCIDENT. An incident report documenting a death or a serious illness, injury, or accident, must be provided within five business days from the date of the incident.

(iii) UNAUTHORIZED ABSENCE. An incident report documenting an individual's unauthorized absence must be provided within five business days from the date of the incident.

(iv) EMERGENCY PHYSICAL RESTRAINT. An incident report documenting the use of an emergency physical restraint must be provided within one business day from the date of the incident.

(v) SAFEGUARDING INTERVENTION AND SAFEGUARDING EQUIPMENT.

(I) TEMPORARY EMERGENCY SAFETY PLANS. If an individual has a Temporary Emergency Safety Plan, an incident report documenting the use of an emergency crisis strategy or physical restraint must be completed in accordance with the requirements outlined in the individual's Temporary Emergency Safety Plan.

(II) INJURY. An incident report documenting the use of a safeguarding intervention or safeguarding equipment, resulting in an injury, must be provided within one business day from the date of the incident.

(III) NO INJURY. An incident report documenting the use of a safeguarding intervention or safeguarding equipment, not resulting in an injury, must be provided within five business days from the date of the incident.

(vi) UNUSUAL INCIDENT. An incident report documenting an unusual incident must be provided within five business days.

(B) An individual's case manager or a Department designee (when applicable) must receive complete copies of all incident reports.

(C) A copy of an incident report provided to an individual's legal representative or other service providers must have confidential

information about other individuals removed or redacted as required by federal and state privacy laws.

(D) A copy of an incident report may not be provided to an individual's legal representative when the report is part of an abuse investigation.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0200 Transportation
(Amended 12/28/2013)

(1) Service providers, including employees and volunteers who own or operate vehicles that transport individuals, must:

(a) Maintain the vehicle in safe operating condition;

(b) Comply with Department of Motor Vehicles laws;

(c) Maintain or assure insurance coverage including liability, on all vehicles and all authorized drivers; and

(d) Carry a first aid kit in the vehicle.

(2) When transporting, the driver must ensure that all individuals use seat belts. Individual car or booster seats must be used for transporting all children as required by law. When transporting individuals in wheel chairs, the driver must ensure that wheel chairs are secured with tie downs and that individuals wear seat belts.

(3) Drivers operating vehicles that transport individuals must meet applicable Department of Motor Vehicles requirements as evidenced by a driver's license.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0210 Individual/Family Involvement Policy

(Repealed 01/06/2012 – See OAR 411-323-0060)

411-325-0220 Individual Furnishings
(Amended 06/29/2016)

(1) Bedroom furniture must be provided or arranged for each individual and include:

(a) A bed including a frame unless otherwise documented by an ISP team decision, a clean comfortable mattress, a waterproof mattress cover if the individual is incontinent, and a pillow;

(b) A private dresser or similar storage area for personal belongings that is readily accessible to the individual; and

(c) A closet or similar storage area for clothing that is readily accessible to the individual.

(2) Individuals must have the freedom to decorate and furnish his or her own bedroom as agreed to within the Residency Agreement.

(3) Two sets of linens must be provided or arranged for each individual and include:

(a) Sheets and pillowcases;

(b) Blankets appropriate in number and type for the season and the comfort of the individual; and

(c) Towels and washcloths.

(4) Each individual must be assisted in obtaining personal hygiene items in accordance with individual needs and items must be stored in a sanitary and safe manner.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400 - 443.455

411-325-0230 Emergency Plan and Safety Review
(Amended 12/28/2014)

(1) Providers must provide the emergency plan and safety review requirements as described in this rule.

(2) EMERGENCY PLANNING.

(a) Providers must post the following emergency telephone numbers in close proximity to all phones used by staff.

(A) The telephone numbers of the local fire, police department, and ambulance service, if not served by a 911 emergency services; and

(B) The telephone number of the executive director, emergency physician, and additional people to be contacted in the case of an emergency.

(b) If an individual regularly accesses the community independently, the provider must provide the information to the individual about appropriate steps to take in an emergency, such as emergency contact telephone numbers, contacting police or fire personnel, or other strategies to obtain assistance.

(3) Providers must develop, maintain, update, and implement a written emergency plan for the protection of all individuals in the event of an emergency or disaster.

(a) The emergency plan must:

(A) Be practiced at least annually. The emergency plan practice may consist of a walk-through of the duties or a discussion exercise dealing with a hypothetical event, commonly known as a tabletop exercise.

(B) Consider the needs of the individuals being served and address all natural and human-caused events identified as a significant risk for the home, such as a pandemic or an earthquake.

(C) Include provisions and sufficient supplies, such as sanitation supplies, to shelter in place, when unable to relocate, for at least three days under the following conditions:

(i) Extended utility outage;

(ii) No running water;

(iii) Inability to replace food or supplies; and

(iv) Staff unable to report as scheduled.

(D) Include provisions for evacuation and relocation that identifies:

(i) The duties of staff during evacuation, transporting, and housing of individuals, including instructions to staff to notify the Department, local office, or designee of the plan to evacuate or the evacuation of the home as soon as the emergency or disaster reasonably allows;

(ii) The method and source of transportation;

(iii) Planned relocation sites that are reasonably anticipated to meet the needs of the individuals in the home;

(iv) A method that provides a person unknown to the individual the ability to identify each individual by name and to identify the name of the supporting provider for the individual; and

(v) A method for tracking and reporting to the Department, local office, or designee, the physical location of each individual until a different entity resumes responsibility for the individual.

(E) Address the needs of the individuals, including provisions to provide:

(i) Immediate and continued access to medical treatment with the evacuation of the individual summary sheets described in OAR 411-325-0180 and the emergency information described in OAR 411-325-0185 and other information necessary to obtain care, treatment, food, and fluids for the individuals.

(ii) Continued access to life-sustaining pharmaceuticals, medical supplies, and equipment during and after an evacuation and relocation;

(iii) Behavior support needs anticipated during an emergency; and

(iv) Adequate staffing to meet the life-sustaining and safety needs of the individuals.

(b) The provider must instruct and provide training about the duties and responsibilities for implementing the emergency plan to all staff.

(c) The provider must re-evaluate and revise the emergency plan at least annually or when there is a significant change in the home.

(d) The emergency plan summary must be sent to the Department annually and upon change of ownership.

(e) Applicable parts of the emergency plan must coordinate with each applicable employment provider to address the possibility of an emergency or disaster during work hours.

(4) A documented safety review must be conducted quarterly to ensure that each home is free of hazards. The provider must keep the quarterly safety review reports for three years and must make them available upon request by the CDDP or the Department.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400-455

411-325-0240 Assessment of Fire Evacuation Assistance
(Amended 12/28/2013)

(1) The service provider must assess, within 24 hours of an individual's entry to the home, the individual's ability to evacuate the home in response to an alarm or simulated emergency.

(2) The service provider must document the level of assistance needed by each individual to safely evacuate the home and the documentation must be maintained in the individual's entry records.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0250 Fire Drill Requirements and Fire Safety
(Amended 12/28/2013)

(1) The service provider must conduct unannounced evacuation drills when individuals are present, one per quarter each year with at least one drill per year occurring during the hours of sleep. Drills must occur at different times during day, evening, and night shifts with exit routes being varied based on the location of a simulated fire.

(2) Written documentation must be made at the time of the fire drill and kept by the service provider for at least two years following the drill. Fire drill documentation must include:

(a) The date and time of the drill or simulated drill;

(b) The location of the simulated fire and exit route;

(c) The last names of all individuals and staff present on the premises at the time of the drill;

(d) The type of evacuation assistance provided by staff to individuals' as specified in each individual's safety plan;

(e) The amount of time required by each individual to evacuate or staff simulating the evacuation; and

(f) The signature of the staff conducting the drill.

(3) Smoke alarms or detectors and protection equipment must be inspected and documentation of inspections maintained as recommended by the local fire authority or State Fire Marshal.

(4) The service provider must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0260 Individual Fire Evacuation Safety Plans
(Amended 12/28/2013)

(1) For individuals who are unable to evacuate the residence within the required evacuation time or who with concurrence of the ISP team request not to participate in fire drills, the service provider must develop a written fire safety and evacuation plan that includes the following:

(a) Documentation of the risk to the individual's medical, physical condition, and behavioral status;

(b) Identification of how the individual evacuates his or her residence, including level of support needed;

(c) The routes to be used to evacuate the residence to a point of safety;

(d) Identification of assistive devices required for evacuation;

(e) The frequency the plan is to be practiced and reviewed by the individual and staff;

(f) The alternative practices;

(g) Approval of the plan by the individual's legal or designated representative (as applicable), case manager, and the service provider's executive director; and

(h) A plan to encourage future participation.

(2) The service provider must maintain documentation of the practice and review of the safety plan by the individual and the staff.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0270 Fire Safety Requirements for Homes on a Single Property or on Contiguous Property Serving Six or More Individuals
(Amended 06/29/2016)

(1) The home must provide safety equipment appropriate to the number and level of individuals served and meet the requirements of the State of Oregon Structural Specialty and Fire Code as adopted by the state:

(a) Each home housing six or more, but fewer than 11 individuals or each home that houses five or fewer individuals, but is licensed as a single facility due to the total number of individuals served per the license or meets the contiguous property provision, must meet the requirements of a SR 3.3 occupancy and must:

(A) Provide and maintain permanent wired smoke alarms from a commercial source with battery back-up in each bedroom and at a point centrally located in the corridor or area giving access to each separate sleeping area and on each floor;

(B) Provide and maintain a 13D residential sprinkler system as defined in the National Fire Protection Association standard; and

(C) Have simple hardware for all exit doors and interior doors that may not be locked against exit that has an obvious method of operation. Hasps, sliding bolts, hooks and eyes, double key deadbolts, and childproof doorknobs are not permitted. Any other deadbolts must be single action release so as to allow the door to open in a single operation.

(b) Each home housing 11 or more, but fewer than 17 individuals must meet the requirements of a SR 3.2 occupancy.

(c) Each home housing 17 or more individuals must meet the requirements of a SR 3.1 occupancy.

(2) The number of individuals receiving services may not exceed the licensed capacity, except that one additional individual at a time may receive community living supports. Community living supports may not violate the safety and health sections of these rules. Relief care may not be provided to any individual for more than 14 consecutive days.

(3) The provider may not admit individuals functioning below the level indicated on the license for the home.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400 - 443.455

411-325-0280 Fire Safety Requirements for Homes or Duplexes Serving Five or Fewer Individuals
(Amended 02/15/2019)

(1) Each home or duplex unit must be made fire safe.

(a) Each home or duplex unit must have a minimum of two exterior doorway exits allowing for egress.

(b) Sleeping and living quarters must have a minimum of two unobstructed exits.

(c) A class 2A10BC fire extinguisher that is easily accessible must be provided on each floor in each home or duplex unit.

(d) Permanent wired smoke alarms from a commercial source with battery back-up must be provided and maintained in each bedroom and at a point centrally located on each floor in the corridor or area giving access to each separate sleeping area.

(e) A 13D residential sprinkler system in accordance with the National Fire Protection Association Code must be provided and maintained. Homes or duplexes are granted an exception from the residential sprinkler system requirement according to section (2) of this rule.

(f) Hardware for all exit doors and interior doors must be simple hardware that may not be locked against exit and must have an obvious method of operation. Hasp, sliding bolts, hooks and eyes, double key deadbolts, and childproof doorknobs are not permitted. A deadbolt must be single action release to allow a door to open in a single operation.

(2) A home or duplex is granted an exception to the requirements in sections (1)(d) and (e) of this rule under the following circumstances:

(a) All individuals residing in the home or duplex have demonstrated the ability to respond to an emergency alarm with or without physical assistance from staff to the exterior and away from the home or duplex in three minutes or less, as evidenced by three or more consecutive documented fire drills.

(b) Battery operated smoke alarms with a 10-year battery life and hush feature have been installed in accordance with the manufacturer's listing, in each bedroom, adjacent hallways, common living areas, basements, and in two-story homes or duplexes at the top of each stairway. Ceiling placement of smoke alarms is recommended. If wall mounted, smoke alarms must be mounted as per the manufacturer's instructions. Alarms must be equipped with a device that warns of low battery condition when battery operated. All smoke alarms must be maintained in functional condition.

(c) A written fire safety evacuation plan is implemented that assures that staff assist all individuals in evacuating the premises safely during an emergency or fire as documented by fire drill records.

(3) The number of individuals receiving services at a home or duplex may not exceed the maximum capacity of five individuals, including an individual receiving community living supports. Relief care may not be provided to any individual for more than 14 consecutive days. Community living supports may not violate the safety and health sections of these rules.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0290 Fire Safety Requirements for Apartments Serving Five or Fewer Individuals
(Amended 06/29/2016)

(1) The apartment must be made fire safe by:

(a) Providing and maintaining in each apartment, battery-operated smoke alarms with a 10-year life in each bedroom and in a central location on each floor;

(b) Providing first floor occupancy apartments. Individuals who are able to exit in three minutes or less without assistance may be granted a variance from the first floor occupancy requirement;

(c) Providing a class 2A10BC portable fire extinguisher easily accessible in each apartment;

(d) Providing access to telephone equipment or intercom in each apartment usable by the individual receiving services; and

(e) Providing constantly usable unblocked exits from the apartment and apartment building.

(2) The number of individuals receiving services at the apartment may not exceed the maximum capacity of five individuals, including an individual receiving community living supports. Relief care may not be provided to any individual for more than 14 consecutive days. Community living supports may not violate the safety and health sections of these rules.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400 - 443.455

411-325-0300 Residency Agreements, Individual Rights, Complaints, Notification of Planned Action, and Hearings
(Amended 02/15/2019)

(1) RESIDENCY AGREEMENTS.

(a) A provider must enter into a written Residency Agreement with each individual specifying, at a minimum, the following:

(A) The rights and responsibilities of the individual and the provider; and

(B) The eviction process, notice requirements, and appeal rights available to each individual.

(b) The Residency Agreement may not violate the rights of an individual as stated in OAR 411-318-0010.

(c) The Residency Agreement may not be in conflict with any of these rules, the certification and endorsement rules in OAR chapter 411, division 323, or the home and community-based services and settings rules in OAR chapter 411, division 004.

(d) Prior to implementing changes to the Residency Agreement, the Residency Agreement may be subject to review by the Department or the designee of the Department.

(e) A provider must review and provide a copy of the Residency Agreement to each individual, and as applicable the legal representative of each individual, at the time of entry and at least 90 calendar days prior to implementing any changes to the Residency Agreement.

(A) The review must be documented by having each individual, or as applicable the legal representative of each individual, sign and date a copy of the Residency Agreement.

(B) A copy of the signed and dated Residency Agreement must be maintained in each individual's record.

(2) INDIVIDUAL RIGHTS.

(a) A provider must protect the rights of individuals described in OAR 411-318-0010 and encourage and assist individuals to understand and exercise these rights.

(b) Upon entry and request and annually thereafter, the individual rights described in OAR 411-318-0010 must be provided to an

individual and the legal or designated representative of the individual (as applicable).

(c) The individual rights apply to all individuals eligible for or receiving developmental disabilities services. A parent or guardian may place reasonable limitations on the rights of a child.

(3) COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(4) NOTIFICATION OF PLANNED ACTION. In the event a developmental disabilities service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form 0947) must be provided as described in OAR 411-318-0020.

(5) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 for a denial, reduction, suspension, or termination or OAR 411-318-0030 for an involuntary reduction, transfer, or exit.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0310 Rights: Confidentiality of Records
(Repealed 01/06/2012 – See OAR 411-323-0060)

411-325-0320 Informal Complaints and Formal Grievances
(Repealed 12/28/2014)

411-325-0330 Medicaid Fair Hearings
(Repealed 12/28/2014)

411-325-0340 Behavior Support
(Repealed 12/01/2017)

411-325-0350 Behavior Supports and Physical Restraints
(Amended 12/01/2017)

For the purpose of this rule, a designated person is the person implementing the behavior supports identified in an individual's Positive Behavior Support Plan.

(1) BEHAVIOR SUPPORTS. Professional behavior services and behavior supports must be delivered in accordance with OAR 411-323-0060.

(2) SAFEGUARDING INTERVENTIONS AND SAFEGUARDING EQUIPMENT.

(a) A designated person must only utilize a safeguarding intervention or safeguarding equipment when --

(A) BEHAVIOR. Used to address an individual's challenging behavior, the safeguarding intervention or safeguarding equipment is included in the individual's Positive Behavior Support Plan written by a qualified behavior professional as described in OAR 411-304-0150 and implemented consistent with the individual's Positive Behavior Support Plan.

(B) MEDICAL. Used to address an individual's medical condition or medical support need, the safeguarding intervention or safeguarding equipment is included in a medical order written by the individual's licensed health care provider and implemented consistent with the medical order.

(b) The individual, or as applicable their legal representative, must provide consent for the safeguarding intervention or safeguarding equipment through an individually-based limitation in accordance with OAR 411-325-0430.

(c) Prior to utilizing a safeguarding intervention or safeguarding equipment, a designated person must be trained.

(A) For a safeguarding intervention, the designated person must be trained in intervention techniques using an ODDS-approved behavior intervention curriculum and trained to the individual's specific needs. Training must be conducted by a person who is appropriately certified in an ODDS-approved behavior intervention curriculum.

(B) For safeguarding equipment, the designated person must be trained on the use of the identified safeguarding equipment.

(d) A designated person must not utilize any safeguarding intervention or safeguarding equipment not meeting the standards set forth in this rule even when the use is directed by the individual or their legal or designated representative, regardless of the individual's age.

(3) EMERGENCY PHYSICAL RESTRAINTS.

(a) The use of an emergency physical restraint when not written into a Positive Behavior Support Plan, not authorized in an individual’s ISP, and not consented to by the individual in an individually-based limitation, must only be used when all of the following conditions are met:

(A) In situations when there is imminent risk of harm to the individual or others or when the individual’s behavior has a probability of leading to engagement with the legal or justice system;

(B) Only as a measure of last resort; and

(C) Only for as long as the situation presents imminent danger to the health or safety of the individual or others.

(b) The use of an emergency physical restraint must not include any of the following characteristics:

(A) Abusive.

(B) Aversive.

(C) Coercive.

(D) For convenience.

(E) Disciplinary.

(F) Demeaning.

(G) Mechanical.

(H) Prone or supine restraint.

(I) Pain compliance.

(J) Punishment.

(K) Retaliatory.

(4) INCIDENT REPORTING. A provider must complete an incident report to ensure the notification of the use of a safeguarding intervention, safeguarding equipment not as prescribed, or an emergency physical restraint, as described in OAR 411-325-0190.

Stat. Auth.: ORS 409.050, 427.104, 443.450, 443.455
Stats. Implemented: ORS 443.400-443.455

411-325-0360 Psychotropic Medications and Medications for Behavior
(Amended 12/28/2014)

(1) Psychotropic medications and medications for behavior must be:

(a) Prescribed by a physician or health care provider through a written order; and

(b) Monitored by the prescribing physician or health care provider, ISP team, and provider for desired responses and adverse consequences.

(2) When medication is first prescribed and annually thereafter, the provider must obtain a signed balancing test from the prescribing health care provider using the Department Balancing Test Form (form SDS 4110) or by inserting the required form content into forms maintained by the provider. Providers must present the physician or health care provider with a full and clear description of the behavior and symptoms to be addressed, as well as any side effects observed.

(3) The provider must keep signed copies of the Balancing Test Forms required in section (2) of this rule in the medical record for the individual for seven years.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400-455

411-325-0370 Individuals' Personal Property
(Amended 12/28/2013)

(1) The service provider must prepare and maintain an accurate individual written record of personal property that has significant or monetary value to each individual as determined by a documented ISP team or legal representative decision.

(2) The record must include:

(a) The description and identifying number, if any;

(b) Date of inclusion in the record;

(c) Date and reason for removal from the record;

(d) Signature of staff making each entry; and

(e) A signed and dated annual review of the record for accuracy.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0380 Handling and Managing Individuals' Money
(Amended 02/15/2019)

(1) A provider must have and implement written policies and procedures for the handling and management of individuals' money. Such policies and procedures must provide for:

(a) An individual to manage his or her own funds unless the ISP documents an individualized need for support to manage personal funds;

(b) Safeguarding of an individual's funds;

(c) Individuals receiving and spending their money; and

(d) Taking into account an individual's interests and preferences.

(2) For an individual identified as needing support to manage their own money, as identified in the individual’s ISP, a provider must prepare and maintain an accurate written record for the individual of all money received or disbursed on behalf of or by the individual. The record must include:

(a) The date, amount, and source of income received;

(b) The date, amount, and purpose of funds disbursed; and

(c) Signature of the staff making each entry.

(3) A provider must reimburse an individual any funds that are missing due to theft or mismanagement on the part of any staff member of the home or for any funds within the custody of the provider that are missing. Such reimbursement must be made within 10 business days of the verification that funds are missing.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0390 Entry, Exit, Transfer, and Closure
(Amended 02/15/2019)

(1) NON-DISCRIMINATION. An individual considered for Department-funded services may not be denied services or otherwise discriminated against on the basis of race, color, religion, sex, gender identity, sexual orientation, national origin, marital status, age, disability, source of income, duration of Oregon residence, or other protected classes under federal and Oregon Civil Rights laws.

(2) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES. An individual who enters a 24-hour residential setting is subject to eligibility as described in this section.

(a) To be eligible for services in a 24-hour residential setting, an individual must meet the following requirements:

(A) Be an Oregon resident.

(B) Be receiving a Medicaid Title XIX (OHP) benefit package through OSIPM or the OCCS Medical Program.

(C) Be determined eligible for:

(i) Developmental disabilities services by the CDDP of the county of origin as described in OAR 411-320-0080; or

(ii) Services for Aging and People with Disabilities as described in OAR chapter 411, division 015.

(D) Meet the level of care as defined in OAR 411-317-0000.

(E) Not receive other Department-funded in-home, community living support, or other services in another residential setting.

(b) Individuals receiving Medicaid Title XIX (OHP) under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 through 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(3) ENTRY.

(a) A provider considering an individual for entry into the home must:

(A) Provide notification to the local CDDP of the intended entry prior to the individual moving into the home;

(B) Verify the provider has been prior authorized to provide Medicaid-funded services to the individual if the individual is not private pay; and

(C) Receive written permission from the Department prior to:

(i) An individual under age 18 moving into a home with individuals age 18 or older;

(ii) An individual 18 or older moving into a home with individuals under the age of 18; or

(iii) An individual who turns 18 and continues to reside in a home with individuals under the age of 18.

(b) A provider must participate in an entry meeting with an individual's case manager prior to delivering services to the individual for services to be funded in the home.

(c) Prior to or upon an entry, a provider must demonstrate efforts to acquire the following individual information from the referring case management entity:

(A) A copy of the eligibility determination document;

(B) A statement indicating the safety skills, including the ability of the individual to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing;

(C) A brief written history of any behavioral challenges, including supervision and support needs;

(D) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The results of any dental evaluation;

(iii) A record of immunizations;

(iv) A record of known communicable diseases and allergies; and

(v) A record of major illnesses and hospitalizations.

(E) A written record of any current or recommended medications, treatments, diets, and aids to physical functioning;

(F) A copy of the most recent needs assessment. If the needs of the individual have changed over time, the previous needs assessments must also be provided;

(G) Copies of protocols, the risk tracking record, and any support documentation (if available);

(H) Copies of documents relating to the guardianship, conservatorship, health care representation, power of attorney,

court orders, probation and parole information, or any other legal restrictions on the rights of the individual (if applicable);

(I) Copies of medical decision-making documents, such as an Advance Directive and Physician Order for Life-Sustaining Treatment (POLST), if applicable;

(J) Written documentation that the individual is participating in out of residence activities, including public school enrollment for individuals less than 21 years of age;

(K) Written documentation to explain why preferences of the individual may not be implemented; and

(L) A copy of the most recent Functional Behavior Assessment, Positive Behavior Support Plan, ISP or Service Agreement, Nursing Service Plan, and Individualized Education Plan (if available).

(d) If an individual is being admitted from the family home of the individual and the information required in subsection (c) of this section is not available, the provider must assess the individual upon entry for issues of immediate health or safety and document a plan to secure the remaining information no later than 30 calendar days after entry. The plan must include a written justification as to why the information is not available.

(e) A provider retains the right to deny entry of any individual if the provider determines the support needs of the individual may not be met by the provider or for any other reason not specifically prohibited by these rules.

(4) VOLUNTARY TRANSFERS AND EXITS.

(a) A provider must promptly notify an individual's case manager if the individual gives notice of the intent to exit or abruptly exits services. An individual is not required to give notice to a provider if the individual chooses to exit the home.

(b) A provider must notify an individual's case manager prior to the voluntary transfer or exit of an individual from the home or services, even when the individual enters into another home operated by the same provider.

(c) Notification and authorization of the voluntary transfer or exit of the individual must be documented in the record for the individual.

(d) A provider is responsible for the provision of services until an individual exits the home when the exit is a voluntary exit from the home.

(5) INVOLUNTARY REDUCTIONS, TRANSFERS, AND EXITS.

(a) A provider must only reduce, transfer, or exit an individual involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others;

(B) The individual experiences a medical emergency;

(C) The service needs of the individual exceed the ability of the provider;

(D) The individual fails to pay for services or room and board, and payment is not available from another third-party reimbursement;

(E) The provider's certification or endorsement described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered;

(F) The provider's license for the home is suspended, revoked, not renewed, or voluntarily surrendered; or

(G) The provider’s Medicaid contract has been terminated.

(b) NOTICE OF INVOLUNTARY REDUCTION, TRANSFER, OR EXIT. A provider must not reduce services, transfer, or exit an

individual involuntarily without giving advance written notice 30 calendar days prior to the reduction, transfer, or exit. The notice of involuntary reduction, transfer, or exit must be provided to the individual and the individual's legal or designated representative (as applicable) and case manager, except in the case of a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others in the home as described in subsection (c) of this section.

(A) The written notice must be provided on the applicable Department form and include:

(i) The reason for the reduction, transfer, or exit; and

(ii) The right of the individual to a hearing as described in section (6) of this rule.

(B) A notice is not required when an individual requests the reduction, transfer, or exit.

(c) A provider may give advance written notice less than 30 calendar days prior to an exit or transfer only in a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others in the home and undue delay in moving the individual increases the risk of harm. The notice must be provided to the individual and the individual's legal or designated representative (as applicable) and case manager immediately upon the provider's determination of the need for a reduction, transfer, or exit.

(d) A provider must demonstrate through documentation, attempts to resolve the reason for the involuntary reduction, transfer, or exit, including consideration of alternatives to the reduction, transfer, or exit.

(e) A provider is responsible for the provision of services until the date of reduction, transfer, or exit identified in the notice, or when an individual requests a hearing, until the hearing is resolved.

(6) HEARING RIGHTS.

(a) An individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction, transfer, or exit, except when a provider's license is revoked, not renewed, voluntarily surrendered, or the provider's Medicaid contract is terminated.

(b) If an individual requests a hearing, the individual must receive the same services until the hearing is resolved.

(c) When an individual has been given written notice less than 30 calendar days in advance of a reduction, transfer, or exit as described in section (5)(c) of this rule and the individual has requested a hearing, the provider must reserve the room of the individual and avail services in accordance with the individual’s needs until receipt of the Final Order.

(7) EXIT MEETING. A provider must participate in an exit meeting before any decision to exit an individual is made if required by the case management entity.

(8) TRANSFER MEETING. A provider must participate in a transfer meeting before any decision to transfer an individual is made if required by the case management entity.

(9) CLOSURE. A provider must notify the Department and case management entity in writing prior to announcing a voluntary closure of a home to individuals and the legal representatives of the individual (as applicable).

(a) The provider must give each individual, the legal representative of the individual (as applicable), and the case management entity written notice 30 calendar days in advance of the planned closure, except in circumstances where undue delay might jeopardize the health, safety, or welfare of the individuals, the provider, or caregivers.

(b) If the provider has more than one home, the individuals may not be transferred from one home to another home without providing each individual, the legal representative of the individual (as applicable), and the case management entity written notice 30

calendar days in advance of the planned closure, unless prior approval is given and agreement obtained from the individuals, the legal representative of the individuals (as applicable), and the case management entity, or when undue delay might jeopardize the health, safety, or welfare of individuals, the provider, or caregivers.

(c) A provider must return the license for a home to the Department if the home closes prior to the expiration of the license.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0400 Grievance of Entry, Exit and Transfer
(Repealed 12/28/2014)

411-325-0410 Community Living Supports
(Amended 06/29/2016)

(1) All individuals considered for community living supports must:

(a) Be referred by the CDDP, Brokerage, or Department; and

(b) Not be discriminated against because of race, color, creed, age, disability, national origin, gender, religion, duration of Oregon residence, method of payment, or other forms of discrimination under applicable state or federal law.

(2) Relief care services may not be provided for more than 14 consecutive days to a single individual.

(3) Exit meetings are waived for individuals receiving community living supports.

(4) Individuals receiving community living supports do not have appeal rights regarding entry, exit, or transfer.

(5) A provider certified and endorsed under OAR chapter 411, division 323 to operate a 24-hour residential program does not require an endorsement under OAR chapter 411, division 450 to deliver community living supports

when the community living supports are in or based out of a 24-hour residential setting licensed under these rules. Unless as part of a recreational outing, a provider endorsed to operate a 24-hour residential program may not deliver community living supports away from the licensed 24-hour residential setting.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400 - 443.455

411-325-0420 Crisis Services
(Repealed 06/29/2016)

411-325-0430 Individual Support Plan
(Amended 12/01/2017)

(1) A provider must collect and summarize the following information prior to an ISP meeting:

(a) One page profile reflecting, at a minimum, information gathered by the provider at the setting where the individual receives services.

(b) Person-centered Information reflecting, at a minimum, information gathered by the provider at the setting where the individual receives services.

(c) Information about known, identified serious risks.

(2) A provider must develop and share the following information with an individual's case manager and the individual, or if applicable the individual's legal or designated representative, as directed by the individual's ISP or Service Agreement.

(a) Implementation strategies, such as action plans, for desired outcomes or goals.

(b) Necessary protocols or plans that address health, behavioral, safety, and financial supports.

(c) A summary of the provider risk management strategies in place, including title of document, date, and where the document is located.

(d) A Nursing Service Plan, if applicable.

(e) Other documents required by the ISP team.

(3) When desired by an individual, their provider must participate in the individual's ISP team meetings.

(4) A provider must agree in writing to implement the portion of the ISP for which the provider is responsible for implementing. Agreement may be recorded by a signature on the ISP or a Service Agreement.

(5) A provider must maintain a copy of the ISP or Service Agreement provided by the case management entity.

(6) A provider must maintain documentation of implementation of each support and services specified in sections (2)(a) to (2)(e) of this rule in an individual's ISP. The documentation must be kept current and be available for review by the individual, the individual's legal representative, case management entity, and Department representatives.

(7) INDIVIDUALLY-BASED LIMITATIONS.

(a) A provider may not place any limitations to the following freedoms without an individually-based limitation:

(A) Support and freedom to access the individual's personal food at any time.

(B) Visitors of the individual's choosing at any time.

(C) A lock on the individual's bedroom, lockable by the individual.

(D) Choice of a roommate, if sharing a bedroom.

(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with their Residency Agreement.

(F) Freedom and support to control the individual's schedule and activities.

(G) Freedom from restraint, except in accordance with the standards for developmental disabilities services set forth in ORS 443.739, OAR chapter 411, or the relevant Title XIX Medicaid-funding authority.

(b) When an individual's freedom in subsection (a) of this section may not be met due to a threat to the health and safety of the individual or others, an individually-based limitation must be authorized and documented in the individual's ISP in accordance with OAR 411-415-0070.

(c) A provider is responsible for all of the following:

(A) Maintaining a copy of the completed and signed form documenting an individual's consent to the appropriate individually-based limitation. The form must be signed by the individual or the individual's legal representative, if applicable.

(B) Regular collection and review of data to measure the ongoing effectiveness of, and the continued need for, the individually-based limitation.

(C) Requesting a review of the individually-based limitation when a new individually-based limitation is indicated, or change or removal of an individually-based limitation is needed.

Stat. Auth.: ORS 409.050, 427.104, 443.450, 443.455
Stats. Implemented: ORS 443.400-443.455

411-325-0440 Children's Direct Contracted Services
(Amended 12/28/2013)

Any documentation or information required for children's direct contracted developmental disability services to be submitted to the CDDP services coordinator must also be submitted to the Department's residential services coordinator assigned to the home.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0450 Conditions
(Repealed 01/06/2012 – See OAR 411-325-0060)

411-325-0460 Civil Penalties
(Amended 02/15/2019)

(1) For purposes of imposing civil penalties, a 24-hour residential setting licensed under ORS 443.400 to 443.455 and ORS 443.991(2) is considered to be a long-term care facility subject to ORS 441.705 to 441.745.

(2) The Department issues the following schedule of penalties applicable to 24-hour residential settings as provided for under ORS 441.705 to 441.745:

(a) Violations of any requirement within any part of the following rules may result in a civil penalty up to $500 per day for each violation not to exceed $6,000 for all violations for any licensed 24-hour residential setting within a 90-day period:

(A) 411-325-0025(3), (4), (5), (6), (7), or (8);

(B) 411-325-0120(2) or (4);

(C) 411-325-0130;

(D) 411-325-0140;

(E) 411-325-0150;

(F) 411-325-0170;

(G) 411-325-0190;

(H) 411-325-0200;

(I) 411-325-0220(1) or (3);

(J) 411-325-0230;

(K) 411-325-0240, 411-325-0250, 411-325-0260, 411-325-0270, 411-325-0280, and 411-325-0290;

(L) 411-325-0300 and 411-325-0350;

(M) 411-325-0360;

(N) 411-325-0380; and

(O) 411-004-0020, 411-004-0030, and 411-004-0040.

(b) Civil penalties of up to $300 per day per violation may be imposed for violations of any section of these rules not listed in subsection (a)(A) to (a)(O) of this section if a violation has been cited on two consecutive inspections or surveys of a 24-hour residential setting where such surveys are conducted by an employee of the Department. Penalties assessed under this section of this rule may not exceed $6,000 within a 90-day period.

(3) Monitoring occurs when a 24-hour residential setting is surveyed, inspected, or investigated by an employee or designee of the Department or an employee or designee of the Office of State Fire Marshal.

(4) In imposing a civil penalty pursuant to the schedule published in section (2) of this rule, the Department considers the following factors:

(a) The past history of the provider incurring a penalty in taking all feasible steps or procedures necessary or appropriate to correct any violation;

(b) Any prior violations of statutes or rules pertaining to 24-hour residential settings;

(c) The economic and financial conditions of the provider incurring the penalty; and

(d) The immediacy and extent to which the violation threatens or threatened the health, safety, or well-being of individuals.

(5) When a provider receives notification from the Department of a violation for which a penalty or other liability may be imposed, the provider must take action to eliminate the violation in a reasonable time:

(a) Not to exceed 30 calendar days after the first notice of a violation; or

(b) In cases where a violation requires more than 30 calendar days to correct, such time as is specified in a plan of correction found acceptable by the Department.

(6) Any civil penalty imposed under ORS 443.455 and 441.710 becomes due and payable when the provider incurring the penalty receives a notice in writing from the Director of the Department. The notice referred to in this section of this rule is sent by registered or certified mail and includes:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matters asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the right of the provider to request a hearing.

(7) The person representing the provider to whom the notice is addressed has 20 calendar days from the date of mailing of the notice in which to make a written application for a hearing before the Department.

(8) All hearings are conducted pursuant to the applicable provisions of ORS chapter 183.

(9) If the provider notified fails to request a hearing within 20 calendar days, an order may be entered by the Department assessing a civil penalty.

(10) If, after a hearing, the provider is found to be in violation of a license, rule, or order listed in ORS 441.710(1), an order may be entered by the Department assessing a civil penalty.

(11) A civil penalty imposed under ORS 443.455 or 441.710 may be remitted or reduced upon such terms and conditions as the Director of the Department considers proper and consistent with individual health and safety.

(12) If the order is not appealed, the amount of the penalty is payable within 10 calendar days after the order is entered. If the order is appealed and is sustained, the amount of the penalty is payable within 10 calendar days after the court decision. The order, if not appealed or sustained on appeal, constitutes a judgment and may be filed in accordance with the provisions of ORS 183.745. Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(13) A violation of any general order or Final Order pertaining to a 24-hour residential setting issued by the Department is subject to a civil penalty in the amount of not less than $5 and not more than $500 for each and every violation.

(14) Judicial review of civil penalties imposed under ORS 441.710 are provided under ORS 183.480, except that the court may, in its discretion, reduce the amount of the penalty.

(15) All penalties recovered under ORS 443.455 and 441.710 to 441.740 are paid into the State Treasury and shall be deposited in the Long-Term Care Ombudsman account established in ORS 441.419.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991

411-325-0470 License Denial, Suspension, Revocation, and Refusal to Renew
(Amended 12/28/2013)

(1) The Department shall deny, suspend, revoke, or refuse to renew a license where the Department finds there has been substantial failure to comply with these rules or where the State Fire Marshal or the State Fire Marshal's representative certifies there is failure to comply with all applicable ordinances and rules relating to safety from fire.

(2) The Department shall suspend the home license where imminent danger to health or safety of individuals exists.

(3) The Department shall deny, suspend, revoke, or refuse to renew a license where it finds that a provider is on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers.

(4) Revocation, suspension, or denial is done in accordance with the rules of the Department and ORS chapter 183.

(5) Failure to disclose requested information on the application or provision of incomplete or incorrect information on the application constitutes grounds for denial or revocation of the license.

(6) The Department shall deny, suspend, revoke, or refuse to renew a license if the licensee fails to implement a plan of correction or comply with a final order of the Department imposing an administrative sanction, including the imposition of a civil penalty.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0480 Criminal Penalties
(Amended 12/28/2013)

(1) Violation of any provision of ORS 443.400 to 443.455 is a Class B misdemeanor.

(2) Violation of any provision of ORS 443.881 is a Class C misdemeanor.

Stat. Auth.: ORS 409.050, 443.450, and 443.455
Stats. Implemented: ORS 443.400 to 443.455

411-325-0490 Provider Eligibility for Medicaid Service Payment
(Adopted 02/15/2019)

(1) In addition to meeting the licensing standards and conditions set forth in these rules, a provider must have an approved prior authorization through the Department payment system for individuals receiving Medicaid-funded

services before the provider is eligible to claim for delivering Medicaid-funded services. The prior authorization includes dates of authorized services and the funding amount allocated.

(2) A provider may only claim for a day of service when:

(a) An individual sleeps in the home overnight; or

(b) An individual does not sleep in the home overnight, but intends to return to the home, and the provider was responsible for an accumulated period of eight hours for the primary care, support, safety, and well-being of the individual, including:

(A) Providing intermittent physical support or care.

(B) Providing stand-by support with the ability to respond in person within the response times as outlined in the individual's ISP.

(C) Being responsible to communicate reciprocally within the response times agreed upon by the individual's ISP team and documented in the individual's ISP, based on the individual’s identified support needs.

(3) A day of service does not apply when an individual:

(a) Has been admitted overnight to a hospital;

(b) Has been admitted to a nursing facility;

(c) Is held in detention or jail; or

(d) Is outside of the United States.

(4) A provider may only claim for a day of service under section (2)(b) of this rule when an individual is away from the home, accompanied by a

provider or staff, for up to 30 consecutive days or 45 calendar days in an ISP year.

(a) The provider is not paid for the 31st and following consecutive days when an individual is away from the home.

(b) A provider is not paid for the 46th and following non-consecutive days an individual is not at the licensed home overnight.

(c) Days not paid do not count in the 45-calendar day total.

Stat. Auth.: ORS 409.050, 441.715, 443.450, 443.455
Stats. Implemented: ORS 441.705-441.720, 441.740, 441.745, 443.384, 443.392, 443.400-443.445, 443.450, 443.455, 443.880, 443.881, 443.991