DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 450

COMMUNITY LIVING SUPPORTS

EFFECTIVE DECEMBER 28, 2018

411-450-0010 Statement of Purpose
(Adopted 06/29/2016)

(1) The rules in OAR chapter 411, division 450 prescribe standards, responsibilities, and procedures for the delivery of community living supports. Supports are intended to permit individuals to live independently in a community-based setting.

(2) Community living supports are designed to prevent out-of-home placement of a child, or to return a child to the family home from a residential setting other than the family home.

(3) These rules prescribe service eligibility requirements for individuals receiving community living supports, and standards and procedures for agency providers operating a community living supports program.

(4) The rules in OAR chapter 411, division 450 effectuate Oregon's Employment First policy under which the employment of individuals with developmental disabilities in competitive integrated employment is the highest priority over unemployment, segregated employment, or other non-work day activities. The delivery of services provided under these rules presumes all individuals eligible for services are capable of working in an integrated employment setting and earning minimum wage or better.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0020 Definitions and Acronyms

(Amended 12/28/2018)

In addition to the following definitions, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 450. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

(1) "ADL" means "Activities of Daily Living".

(2) "ANA-C" means the "Adult In-Home Support Needs Assessment, Version C". The Department incorporates the ANA-C into these rules by this reference. The ANA-C is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm/ANA%20-%20Adult%20In-home%20-%20v_C.47r.xlsm.

(3) "ANA/CNA Manual" means the document that describes how to administer an ANA and CNA. The Department incorporates the ANA/CNA Manual, Version 2 into these rules by this reference. The ANA/CNA Manual is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/bpa/ana-cna-manual.pdf.

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

(5) "CNA-C" means the "Child In-Home Support Needs Assessment, Version C". The Department incorporates the CNA-C into these rules by this reference. The CNA-C is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm/CNA%20-%20Child%20In-home%20-%20v_C.47r.xlsm.

(6) "Facility-Based" means a service operated at a fixed site owned, operated, or controlled by a service provider where an individual has few or no opportunities to interact with people who do not have a disability except for paid staff.

(7) "Family":

> (a) Means a unit of two or more people that includes at least one individual, found to be eligible for developmental disabilities services, where the primary caregiver is:

(A) A family member as defined in OAR 411-317-0000; or

(B) In a domestic relationship where partners share the following:

(i) A permanent residence.

(ii) Joint responsibility for the household in general, such as child-rearing, maintenance of the residence, and basic living expenses.

(iii) Joint responsibility for supporting the individual when the individual is related to one of the partners by blood, marriage, or legal adoption.

(b) The term "family" is defined as described above for purposes of determining the service eligibility of an individual for community living supports as a resident in the family home.

(8) "IADL" means "Instrumental Activities of Daily Living".

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

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

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

(12) "Primary Caregiver" means the person identified in an ISP as providing the majority of services and support for an individual in the home of the individual.

(13) "PSW" means "Personal Support Worker".

(14) "Service Level" means the maximum number of hours available to an individual for any combination of attendant care, skills training services, or state plan personal care. The service level is determined by a formula embedded in the ANA-C and CNA-C. The formula uses the individual items within the areas measured by the assessment to generate the service level.

(15) "These Rules" mean the rules in OAR chapter 411, division 450.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0030 Eligibility for Community Living Supports
(Amended 12/28/2018)

(1) An individual may not be denied community living supports 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) To be eligible for community living supports, an individual must meet the following:

(a) Be an Oregon resident.

(b) Be determined eligible for developmental disabilities services by the CDDP of the county of origin as described in OAR 411-320-0080, except for those enrolled in the Medically Involved Children's Waiver or the Medically Fragile Children's Program as described in OAR chapter 411, division 300.

(c) Choose to use a case management entity for assistance with the design and management of developmental disabilities services.

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

(A) An adult is eligible for community living supports if the adult had been receiving community living supports as a child up to their 18th birthday and has not become ineligible due to section (2)(d)(B) of this rule.

(B) Eligibility for community living supports based on section (2)(d)(A) of this rule ends if:

(i) The individual does not apply for a disability determination and Medicaid within 10 business days of their 18th birthday;

(ii) The Social Security Administration or the Presumptive Medicaid Disability Determination Team of the Department finds the individual does not have a qualifying disability; or

(iii) The individual is determined by the state of Oregon to be ineligible for a Medicaid Title XIX benefit package through OSIPM or the OCCS Medical Program.

(C) Individuals receiving Medicaid Title XIX 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:

(i) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300.

(ii) The equity value of a home, which exceeds the limits in OAR 461-145-0220.

(e) Be determined to meet the level of care defined in OAR 411-415-0020.

(f) POST ELIGIBILITY TREATMENT OF INCOME Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(g) Participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and reassessment annually as required by the Department.

(A) Failure to participate in the functional needs assessment or to provide information necessary to complete the functional needs assessment or reassessment within the applicable time

frame results in the denial of service eligibility. In the event service eligibility is denied, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevents timely participation in the functional needs assessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(h) A child receiving supports and services under the family support program as described in OAR 411-305-0235 is not eligible to receive community living supports.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0040 Community Living Supports Entry and Exit
(Adopted 06/29/2016)

(1) A provider of community living supports must agree in writing to provide those supports identified in an ISP for the individual. Agreement may be shown by a signature on a Service Agreement. The agreement must include acknowledgement of:

(a) Limits of service that may be provided; and

(b) Payment rate.

(2) An individual must have community living supports terminated:

(a) At the end of a service period agreed upon by all parties and specified in the ISP;

(b) At the oral or written request of the individual or legal representative to end the service relationship;

(c) When the individual has been determined to no longer meet eligibility for community living supports as described in OAR 411-450-0030;

(d) When the case management entity has sufficient evidence to believe that an individual has engaged in fraud or misrepresentation, failed to use resources consistent with the services as agreed upon in the ISP, refused to cooperate with documenting expenses, or otherwise knowingly misused public funds associated with these services; or

(e) When the individual either cannot be located or has not responded following 30 days of repeated attempts by staff of the case management entity to complete ISP development or monitoring activities, including participation in a functional needs assessment. An individual, and as applicable the legal or designated representative of the individual, must participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and reassessment within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or provide information necessary to complete the functional needs assessment or reassessment within the applicable time frame results in the denial of service eligibility.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevent timely participation in the functional needs assessment or reassessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(3) INVOLUNTARY REDUCTIONS AND EXITS.

(a) A provider agency must only reduce 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 when required to do so; or

(E) The certification or endorsement for the provider agency described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) PROVIDER AGENCY NOTICE OF INVOLUNTARY REDUCTION OR EXIT. A provider agency must not reduce services, transfer, or exit an individual involuntarily without 30 days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the 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 as described in subsection (c) of this section.

(A) The written notice must be provided on the Notice of Involuntary Reduction or Exit form approved by the Department and include:

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

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

(B) A Notice of Involuntary Reduction or Exit is not required when an individual requests the reduction or exit.

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

(d) NOTICE OF INVOLUNTARY GROUP REDUCTION, TRANSFER, OR EXIT. If a community living supports provider reduces or transfers more than 10 individuals within any 30 calendar day period, the community living supports provider must provide 60 days advance written notice to the individuals, the Department, the legal or designated representative of the individual (as applicable), and the case manager.

(A) The written notice must be provided on the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

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

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

(B) A Notice of Involuntary Group Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(e) HEARING RIGHTS. An individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction or exit. If an individual requests a hearing, the individual must receive the same services until the hearing is resolved. When an individual has been given less than 30 days advance written notice of a reduction, transfer, or exit as described in subsection (c) of this section and the individual has requested a hearing, the provider must reserve service availability for the individual until receipt of the Final Order.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0050 Minimum Standards for Community Living Supports
(Amended 12/28/2018)

(1) ABUSE PROHIBITED. No adult or child shall be abused and abuse shall not be tolerated by any employee, staff, or volunteer of an individual, agency, or case management entity.

(2) Community living supports, purchased with Department funds, must be provided only as a social benefit.

(3) Community living supports must be delivered in a manner consistent with positive behavioral theory and practice, and where behavior intervention is not undertaken unless the behavior:

(a) Represents a risk to health and safety of the individual or others;

(b) Is likely to continue and become more serious over time;

(c) Interferes with community participation;

(d) Results in damage to property; or

(e) Interferes with learning, socializing, or vocation.

(4) Community living supports must be delivered in accordance with applicable state and federal wage and hour regulations.

(5) For a child, community living supports are considered to be for supports that are not typical for a parent or guardian to provide to a child of the same age.

(6) Community living supports may only be reimbursed when they are consistent with the Expenditure Guidelines.

(7) Community living supports shall only be reimbursed after community living supports are delivered as identified in an ISP or Service Agreement.

(8) Department funds may not be used for:

(a) A reimbursement to an individual, legal or designated representative, or family member of the individual, for expenses related to services.

(b) An advancement of funds to an individual, legal or designated representative, or family member of the individual, to obtain services.

(c) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 407-045-0260 or OAR chapter 411, division 317.

(d) Services that restrict the freedom of movement of an individual by seclusion in a locked room under any condition.

(e) Vacation costs that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the need of the individual for ADL, IADL, or health related tasks in all home and community-based settings.

(f) Rate enhancements to existing employment services under OAR chapter 411, division 345.

(g) Services or supports that are not necessary as determined by a functional needs assessment or are not cost-effective.

(h) Services that do not meet the description of community living supports as described in these rules, or that do not meet the definition of social benefits as defined in OAR 411-317-0000.

(i) Educational services for school-age individuals, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills.

(j) Services, activities, materials, or equipment that may be obtained by the individual through other available means, such as private or public insurance, philanthropic organizations, or other governmental or public services.

(k) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds.

(l) Services in circumstances where the case management entity determines there is sufficient evidence to believe that the individual, the legal or designated representative of the individual (as

applicable), legal representative, or provider has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to cooperate with record keeping required to document use of Department funds, or otherwise knowingly misused public funds associated with community living supports.

(m) Services provided in a nursing facility, correctional institution, Behavioral Rehabilitation Services facility, Psychiatric Residential Treatment Services facility, or hospital.

(n) Unless under certain conditions and limits specified in Department guidelines, employee wages or provider agency charges for time or services when the individual is not present or available to receive services, including, but not limited to hourly "no show" charge, and provider travel and preparation hours.

(o) Costs associated with training a PSW, other independent provider, or provider agency staff to deliver services.

(p) After September 1, 2018, services that are not delivered in a home and community-based setting.

(q) Services available to an individual under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. § 701-796l, as amended.

(r) Services available to an individual under the Individuals with Disabilities Education Act, 20 U.S.C §1400, as amended.

(s) Notwithstanding abuse as defined in ORS 419B.005, services that the case management entity determines are characterized by failure to act or neglect that leads to, or is in imminent danger of causing, physical injury through negligent omission, treatment, or maltreatment of an individual.

(t) Support generally provided for a child of similar age without disabilities by the parent or guardian or other family members.

(u) Supports and services that are funded by child welfare in the family home.

(v) Educational and supportive services provided by schools as part of a free and appropriate public education for children and young adults under the Individuals with Disabilities Education Act.

(w) Home schooling.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0060 Community Living Supports
(Amended 12/28/2018)

(1) Department funds may be used to purchase the following community living supports available through the Community First Choice state plan:

(a) Attendant care as described in section (2) of this rule.

(b) Skills training as described in section (3) of this rule.

(c) Relief care as described in section (4) of this rule.

(2) ATTENDANT CARE SERVICES. Attendant care services include direct support provided to an individual in the home or community of the individual by a qualified provider. ADL and IADL services provided through attendant care must be necessary to permit an individual to live independently in a community-based setting.

(a) ADL services include, but are not limited to the following:

(A) Basic personal hygiene - providing or assisting with needs such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene.

(B) Toileting, bowel, and bladder care - assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses,

cleansing an individual or adjusting clothing related to toileting, emptying a catheter, drainage bag, or assistive device, ostomy care, or bowel care.

(C) Mobility, transfers, and repositioning - assisting with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises.

(D) Eating - assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating.

(E) Cognitive assistance or emotional support provided to an individual due to an intellectual or developmental disability - helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.

(b) IADL services include, but are not limited to the following:

(A) Light housekeeping tasks necessary to maintain an individual in a healthy and safe environment - cleaning surfaces and floors, making their bed, cleaning dishes, taking out the garbage, dusting, and laundry.

(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks.

(C) Meal preparation and special diets.

(D) Support with participation in the community:

(i) Support with community participation - assisting an individual in acquiring, retaining, and improving skills to use available community resources, facilities, or

businesses, and improving self-awareness and self-control.

(ii) Support with communication - assisting an individual in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language, social responsiveness, social amenities, and interpersonal skills, and the functional application of acquired reading and writing skills.

(c) Assistance with ADL, IADL, and health-related tasks may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any of the IADL tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal, audio, or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if assistance is needed.

(D) "Reassurance" means to offer an individual encouragement and support.

(E) "Redirection" means to divert an individual to another more appropriate activity.

(F) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so an individual may perform an activity.

(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task if the individual is unable to complete the task independently.

(d) For a child, the primary caregiver is expected to be present or available during the provision of attendant care. ADL and IADL services provided through attendant care must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the family in their primary caregiver role.

(3) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by the functional needs assessment and ISP and permitting an individual to live independently in a community-based setting.

(a) Skills training may be applied to the use and care of assistive devices and technologies.

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable.

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP.

(C) Progress towards the anticipated outcomes are measured and the measurements are evaluated by a case manager no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved within the timeframe outlined in the ISP, the case manager must reassess or redefine the use of skills training with the individual for that particular goal.

(d) For a child, the primary caregiver is expected to be present or available during the provision of skills training. ADL and IADL services provided through skills training must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the family in their primary caregiver role.

(e) Skills training may not replace or supplant the services of the educational system in fulfilling its obligation to educate an individual.

(4) RELIEF CARE.

(a) Relief care may not be characterized as daily or periodic services provided solely to allow a primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential.

(b) Relief care may be provided in any of the following:

(A) The home of an individual.

(B) A licensed or certified setting.

(C) The home of a qualified provider, chosen by the individual or their representative, that is a safe setting for the individual.

(D) The community, during the provision of ADL, IADL, health-related tasks, and other supports identified in the ISP for the individual.

(c) No other community living supports may be provided to an individual during a 24-hour unit of daily relief care.

(5) Community living supports may be delivered:

(a) Individually or in a group as indicated by the outcome of the person-centered planning process for the individual.

(b) In the home, community, or a facility.

(A) Community living supports are facility-based if delivered at a fixed site outside of the home of the individual operated, owned, or controlled by a service provider.

(B) Facility-based community living supports must, at minimum, provide on-going opportunities and encouragement to individuals for going out into the broader community. Providers initially certified or endorsed by the Department or the Oregon Health Authority on or after January 1, 2016, must comply with this requirement prior to being certified and endorsed to provide

services under these rules. Existing providers certified and endorsed prior to January 1, 2016, must make measurable progress toward compliance with this requirement, consistent with a Department-approved transition plan, and be in full compliance with these rules by September 1, 2018.

(6) SETTING LIMITATIONS.

(a) An individual who lives in their own home or family home is eligible for the community living supports described in these rules for which the individual has an assessed need and the person-centered planning process determines to be appropriate unless:

(A) The Department determines the health and safety of the individual may not be reasonably assured through the delivery of community living supports; or

(B) Dangerous conditions in the service setting jeopardize the health or safety of the individual or provider, and the individual, or their legal or designated representative, is unable or unwilling to implement necessary safeguards to minimize the dangers.

(b) An individual enrolled to a residential program, an adult foster home licensed under OAR chapter 411, division 050, or an assisted living facility licensed under OAR chapter 411, division 054 is not eligible for the following:

(A) Community living supports provided by a personal support worker.

(B) Community living supports delivered in the home of the individual, whether the home is a licensed setting or not.

(C) Relief care.

(c) A child living in a Behavior Rehabilitation Services (BRS) program as described in OAR 410-170-0000 through 410-170-0120, or Psychiatric Residential Treatment Services (PRTS) as defined in OAR 309-022-0100, is not eligible for community living supports.

(7) SERVICE LIMITS.

(a) All community living supports must be authorized in an ISP as described in OAR 411-415-0070.

(b) For an individual residing in their own home or family home, the amount of community living supports in any plan year is limited to the service level determined by an ANA-C for an adult, or CNA-C for a child, when conducted as described in the ANA/CNA Manual.

(c) If an individual was receiving community living supports on October 31, 2016, the service level for that individual is the higher service level of:

(A) The service level in place on October 31, 2016; or

(B) The highest service level determined by an ANA or CNA after October 31, 2016.

(d) An increase in service level must be based on a reassessment.

(e) An individual's service level may not be reduced below the service level in place on October 31, 2016.

(f) The ANA-C or CNA-C determines the following:

(A) The service level. The service level may not be exceeded without prior approval from the Department. The service level applies to hours used for the following:

(i) Attendant care as described in this rule.

(ii) Skills training as described in this rule.

(iii) State plan personal care service hours as described in OAR chapter 411, division 034.

(B) The staffing level. The need for two staff to be available simultaneously to provide community living supports to an

individual. When such a need is identified, the ANA-C or CNA-C determines the maximum number of hours two staff may be simultaneously available.

(g) The Department may approve a service level or staffing level greater than was determined by the ANA-C or CNA-C if the individual is unable to have their support needs met within the assessed service level because the individual has-:

(A) Intermittent needs that cannot be scheduled that must be met throughout the day to keep the individual healthy and safe;

(B) A specific support that takes an exceptional amount of time and there is justification of the amount of time needed; or

(C) Support needs that must be met in order to prevent a serious risk of institutionalization.

(h) The Department may put limits on how Department funds and resources are used, as long as those limited funds and resources are adequate to meet the needs of the individual.

(i) For an individual enrolled in a residential program, an adult foster home licensed under OAR chapter 411, division 050, or an assisted living facility licensed under OAR chapter 411, division 054, receipt of any combination of job coaching, supported employment - small group employment support, employment path services, and community living supports may not exceed a combined average of 25 hours per week. Individuals residing in these settings who do not receive employment services, may receive up to 25 hours of community living supports per week.

(j) No more than 14 days of relief care in a plan year are allowed without approval from the Department. Each day of respite services described in and provided under OAR 411-070-0043(5) contributes to the 14-day limit for relief care.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0070 Community Living Supports Providers and Provider Requirements
(Amended 02/28/2017)

Delivery of community living supports is limited to the following provider types:

(1) A PSW who meets the standards described in OAR chapter 411, division 375.

(a) A PSW is not an available provider type when there is not a common law employer as described in OAR 411-375-0070.

(b) A PSW may not provide community living supports to an individual when the PSW and individual reside together unless --

(A) The PSW is a family member;

(B) The PSW does not own or control the property; or

(C) The individual and the PSW have equal homeowner or rental property rights.

(2) A provider agency certified according to OAR chapter 411, division 323 with an endorsement to these rules.

(3) A home health agency with a current license issued under ORS 443.015.

(4) An in-home care agency with a current license issued under ORS 443.315.

(5) A provider organization currently certified under OAR chapter 411, division 340 whose certificate was issued or applied for prior to January 1, 2016.

(6) A provider agency certified under OAR chapter 411, division 323 and endorsed to OAR 411-340-0170 between January 1, 2016 and June 29, 2016.

(7) An agency certified under OAR chapter 411, division 323 and endorsed to OAR chapter 411, division 328 for supported living programs or to OAR chapter 411, division 325 for 24-hour residential programs or OAR chapter 411, division 345 for employment may provide community living supports without an endorsement to these rules until the agency's certification is renewed following the adoption of these rules.

(8) An adult foster home licensed under OAR chapter 411, division 360.This provider type may only deliver community living supports --

(a) When they are in or based out of the licensed setting. An adult foster home provider may not provide community living supports to an individual in or based out of the home of the individual.

(b) To an adult.

(9) A child foster home licensed under OAR chapter 411, division 346. This provider type may only deliver community living supports --

(a) When they are in or based out of the licensed setting. A child foster home provider may not provide community living supports to a child in or based out of the home of the child.

(b) To a child.

(10) An agency certified under OAR chapter 411, division 323 and endorsed to OAR chapter 411, division 325 for 24-hour residential programs does not require endorsement to these rules to deliver community living supports when they are in or based out of the licensed setting. A provider of a 24-hour residential program may not provide community living supports to an individual in or based out of the home of the individual.

(11) Providers qualified to deliver community living supports under sections (5) though (10) of this rule are subject to OAR 411-450-0040, 411-450-0050, 411-450-0060, and sections (6) through (23) of 411-450-0080 when delivering community living supports.

Stat. Auth.: ORS 409.050, 427.104, 430.662
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411-450-0080 Standards for Provider Agencies Delivering Community Living Supports
(Amended 12/01/2017)

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To be endorsed to operate a community living support program, a provider agency must have all of the following:

(a) A certificate and an endorsement to operate a community living support 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.

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

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

(4) PERSONNEL FILES AND QUALIFICATION RECORDS. A provider agency must maintain written documentation of six hours of pre-service training prior to staff supervising individuals that includes mandatory abuse reporting, ISPs, and Service Agreements.

(5) CONFIDENTIALITY OF RECORDS. A provider agency must ensure the confidentiality of individuals' records in accordance with OAR 411-323-0060.

(6) DOCUMENTATION REQUIREMENTS. Unless stated otherwise, all entries required by these rules must be --

(a) Prepared at the time, or immediately following, the event being recorded;

(b) Accurate and contain no willful falsifications;

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

(d) Maintained for no less than five years.

(7) A provider agency must maintain progress notes regarding the community living supports provided. A progress note must include, at minimum, all of the following information regarding the service rendered:

(a) The date and time the service was delivered.

(b) The staff involved.

(c) Information regarding the nature of the support provided and how the support met an identified ADL or IADL support need or was a health-related task.

(8) Progress notes must be made available monthly and upon request by a case management entity.

(9) Failure to furnish written documentation upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, immediately or within timeframes specified in the written request, may be deemed reason to recover payment.

(10) Records must be retained in accordance with OAR chapter 166, division 150, Secretary of State, Archives Division.

(a) Financial records, supporting documents, statistical records, and all other records (except individual records) must be retained for at least three years after the close of a contract period.

(b) Individual records must be kept for at least seven years.

(11) IMMEDIATE NOTIFICATION.

(a) ABUSE. If an incident falls within the scope of abuse as defined in OAR 411-317-0000, a provider agency must immediately notify an

individual's case management entity. In addition to immediately notifying the case management entity, the provider agency 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) SERIOUS ILLNESS, INJURY, ACCIDENT, DEATH. In the case of a serious illness, injury, accident, or death of an individual, a provider agency 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.

(c) UNATHORIZED ABSENCE. In the case of an individual who is away from the residence without support beyond the time frames established by their ISP team, a provider agency 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.

(12) INCIDENT REPORTING.

(a) TYPES OF INCIDENTS. 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 the residence 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) INCIDENT REPORT REQUIREMENTS. 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 their designee within two hours of application.

(c) INCIDENT REPORTING TIMELINES.

(a) A provider agency 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:

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

(B) 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.

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

(D) 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.

(E) 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 a safeguarding intervention or safeguarding equipment 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.

(F) 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.

(13) A provider agency must develop and implement policies and procedures required for administration and operation in compliance with these rules including, but not limited to, all of the following:

(a) INDIVIDUAL RIGHTS. A provider agency must have, and implement, written policies and procedures protecting the individual rights described in OAR 411-318-0010 and that --

(A) Provide for individual participation in selection, training, and evaluation of staff assigned to provide services to individuals;

(B) Protect individuals during hours of service from financial exploitation that may include, but is not limited to, any of the following:

(i) Staff borrowing from, or loaning money to, an individual.

(ii) Witnessing wills in which the staff or provider agency may benefit directly or indirectly.

(iii) Adding the name of a staff member or provider agency to the bank account or other personal property of an individual without the individual's approval or their legal representative (as applicable).

(b) Policies and procedures appropriate to scope of service including, but not limited to, those required to meet minimum standards set forth in sections (16) to (24) of this rule and consistent with the ISPs or written Service Agreements for individuals currently receiving services.

(14) A provider agency must deliver services according to an individual's ISP or written Service Agreement.

(15) Service rates as authorized in Department payment and reporting systems for individuals authorized to receive community living supports and paid to providers for delivering services, as described in these rules, shall be based upon the agency fee schedule published by the Department. For a provider agency offering services to the general public, billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the provider agency.

(16) SERVICE RECORD. A provider agency must maintain a current service record for each individual receiving services. The individual's service record must include all of the following:

(a) The individual's name, current home address, and home phone number.

(b) The individual's current ISP or written Service Agreement.

(c) Contact information for the individual's legal or designated representative (as applicable) and any other people designated by the individual to be contacted in case of incident or emergency.

(d) Contact information for the case management entity assisting the individual to obtain services.

(e) Records of service provided, including type of services, dates, hours, and staff involved.

(17) A provider agency must ensure staff, contractors, and volunteers receive appropriate and necessary training.

(18) A provider agency regulated by these rules must be a drug-free workplace.

(19) A provider agency that owns or leases a site, delivers services to individuals at the site, and regularly has individuals' present and receiving services at the site, must meet all of the following minimum requirements:

(a) A written emergency plan must be developed and implemented and must include instructions for staff and volunteers in the event of fire, explosion, accident, or other emergency, including evacuation of individuals receiving services.

(b) Posting of emergency information including, but not limited to, posting the following telephone numbers by designated telephones:

(A) Local fire, police department, and ambulance service, or "911".

(B) Agency director and other people to be contacted in case of emergency.

(c) A documented safety review must be conducted quarterly to ensure the service site is free of hazards. Safety review reports must be kept in a central location by a provider agency for three years.

(d) When an individual begins receiving services at a service site, a provider agency must deliver training to the individual to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.

(A) A provider agency must conduct an unannounced evacuation drill each month when individuals are present.

(B) Exit routes must vary based on the location of a simulated fire.

(C) Any individual failing to evacuate the service site unassisted within the established time limits set by the local fire authority for the site must be provided specialized training or support in evacuation procedures.

(D) Written documentation must be made at the time of the drill and kept by the provider agency for at least two years following the drill. The written documentation must include all of the following:

(i) Date and time of the drill.

(ii) Location of the simulated fire.

(iii) Last names of all individuals and staff present at the time of the drill.

(iv) Amount of time required by each individual to evacuate if the individual needs more than the established time limit.

(v) Signature of the staff conducting the drill.

(E) In sites delivering services to individuals who are medically fragile or have severe physical limitations, requirements of evacuation drill conduct may be modified. The modified plan must --

(i) Be developed with the local fire authority, the individual or the individual's legal or designated representative (as applicable), and the provider agency's director; and

(ii) Be submitted as a variance request according to OAR 411-450-0100.

(e) A provider agency must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(f) At least once every five years, a provider agency must conduct a health and safety inspection.

(A) The inspection must cover all areas and buildings where services are delivered to individuals, including administrative offices and storage areas.

(B) The inspection must be performed by --

(i) The Oregon Occupational Safety and Health Division;

(ii) A provider agency's worker's compensation insurance carrier;

(iii) An appropriate expert, such as a licensed safety engineer or consultant as approved by the Department; or

(iv) The Oregon Health Authority, Public Health Division, when necessary.

(C) The inspection must cover all of the following:

(i) Hazardous material handling and storage.

(ii) Machinery and equipment used at the service site.

(iii) Safety equipment.

(iv) Physical environment.

(v) Food handling, when necessary.

(D) The documented results of the inspection, including recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider agency for five years.

(g) A provider agency must ensure each service site has received initial fire and life safety inspections performed by the local fire authority or a Deputy State Fire Marshal. The documented results of the inspection, including documentation of recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider agency for five years.

(h) Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual written agreements of the individuals present. When individuals are present, at least one staff member on duty must have the following minimum skills and training:

(A) CPR certification.

(B) Current First Aid certification.

(C) Training to meet other specific medical needs identified in individual ISPs or Service Agreements.

(D) Training to meet other specific behavior support needs identified in individual ISPs or Service Agreements.

(20) A provider agency delivering services to individuals that involve assistance with meeting health and medical needs must --

(a) Develop and implement written policies and procedures addressing all of the following:

(A) Emergency medical intervention.

(B) Treatment and documentation of illness and health care concerns.

(C) Administering, storing, and disposing of prescription and non-prescription drugs, including self-administration.

(D) Emergency medical procedures, including the handling of bodily fluids.

(E) Confidentiality of medical records.

(b) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes all of the following:

(A) Health status as known.

(B) Changes in health status observed during hours of service.

(C) Any remedial and corrective action required and when such actions were taken if occurring during hours of service.

(D) A description of any known restrictions on activities due to medical limitations.

(c) If providing medication administration when an individual is unable to self-administer medications and there is no other responsible person present who may lawfully direct administration of medications, the agency must --

(A) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered;

(B) Administer medications per written orders;

(C) Administer medications from containers labeled as specified per physician written order;

(D) Keep medications secure and unavailable to any other individual and stored as prescribed;

(E) Record administration on an individualized Medication Administration Record (MAR), including treatments and PRN, or "as needed", orders;

(F) Not administer unused, discontinued, outdated, or recalled drugs; and

(G) Not administer PRN psychotropic medication. PRN orders may not be accepted for psychotropic medication.

(d) Maintain a MAR (if required). The MAR must include all of the following:

(A) The name of the individual.

(B) The brand name or generic name of the medication, including the prescribed dosage and frequency of administration as contained on physician order and medication.

(C) Times and dates the administration or self-administration of the medication occurs.

(D) The signature of the staff administering the medication or monitoring the self-administration of the medication.

(E) Method of administration.

(F) Documentation of any known allergies or adverse reactions to a medication.

(G) Documentation and an explanation of why a PRN, or "as needed", medication was administered and the results of such administration.

(H) An explanation of any medication administration irregularity with documentation of a review by the provider agency's executive director or their designee.

(e) Provide safeguards to prevent adverse medication reactions including, but not limited to, all of the following:

(A) Maintaining information about the effects and side-effects of medications the provider agency has agreed to administer.

(B) Communicating any concerns regarding any medication usage, effectiveness, or effects to the individual or the individual's legal or designated representative (as applicable).

(C) Prohibiting the use of one individual's medications by another individual or person.

(f) Maintain a record of visits to medical professionals, consultants, or therapists if facilitated or delivered by the provider agency.

(21) A provider agency that owns or operates vehicles that transport individuals must --

(a) Maintain the vehicles in safe operating condition;

(b) Comply with the laws of the Department of Motor Vehicles;

(c) Maintain insurance coverage on the vehicles and all authorized drivers;

(d) Carry a first aid kit in each vehicle; and

(e) Assign drivers who meet the applicable requirements of the Department of Motor Vehicles to operate vehicles that transport individuals.

(22) If assisting with management of funds, a provider agency must have and implement written policies and procedures related to the oversight of the individual's financial resources that includes the following:

(a) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for staff's own benefit, commingling an individual's personal funds with the provider agency's or another individual's funds, or the provider agency becoming an individual's legal or designated representative.

(b) The provider agency's reimbursement to an individual of any funds that are missing due to theft or mismanagement on the part of any staff of the provider agency, or of any funds within the custody of

the provider agency that are missing. Such reimbursement must be made within 10 business days of the verification that funds are missing.

(23) Additional standards for assisting individuals to manage difficult behavior.

(a) PROFESSIONAL BEHAVIOR SERVICES. A provider agency must have and implement written policies and procedures to assure professional behavior services are delivered by a qualified behavior professional in accordance with OAR chapter 411, division 304.

(b) BEHAVIOR SUPPORTS. A provider agency must have and implement written policies and procedures for the delivery of behavior supports that prohibits abusive practices and assures behavior supports are included in a Positive Behavior Support Plan.

(A) A provider agency must inform each individual, and as applicable their legal or designated representative, of the behavior support policies and procedures at the time of entry and as changes occur.

(B) A decision to alter an individual's behavior must be made by the individual or their legal or designated representative.

(c) Psychotropic medications and medications for behavior must be --

(A) Prescribed by a physician through a written order; and

(B) Monitored by the prescribing physician for desired responses and adverse consequences.

(24) Additional standards for supports that involve restraints. For the purpose of this section, a designated person is the person implementing the behavior supports identified in an individual's Positive Behavior Support Plan.

(a) SAFEGUARDING INTERVENTIONS AND SAFEGUARDING EQUIPMENT.

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

(i) 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.

(ii) 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 411-004-0040.

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

(i) 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.

(ii) 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.

(b) 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:

(i) 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;

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

(iii) 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:

(i) Abusive.

(ii) Aversive.

(iii) Coercive.

(iv) For convenience.

(v) Disciplinary.

(vi) Demeaning.

(vii) Mechanical.

(viii) Prone or supine restraint.

(ix) Pain compliance.

(x) Punishment.

(xi) Retaliatory.

(c) INCIDENT REPORTING. A provider agency 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 section (12) of this rule.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

411-450-0100 Variances
(Adopted 06/29/2016)

(1) The Department may grant a variance to these rules based upon a demonstration by an agency that an alternative method or different approach provides equal or greater agency effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The agency requesting a variance must submit a written application to the Department that contains 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;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) If the variance applies to an individual's service, evidence that the variance is consistent with the individual's current ISP.

(3) The Department's director may approve or deny the request for a variance. The director's decision is final.

(4) The Department must notify the agency of the Department's decision. The decision notice must be sent within 45 calendar days of the receipt of the request by the Department with a copy sent to all relevant Department programs or offices.

(5) The agency may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670