# Compliance Framework Guide

# Community-Based Care
## *(Residential Care and Assisted Living)*

Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES
Safety, Oversight and Quality

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## Preface: The Purpose of this Guide

This guide provides a framework for assessing the compliance of assisted living and residential care facilities, including those with memory care endorsements. The guide describes the corrective action process used to gauge facility compliance and determine noncompliance. The guide is meant to be a useful resource for both providers and the public in understanding the regulatory process used for assisted living and residential care facilities.

Oregon law prioritizes the health, welfare, safety, and rights of residents when regulating assisted living and residential care facilities[1]. The department assesses compliance and takes regulatory action based on surveys (i.e., full inspections of compliance with all applicable rules conducted each time a license is renewed), and complaint investigations by the Licensing Complaint Unit and Adult Protective Services.

Progressive enforcement strategies are applied to facilities that are out of total compliance but are still substantially in compliance with state regulations. Progressive enforcement is used to compel compliance in facilities that are not in substantial compliance with licensing regulations. Progressive enforcement includes technical assistance, training, consultation, and corrective action.

When facilities are found to be out of substantial compliance, the department will assess and determine whether the imposition of more stringent regulatory action is required to achieve substantial compliance.

Oregon Department of Human Services (ODHS) is committed to ensuring each resident receives quality care, dignified treatment, while maintaining their independence, and ability to make personal choices. ODHS strives to encourage a collaborative relationship with providers and ensure long-term care settings meet legal and regulatory requirements.

[1] ORS 441.726 Progressive enforcement process. (1) In regulating residential care facilities and long-term care facilities, the Department of Human Services shall prioritize the health, welfare, safety and rights of residents.

(2) The department may, as appropriate, use a progressive enforcement process that employs a series of actions to encourage and compel compliance with licensing regulations through the application of preventive, positive and progressively more restrictive strategies. Preventive and positive strategies are strategies that include but are not limited to technical assistance, corrective action plans, training and consultation.

(3) This section does not restrict the ability of the department to use more restrictive strategies when necessary to achieve substantial compliance or to protect the health, welfare, safety and rights of residents, including by imposing license conditions under ORS 441.736 or, for residential care facilities, taking additional steps dictated by the framework established under ORS 443.436. [2017 c.679 §3; 2021 c.392 §3]

## Chapter 1: Introduction to The Office of Safety, Oversight and Quality (SOQ)

### Overall Regulatory Purpose

The Office of Safety, Oversight and Quality (SOQ) is responsible for licensing and regulating long-term care facilities for older adults and people with physical disabilities. SOQ licenses and regulates:

- **Community-Based Care (CBC)** facilities - includes Assisted Living and Residential Care Facilities.
- **Adult Foster Homes (AFH)** - local ODHS offices license and regulate, except for homes in Multnomah County, which are licensed and regulated by that county.
- **Nursing Facilities (NF) -** Oregon's Nursing Facilities are licensed by ODHS.
- **Endorsed Memory Care Communities (MCC)** - includes Assisted Living, Residential Care, or Nursing facilities that complete additional requirements to earn an endorsement to the license.
- **Continuing Care Retirement Communities (CCRCs)** - includes campuses with multiple levels of care[2]. In these settings, SOQ licenses the facility types listed above, however, does not license independent living facilities.

SOQ conducts inspections (surveys), and issues initial and renewal licenses in all Nursing facilities, Assisted living, and Residential care facilities. Adult foster homes are licensed through APD or Area Agency on Aging (AAA) local offices. SOQ determines corrective actions based on surveys, licensing complaint reviews, inspections, and Adult Protective Service (APS) investigations. In addition, SOQ certifies Long Term Care Referral Agencies who provide fee-free placement services to clients looking at licensed long-term care facility options.

SOQ employees have an unwavering commitment to the safety, health and well-being of individuals living in Oregon's licensed long-term care settings. All our decisions are guided by this commitment and the tenets of person-centered care. SOQ's priority is to protect older adults and people with disabilities who reside in licensed long-term care settings. This protection is accomplished by accurately and equitably measuring facility compliance and working collaboratively with providers to correct deficiencies as quickly as possible.

**Please note:** Examples included in this guide are intended to illustrate potential regulatory responses.

[2] CCRC's are also distinguished by the requirement that they must collect an entrance fee upon admission that is greater than the sum of the regular periodic charges for one year of residency. OAR411-067-0000(15).

## Residential Care Facilities and Assisted Living Facilities

These settings provide a wide range of individualized services in homelike settings to older adults and people with disabilities, including many individuals with dementia or Alzheimer's disease. Both residential care and assisted living facilities are considered "residential care facilities" as defined in Oregon Revised Statutes (ORS 443.400(7)). Also, residential care, assisted living facilities and memory care communities are collectively known as Community-Based Care (CBC) settings, and are governed by the same set of rules (OAR chapter 411, divisions 054, and 057).

The main difference between residential care and assisted living facilities is that assisted living facilities must provide individual apartments with private bathrooms and kitchenettes, while residential care facilities may have shared rooms and/or bathrooms and often do not have kitchenettes. Both facility types are required to receive a survey/inspection every 24 months (OAR 411-054-0105(2)).

## Endorsed Memory Care Communities (MCC)

Endorsed Memory Care Communities provide specialized dementia care services in a secured environment (OAR chapter 411, division 057). To be endorsed as a Memory Care Community, a facility must first be licensed as a nursing facility, residential care facility or assisted living facility. The memory care endorsement is in addition to a primary license.

In addition to following rules related to their primary licensure, endorsed Memory Care Communities must also follow rules specific to Memory Care Communities (OAR chapter 411, division 057). Only facilities who comply with both the rules of their underlying licensure and the memory care endorsement rules may advertise themselves as "Memory Care Communities."

Endorsed Memory Care Communities must adhere to additional regulatory standards related to the specific care and services for persons living with dementia. Care and services are provided using a person-centered approach, which includes knowing and understanding the resident's routine and preferences. Caregiving staff in endorsed Memory Care Communities must also be specially trained to work with residents with Alzheimer's disease and other dementias.

Endorsed Memory Care Communities must be located on the building ground level (unless they've received a waiver to locate the unit on upper floors); have a secure outdoor area which includes required design features; maintain specific lighting inside the facility; provide locked exit doors with codes for guests; and meet other

facility requirements. Endorsed Memory Care Communities are surveyed/inspected according to their primary license type. Most endorsed Memory Care Communities have a primary license as a residential care facility and are subject to residential care facility survey intervals.

**Adult Foster Homes (AFH)**

Adult Foster Homes are single-family residences that offer 24-hour care in a home-like setting to five or fewer individuals (OAR chapter 411, division 049). A wide variety of residents are served in adult foster homes, ranging from those needing only room, board, and minimal personal assistance to those needing full personal care or skilled care with the help of community-based registered nurses. Adult foster homes are surveyed/inspected/relicensed approximately every 12 months and are guided by OAR chapter 411, division 049, division 050, division 051 and division 052.

It is important to note that ODHS local offices license all adult foster homes except for those in Multnomah County. Multnomah County has exercised its statutory authority to license and regulate all adult foster homes within its border; however, rules that guide these activities in Multnomah County must be at least as stringent as those adopted by ODHS (ORS 443.705 to ORS 443.825; OAR chapter 411, divisions 049 to 052).

**Nursing Facilities (NF)**

Nursing Facilities offer a higher level of skilled, clinical care than other facility types. They provide both short-term, rehabilitative care following hospitalization and long-term care for individuals who may have a chronic illness or disability. Unlike adult foster homes, residential care facilities and assisted living facilities, Nursing Facilities are required to always have certified nursing assistant (CNA) caregivers on site, as well as a licensed nurse on duty for each shift. Nursing Facilities are inspected for compliance with federal regulations (42 CFR part 483, subpart B) and state regulations (ORS 441.087; OAR chapter 411, divisions 085 to 089) every 12 months.

## Chapter 3: Community-Based Care Staff

### Survey Teams

Survey staff conduct regular surveys to inspect facilities and ensure substantial compliance with licensing rules and regulations. The rules for CBC facilities are found in OAR 411-054-0000 to 411-054-0320. Surveyors inspect residential care, assisted living, and endorsed memory care communities. Surveyors determine the scope and severity of survey citations as described in Chapter 5, while corrective action coordinators determine scope and severity for abuse violations based on Adult Protective Services reports, as described in Chapter 10.

### Licensing Complaint Unit

Licensing Complaint Unit (LCU) compliance specialists are the staff who respond to complaints of alleged licensing violations in Community-Based Care facilities. They investigate allegations to determine whether a licensing violation occurred, and forward complaint investigation reports to Corrective Action Coordinators for processing**.** Licensing complaints can potentially result in harm, therefore if LCU finds actual harm or potential for serious harm, the case is immediately referred to APS.

If a licensing violation has occurred and LCU staff determine the harm to residents was negligible, staff will provide technical assistance to assist the facility to correct the problem. If the harm to residents resulting from the rule violation is more than negligible, LCU staff have the authority to cite facilities for violations.

### CBC Operations and Policy Analysts

CBC Operations and Policy Analysts (OPAs) provide technical assistance to facilities in a variety of different ways. OPAs help determine program priorities, ensure rule oversight, write rules, provide rule and regulation interpretation and train providers among other things. . OPAs work directly with families, and residents, the Office of the Long-Term Care Ombudsman (LTCO), local APD and AAA offices, and other entities. Each facility is assigned a Policy Analyst and providers are encouraged to contact their Policy Analyst with questions.

### Corrective Action Coordinators

Corrective Action Coordinators (CACs) promote substantial regulatory compliance by determining the appropriate sanction for a specific violation. CAC staff determine the *scope* (how many people were affected) and *severity* (how serious was the issue) of a violation and apply mitigating and aggravating factors to determine appropriate

regulatory action. Corrective Action Coordinators act to ensure facilities regain substantial compliance with licensing violations and substantiated abuse allegations.

**Other APD Partners**

Adult Protective Services (APS)

The Adult Protective Services (APS) is distinct from SOQ, within the APD program of ODHS. APS investigators are in local offices (ODHS' APD offices and Type B AAA offices) across the state; however, the APS Central Office is in Salem. APS Investigators investigate allegations or complaints of abuse and compile information into complaint investigation reports outlining findings of fact. These reports are sent to SOQ for processing and corrective action related to substantiated allegations of abuse.

**Local Office Case Management**

Each local office or Type B AAA office has a team of case managers who work with Medicaid recipients living in that area. Case managers frequently visit long-term care facility residents. SOQ staff collaborate with case managers to ensure residents of licensed long-term care settings receive quality care and services.

**Central Delivery and Supports**

APD Central Delivery Supports is responsible for the administration of Specific Needs Contracts for Adult Foster Homes, Assisted Living Facilities, Residential Care Facilities, and Specialized Living Programs.

The intent of the specific needs contract is to provide services to residents requiring a complex level of care that exceeds the care rendered in standard Community-Based Care settings. These contracts are developed in accordance with local communities in response to the specific needs of their populations. They are awarded to established and experienced providers who have met a rigorous set of qualifications and demonstrated the ability to soundly serve specific individuals. SOQ and APD Central Delivery Supports staff work together to ensure facilities adhere to applicable licensing rules, as well as the terms of their contract.

**Intergovernmental Partners**

The Oregon Department of Human Services works with a variety of intergovernmental partners who provide the department with information and resources needed to regulate facilities. Agency partners include:

**Office of the Long-Term Care Ombudsman (LTCO)**

The Long-Term Care Ombudsman program is an independent state agency that serves long-term care facility residents through complaint investigation, resolution,

and advocacy. The mission of the agency is to protect individual rights, promote independence, and ensure quality of life for Oregonians living in long-term care and residential facilities and for Oregonians with decisional limitations.

The LTCO program serves residents in nursing facilities, residential care facilities, assisted living facilities, continuing care retirement communities and adult foster care homes. LTCO program staff work with a statewide network of over 180 volunteers. The services of the Long-Term Care Ombudsman program are free and available to residents, families, facility staff, and the public.

**Oregon State Fire Marshal**

The Oregon State Fire Marshal (OSFM) is the state agency responsible for interpreting the Oregon State Fire Code. Assisted living and residential care facilities are required by rule (OAR 411-054-0090) to adhere to the fire code. This includes developing a safe evacuation plan and providing adequate staffing to ensure evacuation can be accomplished in a timely manner. The OSFM is responsible for reviewing facility's building plans and conducting health, fire and life safety surveys before a facility is initially licensed, and before a license is renewed.

**Oregon Department of Veterans' Affairs**

Oregon Department of Veterans' Affairs (ODVA) serves the diverse community of military veterans throughout Oregon. The Aging Veteran Services Division (AVS) is a major program within the ODVA, providing services to the state's most vulnerable veteran populations. One of these services is to manage two Oregon Veterans' Homes. These are long-term care nursing facilities in The Dalles and Lebanon, both are licensed by SOQ.

The ODVA assists veterans, their surviving spouses, minor children or helpless adult children of veterans, and dependent parents in managing their financial affairs and property. The Aging Veteran Outreach program provides education to those other groups who serve aging veterans. The Volunteer Program focuses on mobilizing the power of volunteers to help Oregon veterans understand and use their earned benefits. For more information about ODVA, please see https://www.oregon.gov/ODVA/Pages/default.aspx.

**Governor's Advocacy Office (GAO)**

The Governor's Advocacy Office is part of the ODHS Director's Office. Within the GAO, the ODHS Ombudsman program works on issues related to the department's cash, food, employment, family services, aging and disability medical programs, disability assistance and support services for families, adults and children. This includes adult protective services for vulnerable adults and long-term care service

issues that fall outside the scope of residents' rights in community and nursing care settings.

**Disability Rights Oregon (DRO)**

DRO upholds the civil rights of people with disabilities to live, work, and engage in the community. This nonprofit works to transform systems, policies, and practices to give more people the opportunity to reach their full potential. While not a regulatory authority, DRO does have the right to visit facilities and offer suggestions related to how facilities can best protect the civil rights of residents with disabilities.

## Chapter 4: New Regulatory Programs

The legislature passed new laws since this report was initially drafted in 2019. These new laws and requirements are described below:

### Acuity-Based Staffing Tool

All Oregon Community-Based Care facilities are required to have selected and fully implemented an Acuity-Based Staffing Tool (ABST) and have completed evaluations for all residents, as required by SB 714 (2021). Facilities can choose to use the Oregon Department of Human Services (ODHS) ABST, or a different technology-based ABST.

The department developed an ABST Provider Guide which contains in-depth information regarding the ABST Program. The guide outlines ABST regulations, staffing analysis, department reviews, corrective action, and FAQs. It is located on the Acuity-Based Staffing webpage.

### Kitchen Inspections and Infection Control

House Bill 2600 (2019) requires the department to conduct annual kitchen inspections in all licensed Community-Based Care facilities. The inspections include all food preparation areas in the facility. When a facility is due for a biennial survey inspection, a kitchen inspection is completed as part of that survey. In alternate survey inspection years, the department will conduct a kitchen inspection. Facilities are charged a $200 fee for a kitchen inspection.

The purpose of the kitchen inspection is to ensure that the facility is employing practices to prevent food contamination and the spread of foodborne illness. This helps minimize the risk of residents experiencing an adverse health event due to poor kitchen infection control practices in the kitchen. Survey conducts interviews with the person who is responsible for the kitchen at the time of inspection. The person responsible for kitchen oversight should demonstrate knowledge of the topics listed in OAR 333-150-0000. The kitchen inspection includes, but is not limited to the following considerations:

- Evaluation to ensure the kitchen is clean and maintained in good repair.
- Inspection of all surfaces, but not limited to where contaminates could fall, transfer, or be blown into food during storage, preparation, and serving.
- Observation of food preparation and handling processes. For more detailed information please refer to 411-054-0013(4).

**Infection Control Training** is required for all staff employed by the facility. OAR 411-054-0070 Staffing Requirements and Training states all employees must have completed the pre-service training on standard precautions for infection control and infectious disease prevention prior to beginning their job responsibilities. The only exception to this pre-service training is when the employee has received and completed the training within 24 months prior to their date of hire. All employees of the facility are required to complete an annual training on infection control and infectious disease outbreak.

Each licensed facility is required to develop Infection Control Policies and Procedures that describe the protocols the facility will use to control and prevent infection in the facility as described in OAR 411-054-0050. Infection prevention policies must describe how the facility will establish and maintain a safe, sanitary, and comfortable environment for residents. This must include the facility's protocol on how to prevent the spread of communicable diseases. Examples include but are not limited to: COVID-19, Respiratory Syncytial Virus (RSV), norovirus, and the flu.

Each facility must designate an employee as the Infection Control Specialist for the facility. Specialist responsibilities include working as a primary contact with the department and local public health during a disease outbreak. Once the facility has designated a person for this role, the individual has three months to complete the required trainings.

**Consumer Summary Statement**

Senate Bill 815 (2019) requires Community-Based Care (CBC) facilities must provide potential residents with a Consumer Summary Statement (CSS) before the resident moves in. The CSS is intended to provide potential residents an understanding of available/unavailable services as well as explain how residents can be required to move out if they need a higher level of care than the facility can provide.

Facilities must develop a CSS specific to the services provided by the facility, as required by OAR 411-054-0026(3). The CSS is different than a residency agreement and the Uniform Disclosure Statement. A sample CSS template form (APD 9098CS) can be downloaded on the website. A CSS must be provided to any potential resident before facility admission. The facility must submit an updated CSS to the department any time the facility has a management or ownership change. The CSS must be submitted to the department 60 days prior to the change of ownership or management. All CSSs are posted on the department's licensing webpage.

**Administrator License**

As required per Oregon Administrative Rule (OAR) 411-054-0065, every administrator must obtain a Residential Care Facility Administrator (RCFA) license issued by the Oregon Health Licensing Office, pursuant to OAR chapter 853. Facility administrators must complete department-approved training programs prior to employment.

Before employment as a Facility Administrator, individuals must complete the criminal records check requirements in OAR 407-007-0200 to 407-007-0370 and comply with the tuberculosis screening recommendations in OAR 333-019-0041. An administrator of a facility may not have convictions of any of the crimes described in OAR 407-007-0275.

Newly hired administrators and designees are responsible for the completion of form SDS 0566, Administrator Reference Summary, and are required to email or fax the completed form to the department upon hire. The department may reject a form that has been falsified or is incomplete.

Listed below are the documents that must be sent to the department to record a new administrator for a facility.

- Administrator Reference Summary (SDS 0566) - please provide detailed information regarding experience and education.
- Criminal history check, final fitness determination.
- Uniform Disclosure Statement (SDS 9098A or SDS 9098mc); and
- A copy of your Oregon Administrator License.

**Facility Enhanced Oversight and Supervision**

The Facility Enhanced Oversight and Supervision program was established in response to House Bill 3359 (2017) requirements requiring the department to focus on Community-Based Care facilities that consistently demonstrate a lack of substantial compliance with Oregon statute and administrative rules.

**Collaborating with Facilities Enrolled in the FEOS Program**

Once a facility is enrolled in FEOS, department staff talk with facility administrative staff and leadership about areas the facility was found to consistently demonstrate a lack of substantial compliance. Department staff explain FEOS program enrollment criteria, answer questions, and begin familiarizing facility staff with the specific FEOS plan recommended for the facility.

For more information please refer to 411-054-0106(5)

Facility enrollment information is published to the Licensed Long Term Care Complaints Search website at: https://ltclicensing.oregon.gov/.

**Terminating FEOS Enrollment**

Facilities can submit a written assertion of substantial compliance to the department for consideration after the facility has been enrolled in the FEOS program for at least one year. The department will terminate program enrollment if it is determined the facility has made acceptable progress and they no longer meet the criteria in ORS 443.436(3).

The department also terminates facility enrollment after three years if the facility has shown through at least two consecutive on-site surveys that the facility no longer meets the criteria set forth in ORS 443.436(3).

**Long-Term Care Referral Registry**

Referral agencies assist clients/consumers to find placement in long-term care facilities by evaluating client care needs and helping them find a facility that meets their needs. Referral agents who are paid for placement services must register and obtain a certificate of registration with the ODHS. See ORS 443.370-443.376.

Referral agent placement services are "fee-free" to the client as agents receive payment via a contract with the long-term care facility when a client chooses to become a resident. Agents are not eligible to receive Medicaid money for providing placement referral services. Referral agents must demonstrate they have met registration criteria outlined in the Oregon Administrative Rule for Long-Term Care Referral Services OAR 411-058-0000. Agents and agency employees must obtain an **approved** background check clearance before providing placement referral services. Agents must renew their certificate of registration every two years. Referral agents are mandatory reporters and subject to abuse reporting requirements. See ORS 124.060.

The Long-Term Care Referral Registry website includes a link to a list of registered Long-Term Care Referral Agents and contact information. Questions about the Long-Term Care Referral Registry program can be sent via email to LTCR.Info@ODHS.oregon.gov.

**Quality Measurement Program**

The Quality Measurement Program gathers data to describe the quality of care in Community-Based Care facilities. Each January, facilities are required to report data

on five metrics collected in the previous year to achieve compliance with ORS 443.446 and OAR 411-054-0320. The program publishes a report of the data and analysis each July for the Legislative Assembly. Facilities that substantially fail to submit data are identified in the report.

Quality measurement data helps consumers evaluate the quality of care of facilities. It also helps providers benchmark their performance and provide data for facility quality assurance programs. The metrics are:

(1) Retention of direct care staff,

(2) Compliance with staff training requirements,

(3) The number of resident falls with injury,

(4) The use of antipsychotic medications for non-standard purposes,

(5) The results of an annual resident satisfaction survey conducted by a third party.

The department maintains a website containing guidance for facilities on how to report metrics data and the annual reports to the Legislative Assembly. It also offers webinars to support facilities with program compliance. Questions about the program can be sent to QualityMetrics.Acuity@ODHS.oregon.gov

## Chapter 5: CBC Licensing Process

### Initial License

All CBC facilities must obtain a license from SOQ to operate in Oregon. SOQ issues two-year licenses for the operation of:

- Community-Based Care facilities, which include:
  - Residential Care Facilities
  - Assisted Living Facilities

Before purchasing an existing building or beginning new construction, a CBC facility applicant must provide the department with a Letter of Intent stating an interest in owning a new facility. No less than 60 days prior to the projected opening date, the applicant must submit:

- A licensing application,
- Approved Oregon State Fire Marshal documentation,
- Proposed policies and procedures; and
- Approved background checks for owner/operators.

Applicants must include proof of registration with the Oregon Secretary of State as a business entity, Medicaid paperwork (if serving individuals eligible for Medicaid) and a Memory Care Community Endorsement application if applicable.

### License Renewals

Facilities receive a renewal invoice approximately 60 days before their license expires. Facilities are required to submit a license renewal application and fee at least 45 days prior to the expiration date of their license. If a facility does not submit the application and fee 45 days prior to the renewal date, the assigned SOQ Policy Analyst contacts the facility as a reminder and to provide guidance with completing the required renewal material. **Facilities must submit the application form and fee by the expiration date to maintain an active license.**

Facilities must submit additional documentation when renewing a license:

- Completed background checks for owner entities and management company owners,
- EIN verification of owner entity and management company,
- Fire and life safety approval from the Oregon State Fire Marshal,
- Memory Care Community or Intensive Intervention Endorsement application, if applicable,
- Satisfactory compliance record (i.e., no outstanding sanctions.)

- Additional documentation as requested.

Although it is preferable for these items to be submitted by the renewal deadline, it is not necessary to maintain an active license. If these additional requirements are not completed by the deadline, the existing license is extended until the facility submits this information, and the facility remedies all outstanding regulatory compliance issues and is in substantial compliance. **Once all documentation has been submitted, the new license will be issued.**

**Endorsements**

Residential Care Facilities, Assisted Living Facilities and Nursing Facilities can apply to receive a *Memory Care Endorsement* and serve residents with dementia or Alzheimer's disease, if the licensee meets specific criteria to become endorsed as a Memory Care Community.

Intensive Intervention Communities (IICs) serve no more than five residents with mental, emotional, or behavioral disturbances to keep these individuals safe in a community setting. Specific services are individualized and determined by the individual, their representative, and their team, regulated by OAR 411, division 054 rules.

**Change of Owner or Manager**

*Change of Ownership (CHOW)* - When the licensee (owner) of a facility changes, whether it is an overall change of the licensee or a change in the ownership interest, the current licensee must notify SOQ at least **60 days prior** to the proposed date of change and submit the required form APD 0570.

*Change of Management (CHAM)* – When the management (operator) changes, the licensee must notify SOQ **60 days** in advance and submit the required form APD 0570. For both CHOWs and CHAMs, facility residents or their representatives must be notified via letter **at least 30 days** in advance of the proposed change. The notice to residents must include any rate or policy changes. Questions about CHOWs or CHAMs should be directed to the Operations and Policy Analyst assigned to the facility.

# Chapter 6: CBC Survey Process

## Overview

CBC survey staff conduct regular surveys to inspect facilities and ensure substantial compliance with regulations. The survey teams make unannounced visits to residential care and assisted living facilities, including endorsed memory care communities. A survey is conducted to determine compliance with state licensing regulations. The survey process includes pre-survey preparation, the onsite survey process and post survey activities.

During each survey, the following areas and topics are evaluated:

- Overall physical environment of facility
- Resident living areas
- Kitchen and food service areas
- Medication and treatment administration
- Review of residents' records
- Observation of residents' daily care
- Interviews with direct care staff, residents, families, outside providers and administrative staff to aid in the survey investigative process as it relates to licensing standards.
- Review of staff training
- Fire and life safety

## Survey Preparation – Pre Survey

Prior to initiating a survey visit, the team reviews current information from a variety of ODHS partners. The information includes complaints and concerns that have been investigated since the last licensure survey. Surveyors use a combination of methods during the on-site survey process, including interviews, observations, and record reviews to determine a facility's level of compliance.

## Survey Entrance

During survey, upon entering a facility, the survey team will meet with the administrative staff and provide an overview of the survey process. During the entrance, the team will request any necessary documentation that will aid in establishing compliance with licensing regulations. Signs are posted during the survey to notify residents, staff, and visitors when a survey is in process.

During the survey, the facility environment, kitchen, community living areas and resident rooms will be toured. Surveyors will also review individual resident records, the overall medication systems, outside provider notes, and any applicable staff

training records. The survey team communicates with administrative staff throughout the survey process.

Once the survey team has completed the survey process, the team will meet do discuss areas found during the investigation that do not meet regulation and discuss the scope and severity of each violation and determine the level of harm.

- **"Scope"** refers to the number of residents or locations within a facility that are affected.
- **"Severity"** refers to the seriousness of the violation, or the harm (or potential for harm) the violation has caused.
- "**Harm"** is defined as a measurable negative impact to a resident's physical, mental, financial, or emotional well-being.
  - **Minor harm** means harm resulting in no more than temporary physical, mental or emotional discomfort or pain without loss of function, or in financial loss of less than $1,000.
  - **Moderate harm** means harm resulting in temporary loss of physical, mental, or emotional function, or in financial loss of $1,000 or more, but less than $5,000.
  - **Serious harm** means harm resulting in long-term or permanent loss of physical, mental, or emotional function, or in financial loss of $5,000 or more.

Violations are classified according to the assessed scope and severity.

**Immediate Jeopardy** is the term used when a facility fails to comply with a rule of the department and this failure caused or is likely to cause serious injury, serious harm, serious impairment, or death to a resident. When immediate jeopardy is identified during the survey, the facility will be asked to develop a plan of correction immediately which specifically addresses the situation(s). The survey team will review and approve the plan of correction prior to survey exit.

**Exit Conference and Post Survey**

Upon completion of the survey, surveyors hold an exit conference with facility administrators and other individuals to review findings of the survey. Within 10 business days of leaving the facility, the survey team completes a detailed survey report outlining the citations and specific examples that pertain to the regulations. The facility then has 10 business days from receiving the report to respond and submit a Plan of Correction (POC) to SOQ. The POC describes the action(s) that will be taken by the facility to correct any violations and systemic issues to help ensure violations will not happen again.

## Chapter 7: Licensing Complaint Unit (LCU) Process

### Receipt of Complaints (APS referral, public, internal)

When SOQ receives a complaint of a potential licensing violation within a Residential Care Facility or an Assisted Living Facility, LCU sends a Compliance Specialist to the facility to review the complaint. Complaints come from public citizens; referrals from agency partners, such as APS or LTCO; or from information provided by SOQ staff.

### Review/Investigation

LCU staff investigate complaints that could potentially be the result of licensing rule violation. Compliance specialists review both the circumstances surrounding an individual occurrence and possible systemic issues. If a complaint is confirmed, the Compliance Specialist will either provide technical assistance or, if the non-compliance is more serious, the information will be forwarded to corrective action coordinators to take regulatory action. LCU on-site investigations are unannounced. An LCU investigation is narrower in scope than a survey inspection and is usually focused on specific alleged incidents or practices. LCU does not review allegations of abuse; instead, if a compliance specialist witnesses or suspects abuse, they will immediately refer the situation to APS for an abuse investigation.

### Determination and Follow Up

Technical assistance findings are not posted on the licensing website, nor do they result in sanctions. Facilities may, however, be asked to provide a plan of correction that details how the facility will address the issue. Corrective Action reviews the report and determines what additional regulatory response is merited.

## Chapter 8: Adult Protective Services Process

Local Adult Protective Services (APS) offices (ODHS or Type B AAA) receive, screen, and respond to reports of abuse, suspected abuse, or injuries of unknown cause where abuse cannot be ruled out for residents of licensed facilities, including CBC settings. The process for receiving, screening and investigating reports of abuse of CBC residents is outlined in OAR Chapter 411, Division 20.

### Screening

Facilities are required to report suspected abuse to ODHS. All reports of abuse of residents are screened by APS staff according to OAR 411-020-0060. APS screeners gather information to determine if the individual meets eligibility for adult protective services and whether the reported concern, *if true*, meets a definition of abuse in OAR 411-020-0002(1).

Any resident of a ODHS APD-licensed Residential Care or Assisted Living facility is considered eligible for adult protective services. APS receives reports of suspected abuse of Residential Care or Assisted Living Facility residents from various sources, including residents, families of residents, professionals involved in residents' care, facility care staff or facility management. Every incident self-reported to APS by a facility is considered a report of potential abuse and screened accordingly.

If the reported complaint allegation meets the definition of abuse, it is assigned for APS investigation. If a complaint allegation does not meet the APS definition of abuse, APS staff close the allegation intake and make necessary referrals to case managers, licensors, the Office of Long-Term Care Ombudsman, the Licensing Complaint Unit, or other entities.

### Investigation by APS

APS is required to conduct a complete, thorough, and objective facility investigation when a resident is reported to have been abused by facility staff, contractor or volunteer of the facility and the reported concern, *if true*, meets the APS definition of abuse. OAR 411-020-0002(1) defines the following types of abuse:

- Physical Abuse
- Neglect
- Abandonment
- Verbal or Emotional Abuse
- Financial Exploitation
- Sexual Abuse
- Involuntary Seclusion

- Wrongful Use of a Physical or Chemical Restraint

APS or AAA staff screen and investigate reported incidents on a single-victim basis. This means every resident who is an Alleged Victim (AV) of abuse will have a separate case, separate investigation, and separate determination of whether abuse occurred. In addition, APS names individual staff members alleged to have abused an Alleged Victim as a separate Alleged Perpetrator (AP) in a separate allegation. A report is written on behalf of each AV. A report may contain multiple allegations of abuse against one AV; however, a single report would not include multiple AVs.

In addition to individual staff named as Alleged Perpetrators, APS names the facility licensee as an Alleged Perpetrator to determine whether the facility's actions or inactions contributed to the alleged abuse. The APS investigator conducts interviews and gathers evidence to determine whether the facility actively or passively failed to provide the basic care or services necessary to maintain the health and safety of a resident when *the failure results in abuse as defined previously.*

For example, neglect may be substantiated even if there was no actual harm (physical or emotional) to a resident or if the resident was placed at "risk of serious harm" by the facility's actions or inactions.

**Determination and Processing by APS**

When the investigation of all allegations is complete, the APS investigator evaluates the evidence and reaches a determination for each allegation. Determinations include:

- Substantiated abuse
- Not substantiated abuse
- Inconclusive, or
- Administrative closure when an investigation can't be completed (see OAR 411-020-0121.)

The standard of proof for an APS determination is "preponderance of the evidence," which means that most of the evidence supports a conclusion. To substantiate abuse by the facility, a preponderance of the evidence gathered by the investigator needs to indicate that the facility's actions or inactions led to:

- Physical harm,
- Significant emotional harm,
- Unreasonable discomfort, or serious loss of personal dignity, or

- Risk of serious harm to the resident, defined in OAR 411-020-0002(41) to mean that, "without intervention, the individual is likely to incur substantial injury or loss."

To close the investigation, the APS investigator must make a determination concerning each allegation named in the case. Depending on the facts of the case, the findings against the facility and individual staff will vary. Possible variations include:

1. Facility and individual staff substantiated for wrongdoing (e.g., staff abused a resident and evidence indicated facility could have foreseen or prevented the abuse but did not).
2. Facility substantiated wrongdoing and individual staff not substantiated wrongdoing (e.g., evidence indicated facility actions/inactions resulted in harm to a resident or potential for serious harm to a resident, no individual staff wrongdoing).
3. Facility wrongdoing not substantiated and individual staff substantiated abuse (e.g., individual staff abused a resident and evidence indicated facility could not have foreseen or prevented the wrongdoing).
4. Facility and individual staff wrongdoing not substantiated (e.g., evidence indicated no facility or staff wrongdoing).

APS and SOQ jointly have 120 days to complete an investigation. The preliminary complaint investigation report is provided to the facility to allow immediate action to be taken to ensure resident safety and prevent a recurrence. Facilities are provided an opportunity to dispute report findings once SOQ has approved and finalized the report.

Facilities and the registered agent receive the finalized complaint investigation report and any associated sanctions via written notice from SOQ. Notification information provides an explanation of the facility's opportunity to dispute the findings of the report and/or the sanction. When a sanction is imposed, a facility has the option to request a hearing and engage in an informal conference with SOQ prior to the hearing.

If a sanction is issued, facilities are entitled to request a contested case hearing as provided by ORS 183.415, and they may choose to be represented by an attorney at the hearing. The timeline for requesting a hearing is detailed in the sanction notice. Requests for hearing may be sent by U.S. Mail or by email. A request sent by U.S. mail is "received" on the date it is postmarked.

## Chapter 9: Corrective Action Process

Staff work closely with facilities to address problems as early as possible with open communication, as this achieves the best possible result for the Oregonians living in licensed facilities. The CBC team works with internal and inter-agency partners to apply the appropriate regulatory action to keep residents safe and support person-centered care.

### Alleged Incident

The corrective action process begins when ODHS receives a complaint that a facility is violating the rules, including rules prohibiting neglect and other forms of abuse. Anyone, including residents, their families and the public may make a complaint about a facility. Complaints can come directly to LCU or to LCU through another source such as Adult Protective Services, the Governor's Advocacy Office, or the Office of the Long-Term Care Ombudsman. The allegation receives follow-up regardless of the source.

### APS, Survey and LCU Investigate and Submit Reports to CACs

APS, CBC survey and LCU have unique and complementary roles: APS investigates alleged abuse. CBC survey conducts licensing, biennial re-licensure surveys and annual kitchen inspections. LCU investigates licensing violation complaints. Each of these three programs submit completed reports to the CBC Corrective Action Coordinators for final regulatory action.

Corrective Action Coordinators (CAC) use report information as a basis for issuing sanctions for four basic types of violations:

- **Abuse violations** for substantiated harm or risk of serious harm to a resident, as determined by APS.
- **Survey and LCU Licensing violations** for failures to substantially comply with licensing rules, as determined by SOQ; and/or
- **Failure to self-report** abuse or suspected abuse.
- **Individual professional practice issues** are referred to the appropriate professional practice board (e.g., Board of Nursing, Board of Pharmacy, Long-Term Care Administrators Board, etc.)

**CACs Review Complaint Investigations**

Once the APS report is sent to SOQ, the complaint investigation (abuse or licensing) is assigned to a CAC for review. In that review, CACs:

- Determine scope and severity of the violations.
- Consider aggravating and mitigating factors.
- Issue sanctions appropriate to the violation.

When a CAC receives a complaint investigation report from an APS investigator, the CAC will first determine which finding the APS investigator has made (substantiated abuse, not substantiated abuse, or inconclusive). If the finding is not substantiated abuse, the CAC determines if a licensing violation occurred. The CAC begins by categorizing the violation(s) as follows:

*Was abuse substantiated?* APS determines if a facility has failed to substantially comply with an Oregon Administrative Rule (OAR) related to abuse (OAR chapter 411, division 020). If APS investigates an allegation of abuse and substantiates the findings, the decision is forwarded to corrective action to determine the appropriate regulatory response.

*Did a licensing violation occur?* Licensing violations occur when a facility has failed to substantially comply with an Oregon Administrative Rule (OAR chapter 411, division 054 for Assisted Living and Residential Care facilities and 057 for Memory Care Communities). "Substantial compliance" means a level of compliance with state law and with rules of the department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents of a facility. Licensing violations occur when a state regulation (OAR chapter 411, divisions 54 or 57) is violated. These violations may be issued when deficiencies are:

- Substantiated during the survey process.
- Confirmed during the LCU complaint process.
- Substantiated during an APS investigation.

Facilities are required to immediately report to the department within 24 hours, abuse or suspected abuse of a resident, or injuries of unknown cause where abuse cannot be ruled out. The reporting deadline includes weekends and holidays. If a facility fails to report within 24 hours, the Director may impose a civil penalty of not more than $1,000. The facility must not retaliate in any way against anyone who participates in making an abuse complaint. For more information on abuse investigation and reporting, please see the Abuse Investigation and Reporting Guide for Providers.

**Assessing Civil Penalties**

All instances of substantiated abuse are assessed a civil penalty. Licensing violations result in civil penalties when the licensing violation(s) are not remedied, as required by prior corrective action, and the violation is at a severity level 2 or higher.

Once the severity level of harm and the scope of the violation are determined, the CAC considers relevant aggravating and mitigating factors to determine if the civil penalty amount should be increased or reduced.

**Does the facility have a history of similar violations?**

The CAC reviews the facility's one year compliance history to determine if the facility has similar violations in the past. This history will be used to answer the questions below concerning aggravating and mitigating factors.

Aggravating factors (increase civil penalty amount):

- *Facility's history* – the facility had prior similar violations.
- *Failure to remedy* – the facility failed to satisfactorily correct prior similar violations or failed to prevent a recurrence of similar violations.
- *Financial benefit* – the facility or facility employees gained financially because of the violation.

Mitigating factors (decrease civil penalty amount):

- *Facility's history of correcting past violations* – the facility corrected previous violations and prevented the recurrence of violations.
- *Facility's ownership/management history* – the previous violations happened under prior ownership/management.
- *Self-report* – the facility self-reported immediately.

**Determining Civil Penalty Amount**

After the CAC has reviewed relevant information, identified responsible parties, determined severity and scope of the violation, and considered mitigating and aggravating factors, the CAC determines the appropriate corrective action. Current department policy specifies a civil penalty should be assessed when there is a substantiated abuse determination. Facility Failure to Self-Report Abuse – Civil Penalty

The department may issue a fine of up to $1,000 for each instance in which a facility fails to self-report abuse of a resident as required by state law. The department may issue a violation and a $750 penalty for the first instance of failure to self-report. Each subsequent instance of failure to self-report will result in a violation and a penalty of $1,000.

It is crucial facilities understand when and how to report abuse and suspected abuse. Detailed information related to these issues is outlined in the Abuse Reporting and Investigation Guide for Providers. As discussed above, all substantiated abuse violations will receive a civil penalty. However, in addition to a financial penalty, there are other sanctions that may be imposed for failure to maintain substantial compliance with Oregon Administrative Rules.

## Chapter 10: Regulatory Action

Once the CAC determines responsibility and severity of the violation(s), they determine what regulatory action is appropriate to compel the facility to regain substantial compliance. The coordinator reviews all factors and evaluates progressive regulatory intervention.

### Issuance of Violations

A violation is a formal acknowledgement by the department that a facility is not in substantial compliance with licensing rules. When a licensing violation or substantiated abuse violation is assessed above a Level 1, the violation is published on the Licensed Long Term Care Settings Search website. A Letter of Determination (LOD) is issued directly to the facility alerting them to the violation. The facility is expected to correct violations when issued and encouraged to contact CBC staff with questions.

### Technical Assistance and Support

SOQ staff are available to talk with facility staff, answer questions, identify problems and discuss solutions. SOQ staff may recommend a facility engage in internal or external quality assurance/improvement activities or provide specific training to facility staff.

In certain circumstances where a facility needs to resolve a minor licensing issue the Policy Analyst assigned to the facility talks with the Facility Administrator and collaborates on a follow-up action to resolve issue. The Policy Analyst sends a follow-up email confirming the action(s) the facility will take to resolve the issue. When the matter is quickly and satisfactorily resolved, no further action is taken. However, if the facility fails to satisfactorily resolve the issue, the Policy Analyst recommends corrective action.

Example: A facility employee needs a food handler's card before continuing to assist with preparing meals. The Policy Analyst and Administrator agree via email the facility will provide documentation the staff member earned a food handler's card before preparing any more food.

### Voluntary Letters of Agreement (LOA)

SOQ staff work with facilities using a Voluntary Letter of Agreement to compel a facility to correct violations. SOQ initiates the LOA process and proposes initial terms, allowing a reasonable opportunity for the facility to present alternative remedies. LOAs are not posted on the Licensed Long-Term Care Settings search

website and do not require public signage at the facility when both parties agree upon a voluntary restriction of resident admission.

The length of time an LOA remains in place is dependent on the facility's progress in achieving substantial compliance and with meeting the terms agreed upon in the LOA. The length of time for an LOA is dependent on facility progress and includes department review and/or reinspection once a facility makes an assertion of substantial compliance.

Providers are encouraged to contact the Corrective Action Coordinator assigned to their facility when they believe their progress warrants amendments to the LOA, or to discuss what is necessary to remove the LOA. If a department review/reinspection finds a new potential violation not related to the original LOA, new corrective action may be assessed. If the facility decides to decline a LOA, SOQ may opt to impose a license condition.

**License Conditions**

A **licensing violation** occurs when a facility has failed to substantially comply with an Oregon Administrative Rule (OAR). Substantial compliance is a level of compliance with state law and with rules of the department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents of a facility (OAR 411-054-0005(91)).

CBC imposes a condition on a license when there have been serious licensing violations or substantiated abuses and it has been determined a more restrictive option is necessary. Non-abuse licensing violations occur when an OAR is violated but there is no substantiated abuse. If the facility continues to fail to comply with regulations the department will issue a civil penalty for licensing violations at level 2 severity or above.

Following are examples of instances when a license condition is considered:

- When a facility failed to comply with previous notices from the department, thereby subjecting residents to actual harm or risk of harm.
- When the department becomes aware of serious incidents of non-compliance through survey (such as immediate jeopardy situations) or investigations that resulted in harm or threaten the safety of residents.
- When a facility has ongoing issues with substantiated non-compliance, despite other actions, such as a letter of agreement.
- A license condition specifying restriction of new resident admissions may be imposed when the department determines facility conditions indicate

immediate jeopardy. Therefore, admitting new residents is likely to cause serious harm to future residents. Immediate jeopardy findings must be substantiated within 30 days after imposition of the license condition.

The department provides a facility with a notice of **impending imposition** of license condition at least 48 hours before issuing an order imposing a license condition. The notice must:

- Describe the acts or omissions of the facility and the circumstances that led to the substantiated finding of a rule violation(s).
- Describe why the acts or omissions and the circumstances create a situation for which the imposition of a license condition is warranted.
- Provide a brief statement identifying the nature of the license condition.
- Provide a brief statement describing how the license condition is designed to remediate the circumstances that led to the license condition.

Except in circumstances where the threat to residents is imminent and the department determines it is not safe or practical to give the facility advance notice, the department must provide the required notice within 48 hours of issuing an order imposing the license condition.

License conditions may include requiring the facility to ensure staff complete training courses, hire a consultant to assist with compliance activities, adopt mandatory staffing patterns, temporarily restrict admission of new residents, or other requirements specific to the issue(s) of non-compliance.

**Civil Penalties**

The process for issuing civil penalties is discussed in detail in Chapter 10. Civil penalties are being mentioned here to acknowledge that financial penalties can be considered part of progressive discipline.

**Notice of Intent to Non-Renew, Deny, Suspend, or Revoke a License**

If a facility has significant compliance violations placing residents at serious risk of harm, and/or has repeatedly failed to respond to corrective action directed toward substantial compliance, the department may issue a notice of intent to deny, revoke, suspend or non-renew the license. The requirements for issuance of these notices are described in OAR 411-054-0130.

**Revocation or Non-Renewal of License – Imposed**

If a facility has been issued a notice of intent to non-renew, and the facility continues to fail to address regulatory concerns and come back into substantial

compliance, CBC may deny, suspend, revoke, or refuse to renew the facility's license. See OAR 411-054-0130.

## Appendix A: Glossary of Corrective Action Terms

1. **Abuse violation.** This occurs when a resident has suffered harm or potential for serious harm which has been substantiated by APS.

2. **Civil Penalty**: If abuse is substantiated, the Corrective Action Coordinator will issue a monetary fine against the facility. The amount of the fine corresponds to the level of severity of the harm, the scope of the harm, and the applicable mitigating and aggravating factors.

3. **Condition**: CBC issues a written document to the facility when serious or pervasive licensing violations must be addressed.

4. **Licensing violation**: This is when a licensing regulation is violated per division 411-054-0000

5. **Scope:** This refers to the number of residents or locations within a facility that are affected. Scope is categorized as:
   - **Isolated** - one or a very limited number of residents or employees are affected or a very limited area or number of locations within a facility are affected.
   - **Pattern** - more than a very limited number of residents or employees are affected, or the situation has occurred in more than a limited number of locations, but the locations are not dispersed throughout the facility.
   - **Widespread** - the problems causing the deficiency are pervasive and affect many locations throughout the facility or represent a systemic failure that affected, or has the potential to affect, a large portion or all the residents or employees.
   - **Severity**: This refers to the seriousness of the violation, or the harm (or potential for harm) the violation has caused. “Harm” is defined as a measurable negative impact to a resident’s physical, mental, financial, or emotional well-being.

6. **Substantial compliance**: This means a level of compliance with state law and with rules of the department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents.

## Appendix B: Resources

RCF/ALF Rules: https://www.ODHS.state.or.us/policy/spd/rules/411_054.pdf

Memory Care Rules: http://www.ODHS.state.or.us/policy/spd/rules/411_057.pdf

Abuse Rules: http://www.ODHS.state.or.us/policy/spd/rules/411_020.pdf

Abuse Reporting and Investigation Guide (Form APD 0472); https://apps.state.or.us/Forms/Served/se0472.pdf

CBC Licensing Web Page: https://www.oregon.gov/ODHS/providers-partners/licensing/CBC/pages/index.aspx

Oregon Care Partners Website: https://oregoncarepartners.com/

Alzheimer's Network of Oregon: **https://alznet.org/**

Consumer Guide (ADRC): https://www.adrcoforegon.org/consite/index.phphttps://www.adrcoforegon.org/forms/AssistedLiving_ResidentialCareFacilityGuide.pdf

Comparison Tool (ADRC): https://www.adrcoforegon.org/consite/downloads/ADRC-toolkit-August2017.pdf

Disability Rights Oregon (DRO): https://droregon.org