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

CHAPTER 411
DIVISION 51

ADULT FOSTER HOMES FOR OLDER ADULTS OR ADULTS WITH PHYSICAL DISABILITIES - STANDARDS OF CARE

Table of Contents
(Effective 1/1/2022)

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

CHAPTER 411
DIVISION 51

ADULT FOSTER HOMES FOR OLDER ADULTS OR ADULTS WITH PHYSICAL DISABILITIES - STANDARDS OF CARE

411-051-0105 Resident's Rights *(Adopted 7/1/2019)*

(1) RESIDENT'S BILL OF RIGHTS AND FREEDOMS. The licensee, AFH occupants, and employees of the home must not violate these rights and must help the residents exercise them. The Resident's Bill of Rights and Freedoms provided by the Department must be explained and a copy given to each resident at the time of admission. The Resident's Bill of Rights and Freedoms states each resident has the right to:

(a) Be treated as an adult with respect and dignity.

(b) Be informed of all resident rights and all house policies as written in the Residency Agreement.

(c) Be encouraged and assisted to exercise constitutional and legal rights, including the right to vote.

(d) Be informed of his or her medical condition and the right to consent to or refuse treatment.

(e) Receive appropriate care, services, and prompt medical care as needed.

(f) Be free from abuse.

(g) Complete privacy when receiving treatment or personal care.

(h) Associate and communicate privately with any person of choice and send and receive personal mail unopened.

(i) Have access to, and participate in, activities of social, religious, and community groups.

(j) Have medical and personal information kept confidential.

(k) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space.

(l) Be free from chemical and physical restraints except as ordered by a physician or other qualified practitioner and consented to by the resident or their legal guardian.

> (A) Restraints are used only for medical reasons, to maximize a resident's physical functioning, and after other alternatives have been tried and may not be used for discipline or convenience.
>
> (B) When the right to freedom from restraints must be limited due to a threat to the health and safety of an individual or others, an individually-based limitation is required according to (3) of this rule and OAR 411-004-0040.

(m) Manage his or her own financial affairs unless legally restricted.

(n) Be free from financial exploitation. The licensee may not charge or ask for application fees or non-refundable deposits or solicit, accept, or receive money or property from a resident other than the amount agreed to for services.

(o) A written agreement regarding services to be provided and the rates to be charged. The licensee must give 30 days' written notice before any change in the rates or the ownership of the home.

(p) Not be transferred or moved out of the AFH without 30 calendar days' written notice and an opportunity for a hearing. A licensee or administrator may transfer a resident only for medical reasons, for the welfare of the resident or other residents, or for nonpayment.

(q) A safe and secure environment.

(r) Be free of discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.

(s) Make suggestions or complaints without fear of retaliation.

(t) Be free of discrimination regarding the execution of an Advance Directive, Physician's Order for Life-Sustaining Treatment (POLST), or Do Not Resuscitate (DNR) orders.

(2) HCBS FREEDOMS. Residents have the following rights and freedoms authorized by 42 CFR 441.301(c)(4) and 42 CFR 441.530(a)(1):

(a) To live under a legally enforceable Residency Agreement with protections substantially equivalent to landlord-tenant laws.

(b) The freedom and support to access food at any time.

(c) To have visitors of the resident's choosing at any time.

(d) To privacy in the resident's bedroom, and to have a lockable door in the resident's bedroom, which may be locked by the resident.

(e) To choose a roommate when sharing a bedroom.

(f) To furnish and decorate the resident's bedroom according to the Residency Agreement.

(g) The freedom and support to control the resident's schedule and activities.

(3) INDIVIDUALLY-BASED LIMITATIONS. Effective July 1, 2019 and no later than June 30, 2020, a limitation to (1)(l) of this rule and any freedom in section (2)(b) through (g) of this rule must be supported by a specific assessed need due to a threat to the health and safety of the resident or others. All individually-based limitations (IBL) considered must be documented on the Department-approved consent form.

(a) For Medicaid-eligible residents, the person-centered service plan must be developed as outlined in OAR 411-051-0120.

(b) For Medicaid-eligible residents, the person-centered service plan coordinator must authorize the IBL and the individual, or their representative, must consent to the limitation.

(c) The licensee or administrator must incorporate and document all applicable elements identified in OAR 411-004-0040, including:

(A) The specific and individualized assessed need justifying the limitation.

(B) The positive interventions and supports used before imposing a limitation.

(C) Less intrusive methods that have been tried, but did not work.

(D) A clear description of the condition that is directly proportionate to the specific assessed need.

(E) Regular reassessment and review to measure the ongoing effectiveness of the limitation.

(F) Established time limits for periodic review of the limitation to determine if the limitation should be terminated or remains necessary. The limitation must be reviewed at least annually.

(G) The informed consent of the resident or, as applicable, the legal representative of the resident, including any discrepancy between the wishes of the resident and the consent of the legal representative.

(H) An assurance that the interventions and support do not cause harm to the individual.

(d) Limitations are not transferable between care settings. Continued need for any limitation at a new care setting must comply with the requirements in these rules.

(4) RESIDENT CARE.

(a) Care and supervision of residents must be in a homelike atmosphere. The training of the licensee and caregivers and care and supervision of residents must be appropriate to the age, care needs, and conditions of the residents in the home. Additional staff may be required if, for example, day care individuals are in the home or if necessary to safely evacuate the residents and all occupants from the home as required by OAR 411-050-0725.

(b) If a resident has a medical regimen or personal care plan prescribed by a licensed health care professional, the licensee or administrator must cooperate with the plan and ensure the plan is implemented as instructed.

(c) NOTIFICATION. The licensee or administrator must notify emergency personnel, the resident's physician, nurse practitioner, physician assistant, registered nurse, family representative, and case manager, as applicable, under the following circumstances:

(A) EMERGENCIES (MEDICAL, FIRE, POLICE). In the event of an emergency, the licensee or caregiver with the resident at the time of the emergency must first call 911 or the appropriate emergency number for the home's community. This does not apply to a resident with a medical emergency who practices Christian Science.

(i) If a resident is receiving hospice services, the caregivers must follow the written instructions for medical emergencies from the hospice nurse.

(ii) If a resident has a completed Physician's Orders for Life-Sustaining Treatment (POLST) or other legal documents, such as an Advance Directive or Do Not Resuscitate (DNR) order, copies of the documents must be made available to the emergency personnel when they arrive.

(B) HOSPITALIZATION. In the event the resident is hospitalized.

(C) HEALTH STATUS CHANGE. When the resident's health status or physical condition changes.

(D) DEATH. Upon the death of the resident.

(d) The licensee shall not inflict, or tolerate to be inflicted, abuse of any resident, as defined in OAR 411-020-0002.

(e) REASONABLE PRECAUTIONS. The licensee must exercise reasonable precautions against any conditions that may threaten the health, safety, or welfare of the residents.

(f) A qualified caregiver must always be present and available at the home when a resident is in the home. A resident may not be left in charge in lieu of a caregiver.

(g) DIRECT INVOLVEMENT OF CAREGIVERS. The licensee or caregivers must be directly involved with the residents daily. If the physical characteristics of the AFH do not encourage contact between the caregivers and residents and among residents, the licensee must demonstrate how regular positive contact occurs.

(5) ACTIVITIES. The licensee or administrator must make available at least six hours of activities per week, not including television and movies, that are of interest to the residents. Information regarding activity resources is available from the LLA. Activities must be oriented to individual preferences as indicated in the resident's care plan. (See OAR 411-051-0115). Documentation of the activities offered to each resident and the resident's participation in those activities must be recorded in the resident's records.

(6) RESIDENT MONEY. If the licensee or administrator manages or handles a resident's money, a separate account record must be maintained in the resident's name. The licensee or administrator may not under any circumstances commingle, borrow from, or pledge any of a resident's funds. The licensee or administrator may not act as a resident's guardian, conservator, trustee, or attorney-in-fact unless related by birth, marriage, or adoption to the resident as follows: parent, child, brother, sister, grandparent, grandchild, aunt, uncle, niece, or nephew. Nothing in this rule may be construed to prevent the licensee or the licensee's employee from

acting as a representative payee for the resident. (See also OAR 411-020-0002).

(a) Personal incidental funds (PIF) for individuals eligible for Medicaid services must be used at the discretion of the individual for such things as clothing, tobacco, and snacks (not part of daily diet).

(b) The licensee and other caregivers may not accept gifts from the residents through undue influence or accept gifts of substantial value. Caregivers and family members of the caregivers may not accept gifts of substantial value or loans from the resident or the resident's family. The licensee or other caregivers may not influence, solicit from or suggest to any residents or resident's representatives that the residents or the resident's representatives give the caregiver or the caregiver's family money or property for any purpose.

(c) The licensee may not subject the resident or the resident's representative to unreasonable rate increases.

(d) The licensee and other caregivers may not loan money to the residents.

Stat. Auth.: ORS 127.520, 409.050, 410.070, 413.085, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790
Stats. Implemented: ORS 409.050, 410.070, 413.085, 441.373, 443.001 - 443.004, 443.705 - 443.825, 443.875, 443.991

411-051-0110 Pre-Admission *(Amended 6/24/2020)*

(1) PRE-ADMISSION SCREENING AND ASSESSMENT.

(a) Before admission, the licensee or administrator must conduct and document a screening using the Department's current Adult Foster Home Screening and Assessment and General Information form (SDS 0902) to determine if a prospective resident's care needs exceed the license classification of the home. The screening must:

(A) Evaluate the ability of the prospective resident to evacuate the home within three minutes along with all the occupants of the home.

(B) Determine if the licensee and caregivers can meet the prospective resident's needs in addition to meeting the needs of the other residents of the home.

(C) Include medical diagnoses, medications, personal care needs, nursing care needs, cognitive needs, communication needs, night care needs, nutritional needs, activities, lifestyle preferences, and other information, as needed, to assure the prospective resident's care needs shall be met.

(b) The screening process must include interviews with the prospective resident and the prospective resident's family, prior care providers, and case manager, as appropriate. The licensee or administrator must also interview, as necessary, any physician, nurse practitioner, physician assistant, registered nurse, pharmacist, therapist, or mental health or other licensed health care professional involved in the care of the prospective resident. A copy of the screening document must be:

(A) Given to the prospective resident or their representative.

(B) Placed in the resident's record if admitted to the home; or

(C) Maintained for a minimum of three years if the prospective resident is not admitted to the home.

(c) If the Department or AAA knows a person who is on probation, parole, or post-prison supervision after being convicted of a sex crime as defined in ORS 163A.005 is applying for admission to an AFH, the Department or AAA shall notify the home of the person's status as a sex offender.

(d) The licensee or administrator may refuse to admit a person who is on probation, parole, or post-prison supervision after being convicted of a sex crime as defined in 163A.005.

(e) REQUIRED DISCLOSURES.

(A) The licensee or administrator must disclose the home's policies to a prospective resident or the prospective resident's representative, as applicable. A copy of the home's current Residency Agreement identifying the home's policies shall be provided to the prospective resident and their representative. (See OAR 411-050-0705).

(B) LONG-TERM CARE ASSESSMENT. The licensee or administrator must inform a prospective private-pay resident or the prospective resident's representative, if appropriate, of the availability of long-term care assessment services provided through the Department or a certified assessment program. The licensee or administrator must document on the Department's form (SDS 913) that the prospective private-pay resident has been advised of the right to receive a long-term care assessment. The licensee or administrator must maintain a copy of the form in the resident's record upon admission and make a copy available to the Department upon request.

(2) BEFORE ADMISSION.

(a) The licensee or administrator must obtain and document general information regarding a resident before the resident's admission. The information must include the names, addresses, and telephone numbers of the resident's relatives, significant persons, case managers, and medical or mental health providers. The information must also include the date of admission and, if available, the resident's medical insurance information, birth date, prior living facility, and mortuary.

(b) Before admission, the licensee or administrator must obtain and place in the resident's record:

(A) Prescribing practitioner's written or verbal orders for medications, treatments, therapies, and special diets, as applicable. Any verbal orders must be followed by written orders within seven calendar days of the resident's admission.

Attempts to obtain written orders must be documented in the resident's record.

(B) Prescribing practitioner or pharmacist review of the resident's preferences for over-the-counter medications and home remedies.

(C) Any medical information available, including the resident's history of accidents, illnesses, impairments, or mental status that may be pertinent to the resident's care.

(c) The licensee or administrator must ask for copies of the resident's Advance Directive, Physician's Order for Life Sustaining Treatment (POLST), and proof of court-appointed guardianship or conservatorship, if applicable. Copies of these documents must be placed in a prominent place in the resident's record and sent with the resident if the resident is transferred for medical care.

(d) The licensee or administrator must review the home's current Residency Agreement with the resident and the resident's representative, as appropriate. These reviews must be documented by having the resident, or the resident's representative, sign and date a copy of the Residency Agreement. A copy of the signed and dated Residency Agreement must be maintained in the resident's record.

(e) Upon admission of a resident, the licensee or administrator shall provide the resident or the resident’s representative with information developed by the Long-Term Care Ombudsman describing the availability and services of the ombudsman. The facility shall document that the facility provided this information as required.

(3) SCREENING BEFORE RE-ADMISSION. When a resident temporarily leaves the home including, but not limited to, a resident's hospitalization, the licensee or administrator shall conduct the necessary elements of the pre-admission and screening assessment requirements, and document those findings to:

(a) Determine whether readmission to the home is appropriate for the classification of the home.

(b) Determine whether the licensee or administrator can continue to meet the resident's care and safety needs in addition to those of the other residents.

(c) Demonstrate compliance with these rules.

(d) If applicable, demonstrate the basis for refusing the resident's re-admission to the home according to reasons identified in OAR 411-050-0760(3).

Stat. Auth.: ORS 127.520, 409.050, 410.070, 413.085, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790
Stats. Implemented: ORS 409.050, 410.070, 413.085, 441.373, 443.001 - 443.004, 443.705 - 443.825, 443.875, 443.991

411-051-0115 Care Plan *(Adopted 7/1/2019)*

(1) During the initial 14 calendar days following the resident's admission to the home, the licensee or administrator must continue to assess and document the resident's preferences and care needs. The assessment and care plan must be completed by the licensee or administrator and documented within the initial 14-day period. The care plan must describe the resident's needs, preferences, capabilities, what assistance the resident requires for various tasks, and must include:

(a) By whom, when, and how often care and services shall be provided.

(b) The resident's ability to perform activities of daily living (ADLs).

(c) Special equipment needs.

(d) Communication needs (examples may include, but are not limited to, hearing or vision needs, such as eraser boards or flash cards, or language barriers, such as sign language or non-English speaking).

(e) Night needs.

(f) Medical or physical health problems, including physical disabilities, relevant to care and services.

(g) Cognitive, emotional, or other impairments relevant to care and services.

(h) Treatments, procedures, or therapies.

(i) Registered nurse consultation, teaching, delegation, or assessment.

(j) Behavioral interventions.

(k) Social, spiritual, and emotional needs, including lifestyle preferences, activities, and significant others involved.

(l) The ability to exit in an emergency, including assistance and equipment needed.

(m) Any use of physical restraints or psychotropic medications.

(n) Dietary needs and preferences.

(o) Any individually-based limitations according to OAR 411-051-0105(3).

(A) Effective July 1, 2019 and no later than June 30, 2020, the licensee or administrator must identify any individually-based limitations to the use of restraints or the HCBS rights as listed in OAR 411-051-0105(2).

(B) For Medicaid-eligible residents, the person-centered service plan coordinator must authorize the limitation and the individual must consent to the limitation. The licensee or administrator must incorporate and document all applicable elements identified in OAR 411-051-0105(3).

(C) Limitations are not transferable between care settings. Continued need for any limitation at the new care setting must comply with the requirements as stated in OAR 411-051-0105.

(2) The licensee or administrator must:

(a) Review and update each resident's care plan every six months.

(b) Review and update a resident's care plan when a resident's condition changes.

(c) Document in the resident's record at the time of each review and include the date of the review and the licensee or administrator 's signature. If a care plan contains many changes and becomes less legible, a new care plan must be written.

(3) The licensee or administrator is responsible for ensuring implementation of the resident's care plan and, if applicable, the behavioral support plan with suggested interventions.

Stat. Auth.: ORS 127.520, 409.050, 410.070, 413.085, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790
Stats. Implemented: ORS 409.050, 410.070, 413.085, 441.373, 443.001 - 443.004, 443.705 - 443.825, 443.875, 443.991

411-051-0120 Person-Centered Service Plan *(Adopted 7/1/2019)*

(1) A Medicaid-eligible resident's case manager shall complete a person-centered service plan, pursuant to OAR 411-004-0030. The licensee or administrator must incorporate all applicable elements identified in the person-centered service plan that the licensee or administrator is responsible for implementing. The licensee or administrator must notify the resident's case manager in the event a review and change or removal of an existing limitation is warranted, and when a new limitation is supported by a specific assessed need.

(a) All attempts to notify the resident's case manager about a review to change, remove, or add a limitation must be documented, and available in the resident's record.

(b) The licensee or administrator may not be held responsible for any failure on the case manager's part to conduct a review of current limitations or to complete the person-centered service plan if there have been multiple documented attempts to contact the resident's case manager and the resident has been reasonably protected from harm.

(2) Licensees or administrators may assist non-Medicaid residents in developing a person-centered service plan when no alternative resources are available.

Stat. Auth.: ORS 127.520, 409.050, 410.070, 413.085, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790
Stats. Implemented: ORS 409.050, 410.070, 413.085, 441.373, 443.001 - 443.004, 443.705 - 443.825, 443.875, 443.991

411-051-0125 Registered Nurse Consultation *(Adopted 7/1/2019)*

(1) RN CONSULTATION AND ASSESSMENT. A licensee or administrator must have an arrangement with at least one registered nurse, who has a current, active, unencumbered Oregon license to provide consultation, assessment, teaching, delegation, or review of medication administration processes, as needed to meet the care needs of non-Medicaid residents as required by these rules.

(a) The licensee or administrator must check to confirm the RN has a current, active, unencumbered Oregon license on the OSBN website at: https://osbn.oregon.gov/OSBNVerification/Default.aspx.

(b) Verification of the RN's status with the OSBN must be documented and readily accessible in the facility's records.

(2) An RN consultation must be obtained when a nursing procedure has been ordered by a health care professional with prescribing authority for any medical treatment other than medications that are taken by mouth.

(3) A licensee or administrator must also request a registered nurse consultation under the following conditions:

(a) When a resident has a health concern or behavioral symptoms that is unfamiliar to caregivers.

(b) To clarify a prescribing practitioner's PRN order when it includes dose or frequency ranges, or when there is no information given about what the medication is treating, or signs and symptoms for when to give the PRN medication to the resident.

(c) Before the use of physical restraints when not assessed, taught, and reassessed, according to section OAR 411-051-0130(14) of this rule, by a physician, nurse practitioner, physician assistant, Christian Science practitioner, mental health clinician, physical therapist, or occupational therapist.

(d) When there are concerns about resident behaviors that do not respond to non-medication interventions, or the use of new psychotropic medications when not assessed, taught, and reassessed according to section OAR 411-051-0130(8), by a physician, nurse practitioner, physician assistant, or mental health practitioner.

(e) When care procedures are ordered that are new for a resident, the licensee, or other caregivers.

(4) RN DELEGATIONS. A registered nurse may determine a nursing care procedure must be delegated before the caregiver can perform the procedure. The delegation of a nursing procedure must be completed prior to any caregiver performing the procedure.

(a) RN delegations are not transferable to other residents or caregivers. (Refer to OAR chapter 851, division 047).

(b) A Long-Term Care Community Nurse (LTCCN) may be available to provide consultation, teaching, and delegation for Medicaid consumers only.

(5) DOCUMENTATION OF RN VISITS. Documentation of nurse consultations, teaching, and step-by-step instructions on any delegated nursing procedure or other taught procedure, assessments, and

reassessments must be maintained in the resident's record and made available to the Department upon request.

Stat. Auth.: ORS 127.520, 409.050, 410.070, 413.085, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790
Stats. Implemented: ORS 409.050, 410.070, 413.085, 441.373, 443.001 - 443.004, 443.705 - 443.825, 443.875, 443.991

411-051-0130 Standards for Medications, Treatments, and Therapies
(Amended 1/1/2022)

(1) MEDICATIONS. The licensee and caregivers must demonstrate an understanding of each resident's medication administration regimen, including the reason for the medication, specific instructions, the medication's actions, and common side effects. Medication resource material must be readily available at the home and include:

(a) The product or drug information sheet;

(b) A current drug manual; or

(c) Internet access to a drug reference website that is readily available for all caregivers.

(2) WRITTEN ORDERS. The licensee or administrator must obtain and place a signed order in the resident's record for any medications, dietary supplements, treatments, or therapies that have been ordered by a prescribing practitioner. The written orders must be carried out as prescribed unless the resident or the resident's legal representative refuses to consent. The prescribing practitioner must be notified if the resident refuses to consent to an order.

(a) CHANGED ORDERS. Changes to a written order may not be made without a prescribing practitioner order. The prescribing practitioner must be notified if the resident refuses to consent to the change order. Changes to medical orders obtained by telephone must be followed-up with signed orders within seven calendar days. Changes in the dosage or frequency of an existing medication require

a new properly labeled and dispensed medication container. If a new properly labeled and dispensed medication container is not obtained, the change must be written on an auxiliary label attached to the medication container, not to deface the existing original pharmacy label, and must match the new medication order. Attachment of the auxiliary label must be documented in the residents' record. (See section (6)(d) of this rule).

(b) DOCUMENTATION OF CHANGED ORDERS. Attempts to obtain the signed written changes must be documented and readily available for review in the resident's record. The resident's medications, including medications that are prescribed, over-the-counter medications, and home remedies, must be reviewed by the resident's prescribing practitioner or pharmacist at least annually. The review must be in writing, include the date of the review, and contain the signature of the prescribing practitioner or a pharmacist.

(3) MEDICATION SUPPLIES. The licensee or administrator must have all currently prescribed medications, including PRN medications, and all prescribed over-the-counter medications available in the home for administration. Refills must be obtained before depletion of current medication supplies. Attempts to order refills must be documented in the resident's record.

(4) HEALTH CARE PROFESSIONAL ORDERS (IMPLEMENTED BY AFH STAFF). The licensee or administrator who implements a hospice, home health, or other licensed medical professional-generated order must:

(a) Have a copy of the hospice, home health, or licensed medical professional document that communicates the written order.

(b) Transcribe the order onto the medication administration record (MAR).

(c) Implement the order as written.

(d) Include the order on subsequent medical visit reports for the prescribing practitioner to review.

(5) HOSPICE AND HOME HEALTH ORDERS (IMPLEMENTED BY NON-AFH STAFF). A licensee or administrator must allow a resident to receive hospice services. The licensee or administrator who provides AFH services to a recipient of hospice or home health services, but who does not implement a hospice or home health-generated order must:

(a) Have a copy of the hospice or home health document that communicates the written order.

(b) Include the order on subsequent medical visit reports for the prescribing practitioner to review.

(6) MEDICATION ADMINISTRATION RECORD. A current, written MAR, or electronic MAR (see OAR 411-050-0755(4)), must be kept for each resident and must:

(a) List the name of all medications administered by a caregiver, including over-the-counter medications and prescribed dietary supplements. The MAR must identify the dosage, route, date, and time each medication and supplement is to be given.

(b) Identify any treatments and therapies administered by a caregiver. The MAR must indicate the type of treatment or therapy and the time the procedure must be performed.

(c) Be immediately initialed by the caregiver administering the medication, treatment, or therapy as it is completed. A resident's MAR must contain a legible signature that identifies each set of initials.

(d) Document changed and discontinued orders immediately showing the date of the change or discontinued order. A changed order must be written on a new line with a line drawn to the start date and time.

(e) Document missed or refused medications, treatments, or therapies. If a medication, treatment, or therapy is missed or refused by the resident, the initials of the caregiver administering the medication, treatment, or therapy must be circled, and a brief, but complete, explanation must be recorded on the back of the MAR.

(7) PRN MEDICATIONS. Prescription medications ordered to be given "as needed" or "PRN" must have specific parameters indicating what the medication is for and specifically when, how much, and how often the medication may be administered. Any additional instructions must be available for the caregiver to review before the medication is administered to the resident.

(a) PRN DOCUMENTATION. As needed medications must be documented on the resident's MAR with the time, dose, the reason the medication was given, and the outcome.

(b) PRN ADVANCE SET-UP. As needed medications may not be included in any advance set-up of medication.

(8) PSYCHOTROPIC MEDICATIONS.

(a) A licensee or administrator is not required to request an evaluation of a resident's use of a psychotropic medication if the resident is admitted to the home and the resident has been prescribed the psychotropic medication for a condition that is currently monitored by a physician, nurse practitioner, physician assistant, or mental health professional and the written order for the psychotropic medication is in the resident's record.

(b) If a resident is admitted to a home with no documented history as to the reason for taking a psychotropic medication, or if the licensee or administrator requests medical professional intervention to address behavioral symptoms, the licensee or administrator must request a physician, nurse practitioner, physician assistant, or mental health professional evaluate the resident's need for the psychotropic medication and the intended effect of the medication, common side effects, and circumstances for reporting. The evaluation request must be documented in the resident's record and include:

(A) The unmet need resulting in the resident's behavior.

(B) Non-pharmacological interventions to be used instead of or in addition to psychotropic medication, if applicable. Alternative interventions must be tried as instructed by a licensed medical professional and the resident's response to the alternative

interventions must be documented in the resident's record before administering a psychotropic medication.

(C) A plan, which includes a specified timeframe, for reassessment by the resident's prescribing physician, nurse practitioner, physician assistant, or mental health professional.

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

(d) The prescription and order for a psychotropic medication must specify the dose, frequency of administration, and the circumstance for use (i.e., specific symptoms). The licensee and all caregivers must be aware of and comply with these parameters.

(e) The licensee and all caregivers must know the intended effect of a psychotropic medication for a particular resident and the common side effects, as well as the circumstances for reporting to the resident's physician, nurse practitioner, physician assistant, or mental health professional. The licensee and other caregivers must know all non-pharmacological interventions and use those interventions as directed by the prescribing practitioner or the registered nurse.

(f) The resident's care plan must identify and describe the behavioral symptoms the psychotropic medications are prescribed for and a list of all interventions, including interventions that are non-pharmacological and medications.

(g) Psychotropic medications must never be given to discipline a resident or for the convenience of the caregivers.

(9) MEDICATION CONTAINERS AND STORAGE. The licensee or administrator must ensure the resident's prescription medications are packaged in a manner that reduces errors in the tracking and administration of the drugs, including, but not limited to, the use of unit

dose systems or blister (bubble) packs. This paragraph does not apply to residents receiving pharmacy benefits through the United States Department of Veterans Affairs if the pharmacy benefits do not reimburse the cost of such packaging.

(a) MEDICATION CONTAINERS. Each of the resident's prescribed medication containers, including bubble packs, must be clearly labeled by the pharmacy. All medications, including over-the-counter medications, must be in the original container, except as indicated in (9)(b) of this rule. Medications stored in advanced set up containers are required to be labeled as described in these rules.

(b) ADVANCED SET-UP. The licensee or administrator may set-up each resident's medications for up to seven calendar days in advance (excluding PRN medications) by using a closed container manufactured for the advanced set-up of medications.

(A) If used, each resident must have their own container with divisions for the days of the week and times of day the medications are to be given.

(B) The container must be clearly labeled with the resident's name, name of each medication, time to be given, dosage, amount, route, and description of each medication that includes the color, shape and any markings according to the label.

(C) The container must be stored in the locked area with the residents' medications.

(c) OVER-THE-COUNTER PRODUCTS. Over-the-counter products such as medications, vitamins, and supplements purchased for a specific resident's use must be marked with the resident's name. Over-the-counter items in stock bottles (with original labels) may be used for multiple residents in the home and must be clearly marked as the house supply.

(d) STORAGE OF RESIDENT MEDICATION. All resident medications, including over-the-counter medications, must be stored as directed by the manufacturer and kept in a locked, central location

that is cool, clean, dry, not subject to direct sunlight or fluctuations in temperature.

(A) Resident medications must be stored separately from medications belonging to the licensee, caregivers, and all other non-residents.

(B) Medications requiring refrigeration must also be locked and stored separately from non-resident medications.

(C) Residents shall not have access to medications belonging to other residents.

(e) STORAGE OF NON-RESIDENT MEDICATION. All non-resident medications, including non-resident medications that must be refrigerated, must be kept locked and separate from resident medications. Residents shall not have access to medications belonging to the licensee, caregivers, other household members, or pets.

(10) DISPOSAL OF MEDICATION. Outdated, discontinued, recalled, or contaminated medications, including over-the-counter medications, may not be kept in the home and must be disposed of within 10 calendar days of expiration, discontinuation, or the licensee or administrator 's knowledge of a recall or contamination. The licensee or administrator must contact the local DEQ waste management company in the home's area for instructions on proper disposal of unused or expired medications. Prescription medications for residents that have died must be disposed of within 24 hours according to section (11) of this rule.

(a) TRANSDERMAL PATCHES. Used transdermal patches and unused patches, such as when the order was discontinued, or the patches have expired, must be folded in half with the sticky side together and disposed of as directed on the product information sheet or by the pharmacy.

(b) ITEMS CONTAMINATED WITH BODILY FLUIDS. Contaminated disposable supplies such as bandages, dressings, gauze, gloves, masks, and other supplies that are not sharps, but may have come

into contact with body fluids, must be disposed of in a closed plastic bag, and placed out of residents' reach in the garbage bin.

(11) DOCUMENTATION OF DISPOSAL. The disposal of a resident's medication must be documented in the resident's record and the documentation must be readily available. Documentation must include the name of each drug destroyed, the number of remaining pills, liquid, or patches, the date and time destroyed, and the signature of each staff that counted the medication.

(a) The disposal of a controlled substance must be witnessed by a caregiver who is 18 years of age or older and signed by both caregivers.

(b) Documentation regarding the disposal of medications, including controlled substances, must be available in the resident's record and include:

(A) The date of disposal.

(B) Description of the medication, (i.e., name, dosage, and amount being disposed).

(C) Name of the resident for whom the medication was prescribed.

(D) Reason for disposal.

(E) Method of disposal.

(F) Signature of the person disposing of the medication.

(G) For controlled substances, the signature of the caregiver who witnessed the disposal according to this rule.

(12) SELF-ADMINISTRATION OF MEDICATION. The licensee or administrator must have a prescribing practitioner written approval for a resident to self-medicate. A resident able to handle his or her own medical regimen may keep his or her medications in his or her own room in a lockable storage area or device. Medications must be kept locked except

those medications on the residents' own person. The licensee or administrator must notify the prescriber of the medication if the resident shows signs of no longer being able to self-medicate safely.

(13) INJECTIONS. Subcutaneous, intramuscular, and intravenous injections may be self-administered by a resident if the resident is fully independent in the task or may be administered by a relative of the resident or an Oregon licensed registered nurse (RN). An Oregon licensed practical nurse (LPN) may give subcutaneous and intramuscular injections. A caregiver who has been delegated and trained by a registered nurse under provision of the OSBN (OAR 851-047-0000 to 851-047-0040) may give subcutaneous injections. Intramuscular and intravenous injections may not be delegated. (See OAR 411-050-0720(15) for storage and disposal requirements of sharps, including, but not limited to used needles and lancets).

(14) PHYSICAL RESTRAINTS. Physical restraints may only be used when required to treat a resident's medical symptoms or to maximize a resident's physical functioning. Physical restraints may only be used after a written assessment is completed as described below and all alternatives have been exhausted.

(a) Licensees and caregivers may use physical restraints in AFHs only in compliance with these rules (See OAR 411-051-0105).

(b) INDIVIDUALLY-BASED LIMITATION. The use of any physical restraint requires an individually-based limitation as described in OAR 411-004-0040.

(c) ASSESSMENT. A written assessment must be obtained from the resident's physician, nurse practitioner, physician assistant, registered nurse, mental health clinician, physical therapist, or occupational therapist that includes consideration of all other alternatives.

(d) ORDERS. If it is determined that a physical restraint is necessary following the assessment and trial of other measures, the least restrictive restraint must be used as infrequently as possible. The licensee or administrator must obtain a written order from the resident's physician, nurse practitioner, or physician assistant before

the use of a physical restraint. The written order must include specific parameters, including the type of physical restraint, circumstances for use, and duration of use, including:

(A) Procedural guidance for the use of the physical restraint.

(B) The frequency for reassessment.

(C) The frequency and procedures for nighttime use.

(D) Dangers and precautions for using the physical restraint.

(e) Physical restraints may not be used on an as needed (PRN) basis in an AFH.

(f) CONSENT. Physical restraints must not be used without first obtaining the written consent of the resident or the resident's legal representative.

(g) DOCUMENTATION. If it is determined a physical restraint is necessary following the assessment and trial of other measures, the written order for the use of a physical restraint must be documented in the resident's care plan explaining why and when the restraint is to be used, along with instructions for periodic release. Any less restrictive, alternative measures planned during the assessment, and cautions for maintaining the resident's safety while restrained, must also be recorded in the resident's care plan. The resident's record must include:

(A) The completed assessment as described in this rule.

(B) The written order authorizing the use of the physical restraint from the resident's physician, nurse practitioner, or physician assistant.

(C) Written consent of the resident or the resident's legal representative to use the specific type of physical restraint.

(D) The reassessments completed by a medical professional as described in OAR 411-051-0105(3)(c)(E).

(h) DAYTIME USE. A resident physically restrained during waking hours must have the restraints released at least every two hours for a minimum of 10 minutes and be repositioned, offered toileting, and provided exercise or range-of-motion exercises during this period. The use of restraints, restraint release, and activities that occurred during the release period must be documented in the resident's record.

(i) NIGHTTIME USE. The use of physical restraints at night is discouraged and must be limited to unusual circumstances. If used, the restraint must be of a design to allow freedom of movement with safety. The frequency of night monitoring to address resident safety and care needs must be determined in the assessment. Tie restraints of any kind must not be used to keep a resident in bed.

(j) If any physical restraints are used in an AFH, the restraints must allow for quick release at all times. Use of restraints may not impede the three-minute evacuation of all occupants of the home.

(k) Physical restraints may not be used for the discipline of a resident or for the convenience of the AFH.

Stat. Auth.: ORS 127.520, 409.050, 410.070, 413.085, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790
Stats. Implemented: ORS 409.050, 410.070, 413.085, 441.373, 443.001 - 443.004, 443.705 - 443.825, 443.875, 443.991