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To: Oregon In-home care agencies

From: Health Facility Licensing and Certification (HFLC)
In-home care agency (IHCA) program

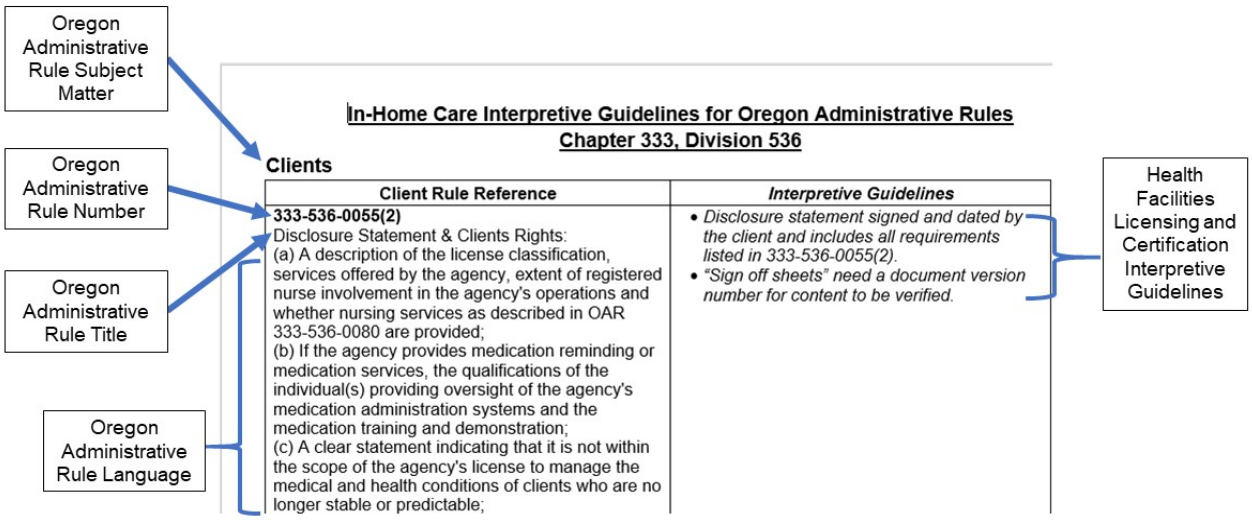
RE: **IHCA Interpretive Guidelines for Oregon Administrative Rules**

The purpose of this memo is to provide Interpretive Guidelines for IHCA Oregon Administrative Rules (OAR) Chapter 333, Division 536.

The document is divided by subject matter. The subject matter topics are clients, caregivers, quality assessment and performance improvement program, complaint and grievance process and policies and procedures.

Left Column:
The left column contains first the specific rule number, followed by the rule title, and then the rule language.

Right Column:
The right column is HFLC interpretive guidelines, including required documentation or forms.



If you have any questions please email the IHC survey team at mailbox.hclc@state.or.us.

In-Home Care Interpretive Guidelines for Oregon Administrative Rules Chapter 333, Division 536

Clients

Client Rule Reference	*Interpretive Guidelines*
333-536-0055(2) Disclosure Statement & Clients Rights: (a) A description of the license classification, services offered by the agency, extent of registered nurse involvement in the agency's operations and whether nursing services as described in OAR 333-536-0080 are provided; (b) If the agency provides medication reminding or medication services, the qualifications of the individual(s) providing oversight of the agency's medication administration systems and the medication training and demonstration; (c) A clear statement indicating that it is not within the scope of the agency's license to manage the medical and health conditions of clients who are no longer stable or predictable; (d) The qualifications /training requirements determined by the agency for individuals providing direct client care; (e) The charges for the services provided by the agency; (f) A description of how the service plans are developed and reviewed and the relationship between the service plans and the cost of services; (g) A description of billing methods, payment systems, and due dates; (h) The policy for client notification of increases in the costs of services; (i) The agency's refund policy; (j) Criteria, circumstances, conditions which may result in termination of services by the agency and client notification of such; (k) Procedures for contacting agency administrator or designee during all of the hours during which services are provided; and (l) A copy of the client's rights as written in OAR 333-536-0060.	• *Disclosure statement signed and dated by the client and includes all requirements listed in 333-536-0055(2).* • *"Sign off sheets" need a document version number for content to be verified.*
333-536-0060(1)(a-m) Client's Rights Included as Written: (1) The agency owner or administrator shall ensure that the agency recognizes and protects the following rights of each client: (a) The right to be treated with dignity and respect; (b) The right to be free from theft, damage, or misuse of one's personal property; (c) The right to be given the informed choice and opportunity to select or refuse service and to	• *An agency shall provide each client with a written notice of the client's rights as a part of the disclosure statement, prior to furnishing care to a client. Must match rule language (as written).* • *The surveyor will request a list of clients whose services were terminated by the agency. The files for the agency terminated clients will be reviewed for the required*

accept responsibility for the consequences; (d) The right to be free from neglect of care, verbal, mental, emotional, physical, and sexual abuse; (e) The right to be free from financial exploitation; (f) The right to be free from physical and chemical restraints; (g) The right to voice grievances or complaints regarding services or any other issue without discrimination or reprisal for exercising such rights; (h) The right to be free from discrimination in regard to race, color, national origin, gender, sexual orientation, or religion. (i) The right to participate in planning of the services and care to be furnished, any changes in the services and care, the frequency of visits, and cessation of services; (j) The right to have access to his or her client record; (k) The right to have client information and records confidentially maintained by the agency; (l) The right to be advised in writing, before care is initiated, of the charges for the services to be furnished, and the amount of payment that will be required from the client; (m) The right to a written 30-day notice of termination of services by the agency that specifies the reason(s) for the termination with the following exceptions: (A) The right to immediate oral or written notice of termination of services by the agency at the time the agency determines that the safety of its staff or the client cannot be ensured. If oral notice is given, the agency must also subsequently provide the client a written confirmation of the oral notice of termination of services. (B) The right to a written 48-hour notice of termination of services by the agency in the event of non-payment in accordance with the agency's disclosed payment requirements.	*written notification and documentation.*
333-536-0060(2) Client's rights Additional Requirements: The client's rights notice shall also include: (a) Procedures for filing a grievance or complaint with the agency; (b) Procedures for filing a grievance or complaint with the Division, along with the telephone number and contact information of the Division; and (c) Notice that the Division has the authority to examine clients' records as part of the Division's regulation and evaluation of the agency.	• *This information must be included or attached to the client's rights section of the disclosure statement.*

333-536-0065(1) Initial Evaluation: For clients receiving services described in OAR 333-536-0045, the services provided shall be in accordance with a written service plan developed in conjunction with a client or the client's representative based on the client's or the client's representative's request and an evaluation of the client's physical, mental, and emotional needs. The agency administrator or designee shall conduct an initial evaluation of the client. The evaluation must be documented, dated, and signed by the individual who conducted the evaluation, and maintained in the client's agency record.	• *File must include a documented initial evaluation (which is different than initial screening required in 333-536-0055(3), which should also be included in the client's file).* • *The evaluation must include the client's mental, physical and emotional needs. It must be documented, dated & signed by the individual conducting the evaluation.*
333-536-0065(2)&(5) Service Plan: (2) The agency administrator or designee, in conjunction with the client or the client's representative, shall complete a written service plan within seven days after the initiation of services. The agency administrator or designee shall ensure that the service plan includes a list of individuals participating in development of the plan. The agency administrator or designee shall also sign and date the service plan when it is complete and acceptable to all individuals participating in development of the plan. (5) An agency shall maintain the original service plan and all updated service plans in each client's agency record. Complete and legible copies of the service plan shall be given to the client or client's representative upon request.	• *Original and most recent service plan must be included in the file.* • *Completed within 7 days of initiation of service, list of individuals participating in the plan, signature and date of administrator or administrator designee.*
333-536-0065(3)(a) Current Service Plan: The completed service plan shall be client-directed or client representative-directed and include at least the following: The schedule for the provision of services specifying a range of hours for services per month;	• *The schedule or range of hours must be documented on the service plan, the services to be provided specifying the tasks and pertinent information about client needs (specific days and times or range of hours per month).*
333-536-0065(3)(b) Current Service Plan: The services to be provided, specifying the tasks to be conducted;	• *All individual and specific tasks to be conducted by agency caregivers must be listed on the service plan, including housekeeping, companion care, personal care, medication reminders, medication assistance, medication administration and delegated and non-delegated nursing services.*

	• *The service plan should match the documentation of services. Information specific to the client must be included, such as frequency, independence, and preferences.*
333-536-0065(3)(c) Current Service Plan: Pertinent information about the client's needs in relation to the services to be provided to ensure the provision of safe and appropriate care.	• *Includes pertinent information about client's function and needs (specific information related to the client's needs).* • *Example: "Must go on daily walk around the courtyard, use tennis shoes" vs. "mobility."*
333-536-0065(4) Current Service Plan Changes: A client or a client's representative may request changes in the service plan. All changes must be communicated to the caregiver(s) and documented.	• *Changes to the service plan must be documented and communicated to staff.* • *Documentation of changes and proof that it was communicated to the caregivers prior to service is required*
333-536-0045(1-3) Client's Ability to Self-Direct Medication Evaluation: An agency may provide medication reminding services for clients who can self-direct as defined in OAR 333-536-0005 if the agency: (a) Documents the client's knowledge of the following information using a standardized form required by the Division: (A) The reason why each medication is taken; (B) The amount or dose of each medication that needs to be taken; (C) The route the medication needs to be taken; and (D) The time of day each medication needs to be taken. (b) Retains a copy of the standardized form, signed by the client, where an agency has determined the client can self administer medications. (3) An agency must evaluate whether a client can continue to self-direct at a minimum of every 90 days. If it is determined that a client can no longer self-direct, arrangements shall be made to transfer the client to an agency with a higher license classification within 30 days if the agency providing current services is not classified as such.	• *If medication reminders or assistance is provided, the client must be evaluated at start of service and every 90 days thereafter.* • *The standardized form must be used and must contain required information including the medications listed.* • *The form must be completed prior to providing services and every 90 days thereafter.*
333-536-0065(6) Initial Site Visit: The administrator or designee must conduct an initial visit at the client's residence within 30 days of the initiation of services to evaluate compliance by the caregiver(s) with the service plan and to assess the client's satisfaction. The initial visit must occur between the 7th and 30th day. An initial visit	• *Documentation that an on-site initial visitation was conducted and completed between the 7th and 30th day of service.* • *Not required when the client meets the a, b or c of this rule and it is documented by the agency.* • *The content of the initial site visit is not*

is not required when: (a) A client cancels service on or before the 30th day; (b) A client is residing in a nursing facility or a hospital; or (c) A client refuses.	*prescribed in rule; content can be the same as the monitoring visits but there are no requirements.*
333-536-0065(7-8) Monitoring Visits: The administrator or designee must conduct quarterly monitoring visits after the initial site visit. Quarterly monitoring visits may occur by phone or by other electronic means at the discretion of the administrator or designee under the following circumstances: impending discharge from services; relocation to a facility; when minimal services, such as one shift a month, would cause the client to incur undue financial burden; or, due to other circumstances that are justified in chart note(s). In no case shall the time between the in-person monitoring visits exceed a six-month period.	• *Conducted on-site every 90 days. Must include questions listed in rule and be signed/dated by administrator or designee.* • *Can occur by phone or email if the client meets the specific circumstances in rule and it is documented by the agency. An in-person monitoring visit must be made at least every 6 months.*
333-536-0065(9): Monitoring Visit Documentation Content: (a) Appropriate and safe techniques have been used in the provision of care; (b) The service plan has been followed as written; (c) The service plan is meeting the client's needs or needs to be updated; (d) The caregiver has received sufficient training for the client; (e) The client is satisfied with his or her relationship with the caregiver(s); and (f) Appropriate follow-up is necessary for any identified issues or problems.	• *Monitoring visit documentation contains at least the questions listed in rule.* • *Monitoring visits must be completed, signed and dated by the administrator or designee.* • *If follow-up or dissatisfaction was indicated on the documentation, the surveyor will review the file for related agency actions.*
333-536-0085(2-6) Client Records: A legible, reproducible client record shall include at least the following: (a) Identification data; (b) Referral and intake information; (c) Start-of-service date; (d) Screening and disclosure documents and documentation required by these rules; (e) Clients' rights documentation required by these rules; (f) All client evaluation and assessment documentation; (g) Client service plan and updates; (h) Documentation of all services provided; (i) Service and financial agreement signed by a client or a client's representative before the	• *All client records must include the requirements identified in rule.* • *All entries and documentation must be recorded in ink, typescript, or computer generated.* • *All entries must be dated, signed and authenticated by the person making the entry.* • *Client records must be easily retrievable.* • *Client records must be protected from theft, fire, water or unauthorized access.*

initiation of services that specifies the services to be provided in accordance with the service plan, and the costs for those services; (j) End-of-services date; and (k) End-of-service summary, including the dates of service and the disposition of the client. (3) All entries and documents in the record must be recorded in ink, typescript, or computer-generated. (4) All entries in a client's record must be dated and signed, or otherwise authenticated by the person making the entry. For purposes of this rule, authenticated means verification by the author that an entry in the client record is genuine. Electronic authentication is acceptable as long as there is a process for reconstruction of the information and there are safeguards to prevent unauthorized access to the records. (5) A client record shall be maintained in a manner that renders it easily retrievable. (6) Reasonable precautions must be taken to protect a client's record and information from unauthorized access, fire, water, and theft.	
333-536-0085(2-4) Documentation of All Services Provided: A client record shall be maintained for every client served by an agency, unless the client receives only housekeeping or support services, and shall be maintained in the agency's office. (2) A legible, reproducible client record shall include at least the following: … (h) Documentation of all services provided;	• *Paper and electronic records reflect provisions of all services provided by the agency and agency caregivers.* • *Documentation of services must match the service plan. There shouldn't be services being regularly documented that are not on the service plan nor should there be services not being regularly provided that are on the service plan. Surveyors will also review schedules and caregiver notes.* • *Example: If it says PM showers only is that being reflected in the documentation?*
333-536-0075(5) Medication Services Reflected in Service Plan: A client's service plan must specify the medication tasks to be performed.	• *Service plan should clearly state type of medication services (assistance, administration and/or medication set-up into a secondary container) with applicable instructions and responsible parties.*
333-536-0075(2) Medication Set-up by Client or Family: If a client representative or family member performs the task of filling secondary non-injectable medication containers from which an agency caregiver is to administer medication, an agency shall: (a) Obtain a signed agreement from the client representative or family member that identifies their obligation to: (A) Provide a list of the client's medication and a	• *Documentation that is signed by client rep or family member that meets A, B & C of 333-536-0075(2), including a list of medications and physical description of each with special instructions (attached to form or on form itself).*

physical description of each with any special instructions. The list must be updated when changes to the client's medication regimen are made; (B) Keep the original labeled medication containers in the home for verification should the caregiver have questions; and (C) Use closed non-injectable medication secondary containers designed and manufactured for that purpose that meet the labeling requirements of subsection (7)(d) of this rule.	
333-536-0075(3) Medication Services Physician Orders: Agency staff shall obtain written or telephone orders from a physician or other legally recognized practitioner for all medications managed or administered by an agency under this rule and for any changes to those medications. (a) Written orders shall be signed or confirmed by a physician or practitioner. (b) Telephone orders shall be immediately recorded, dated, and signed by agency staff, and transmitted within 72 hours to the physician or practitioner for confirmation. The orders that have been signed or confirmed by the physician or practitioner shall be incorporated into the client's record within 30 days.	• *Current list of medications or medication orders that matches the medication administration records (MARS) and is signed and dated by the physician (MD or DO) or a nurse practitioner (FNP or NP) (PA is not qualified).* • *Written and telephone orders must be processed in the timeframe and manner described in rule.*
333-536-0075(8) All Medication Services Documented: The provision of medication tasks as described in this rule shall be documented by the individuals performing the tasks. The documentation shall include the tasks completed, the date and signature of the individual(s) performing the task(s), and shall be maintained in accordance with agency policies and procedures.	• *Paper and electronic records reflect provision of all medication tasks and services including filling of secondary containers (set-up) and medication assistance* • *Documentation must include the medication service being provided (type, by whom, when, any problems/notes) for all medication service types (assistance, administration and medication set-up into secondary containers).*
333-536-0075(6) Medication Administration Documentation: Records for medication administration shall include, but are not limited to, the name of each medication, the dosage to be administered, the route of administration, the frequency of administration, client medication allergies and sensitivities, client specific indicators for administration of as needed medications and other special instructions necessary for safe and appropriate administration.	• *The Medication Administration Documentation (MAR) must include:* ➢ *Name with strength;* ➢ *Dosage;* ➢ *Route;* ➢ *Frequency;* ➢ *Client specific instructions for PRNs; and* ➢ *Other special instructions necessary for safe and appropriate administration.* ➢ *The MAR shall also identify and list the client's medication allergies and sensitivities.*

	• *Must be used for medication administration, including set-up into secondary containers, and must include all the information listed in 333-536-0075(6) and must match the physician's orders.*
333-536-0075(4) Medication Services: An agency owner or administrator shall be responsible for developing and implementing safe and appropriate medication administration delivery systems and policies and procedures that include, but are not limited to: (a) Provisions to ensure that each client receives the right medication, in the right amount, by the right route, and at the right time; (b) Provisions to ensure that the caregivers are informed about the potential adverse reactions, side effects, drug-to-drug interactions and food-to-drug interactions, and contraindications associated with each client's medication regimen; (c) Provisions to ensure that the caregivers promptly report problems or discrepancies related to each client's medication regimen to the caregivers' supervisor, agency administrator or designee; (d) Provisions to ensure storage of medications at appropriate temperatures based on the manufacturer's recommendations; and (e) Provisions to ensure the security and integrity of narcotics and controlled substances.	• *Medication services documentation must reflect that the client receives the right medication, in the right amount, by the right route, and at the right time.* • *Medication services documentation must reflect that the caregivers are informed about the potential adverse reactions, side effects, drug-to-drug interactions and food-to-drug interactions, and contraindications associated with each client's medication regimen.* • *Documentation must reflect that all client medication regimen problems or discrepancies are promptly reported to the appropriate agency supervisor.* • *Documentation must reflect that the storage of medications is at appropriate temperatures based on the manufacturer's recommendations.* • *Documentation of the integrity and security of narcotics and controlled substance medications must be maintained for all medications classified as narcotics or controlled substances. Sometimes called "Count Sheets." This includes PRN medication or "zero" counts where the client does not take one of these medications while the caregiver is present in the home.*
333-536-0075(7) Packaging and Labeling: (a) Prescription medications shall be in the original pharmacy containers and clearly labeled with the pharmacists' labels. (b) Samples of medications received from the physician or practitioner shall be in the original containers and have the original manufacturers' labels. (c) Over-the-counter medications shall be in the original containers and have the original manufacturers' labels. (d) Secondary containers and all removable compartments must be labeled with the client's name, the specific time the medications in each compartment are to be administered, the date and time the secondary container was filled, and the	• *All medication packaging and labeling must be meet the requirements in rule.* • *Secondary containers and all removable compartments must be labeled with the client's name, the specific time the medications in each compartment are to be administered, the date and time the secondary container was filled, and the name of the individual who filled the container.*

name of the individual who filled the container. (e) Liquid and non-pill medications that cannot be put in secondary containers shall be appropriately labeled.	
333-536-0075(9) RN Evaluation of Client's Medication Regimen: Visits by a registered nurse to evaluate a client's medication regimen and the provision of medication administration services shall be conducted and documented at least every 90 days for each client receiving medication administration services.	• *Documentation of a medication regimen evaluation, what did the RN check, when, and conclusions or follow up. A check box does not meet these criteria.*
333-536-0080(1)&(3) Nursing Services Reflected in Service Plan: (1) If an agency has been approved to provide nursing services, the services must be provided by an Oregon-licensed registered nurse employed by the agency and provided only to a client whose medical condition and health status is stable and predictable. The services shall be provided as requested by a client or a client's representative and shall be in accordance with these rules, the applicable administrative rules of the Oregon State Board of Nursing (OAR chapter 851, division 047), and the service plan. (3) A client's service plan shall include current identification of the delegated specific task(s) of nursing care to be provided and shall specify the caregivers to whom the task(s) have been delegated.	• *Service plan should clearly state type of nursing service with applicable instruction & responsible parties.*
333-536-0080(2-3) Service Plan When Delegated Tasks are Provided: A client's service plan shall include current identification of the delegated specific task(s) of nursing care to be provided and shall specify the caregivers to whom the task(s) have been delegated.	• *Service plan should clearly state the current caregivers delegated to provide nursing services, the specific delegated tasks and the name of the RN responsible for the delegations.*
333-536-0080(5) Nursing Services Physician Orders: For all medications and medical treatments managed or administered by an agency under this rule, and for any changes to those medications or medical treatments, a registered nurse shall obtain written or telephone orders from a physician or other legally recognized practitioner. (a) Written orders shall be signed or confirmed by a physician or practitioner. (b) Telephone orders shall be immediately	• *Current list or Doctor's orders of treatments (tasks of nursing care) signed by client's physician (MD or DO) or Nurse Practitioner (PA is not qualified).* • *Written and telephone orders must be processed in the timeframe and manner described in rule.*

recorded, dated, and signed by the registered nurse, and transmitted within 72 hours to the physician or practitioner for confirmation. The orders that have been signed or confirmed by the physician or practitioner shall be incorporated into the client's record within 30 days.	
333-536-0085(4) Nursing Services Documented: The provision of nursing services as described in this rule shall be documented by the individual(s) providing the service(s) or performing the task(s). The documentation shall include the services(s) or task(s) completed, the date and signature of the individual(s) performing the service(s) or task(s), and shall be maintained in accordance with an agency's policies and procedures.	• *Paper and electronic records must reflect provision of all nursing tasks and services including those provided by RNs, LPNs, and delegated tasks by CGs.* • *Documentation that includes the nursing service being provided (type, by who, when, any problems/notes).*

OSBN OARs in Chapter 851, Division 047 (851-047-0030(3) & OAR 333-536-0080(2)
RN Delegation of Unlicensed Caregivers:
 	
333-536-0080 - Delegation of specific tasks of nursing care to unlicensed persons shall be conducted and documented by the registered nurse as required by the Oregon State Board of Nursing administrative rules chapter 851, division 047. A client's record shall contain documentation that all requirements within those rules have been met, including but not limited to: assessment, instruction, observation, supervision, and re-evaluation.
 	
851-047-0030 - The Registered Nurse shall use the following process to delegate a task of nursing care:
(a) Perform a nursing assessment of the client's condition;
(b) Determine that the client's condition is stable and predictable prior to deciding to delegate;
(c) Consider the nature of the task, its complexity, the risks involved and the skills necessary to safely perform the task;
(d) Determine whether or not an unlicensed person can perform the task safely without the direct supervision of a Registered Nurse;
(e) Determine how often the client's condition needs to be reassessed to determine the appropriateness of continued delegation of the task to the unlicensed persons; and
(f) Evaluate the skills, ability and willingness of the unlicensed persons.
(g) Provide initial direction by teaching the task of
	• *RN Delegation documentation (per OSBN OARs in Chapter 851, Division 047), must include:*
	  ➢ *Assessment of client condition;*
	  ➢ *Rationale for deciding that the task of nursing care can be safely delegated;*
	  ➢ *Skills, ability and willingness of the unlicensed person;*
	  ➢ *Teaching of the task to the unlicensed person;*
	  ➢ *The written instructions left for the unlicensed person;*
	  ➢ *Evidence that the unlicensed person was instructed that the task is client specific and not transferable to any other client;*
	  ➢ *How frequently the client should be re-assessed by the RN for continued delegation;*
	  ➢ *How frequently the unlicensed person should be supervised and re-evaluated by the RN;*
	  ➢ *A statement that the RN takes responsibility for delegation of the task to the unlicensed person and for continued supervision.*
	• *Copies of written instruction should be included in the file or available for review by surveyor.*
	• *Only an RN can delegate tasks. Insulin injection is most common type of delegation. Some tasks cannot be delegated.*
	• *Surveyor may discuss the delegation processes used with the agency RN.*

nursing care, including: (A) The proper procedure/technique; (B) Why the task of nursing care is necessary; (C) The risks associated with; (D) Anticipated side effects; (E) The appropriate response to untoward or side effects; (F) Observation of the client's response; and (G) Documentation of the task of nursing care. (h) Observe the unlicensed persons performing the task to ensure that they perform the task safely and accurately. (i) Leave procedural guidance for performance of the task for the unlicensed persons to use as a reference. These written instructions shall be appropriate to the level of care, based on the previous training of the unlicensed persons and shall include: (A) A specific outline of how the task of nursing care is to be performed, step by step; (B) Signs and symptoms to be observed; and (C) Guidelines for what to do if signs and symptoms occur. (j) Instruct the unlicensed persons that the task being taught and delegated is specific to this client only and is not transferable to other clients or taught to other care providers. (k) Document the following: (A) The nursing assessment and condition of the client; (B) Rationale for deciding that this task of nursing care can be safely delegated to unlicensed persons; (C) The skills, ability and willingness of the unlicensed persons; (D) That the task of nursing care was taught to the unlicensed persons and that they are competent to safely perform the task of nursing care; (E) The written instructions left for the unlicensed persons, including risks, side effects, the appropriate response and that the unlicensed persons are knowledgeable of the risk factors/side effects and know to whom they are to report the same; (F) Evidence that the unlicensed person(s) were instructed that the task is client specific and not transferable to other clients or providers; (G) How frequently the client should be reassessed by the registered nurse regarding continued delegation of the task to the unlicensed persons, including rationale for the frequency based on the client's needs; (H) How frequently the unlicensed persons should	

be supervised and reevaluated, including rationale for the frequency based on the competency of the caregiver(s); and (I) That the Registered Nurse takes responsibility for delegating the task to the unlicensed persons, and ensures that supervision will occur for as long as the Registered Nurse is supervising the performance of the delegated task.	
OSBN OARs in Chapter 851, Division 047 (851-047-0030(4)) RN Reassessment of Client and Supervision/Re-Evaluation of Delegated Caregivers: The Registered Nurse shall provide periodic inspection, supervision and re-evaluation of a delegated task of nursing care by using the following process and under the following conditions: (a) Assess the condition of the client and determine that it remains stable and predictable; and (b) Observe the competence of the caregiver(s) and determine that they remain capable and willing to safely perform the delegated task of nursing care. (c) Assessment and observation may be on-site or by use of technology that enables the Registered Nurse to visualize both the client and the caregiver. (d) Evaluate whether or not to continue delegation of the task of nursing care based on the Registered Nurse's assessment of the caregiver and the condition of the client within at least 60 days from the initial date of delegation. (e) The Registered Nurse may elect to re-evaluate at a more frequent interval until satisfied with the skill of the caregiver and condition of the client. (f) The subsequent intervals for assessing the client and observing the competence of the caregiver(s) shall be based on the following factors: (A) The task of nursing care being performed; (B) Whether the Registered Nurse has taught the same task to the caregiver for a previous client; (C) The length of time the Registered Nurse has worked with each caregiver; (D) The stability of the client's condition and assessment for potential to change; (E) The skill of the caregiver(s) and their individual demonstration of competence in performing the task; (F) The Registered Nurse's experience regarding the ability of the caregiver(s) to recognize and report change in client condition; and	• *RN Delegation documentation (per OSBN OARs in Chapter 851, Division 047), must include documentation that the delegation was re-evaluated within 60 days of initial delegation, and no more than 180 days thereafter. This must be documented and based on the same criteria above.*

(G) The presence of other health care professionals who can provide support and backup to the delegated caregiver(s). (g) The less likely the client's condition will change and/or the greater the skill of the caregiver(s), the greater the interval between assessment/supervisory visits may be. In any case, the interval between assessment/supervisory visits may be no greater than every 180 days.	
OSBN OARs in Chapter 851, Division 047 (851-047-0030(6)&(7)) Changes to Delegation of Tasks: The Registered Nurse may transfer delegation and supervision to another Registered Nurse by using the following process. Transfer of delegation and supervision to another Registered Nurse, if it can be done safely, is preferable to rescinding delegation to ensure that the client continues to receive care: (a) Review the client's condition, teaching plan, competence of the unlicensed person, the written instructions and the plan for supervision; (b) Redo any parts of the delegation process which needs to be changed as a result of the transfer; (c) Document the transfer and acceptance of the delegation/supervision responsibility, the reason for the transfer and the effective date of the transfer, signed by both Registered Nurses; and (d) Communicate the transfer to the persons who need to know of the transfer. The Registered Nurse has the authority to rescind delegation. The decision to rescind delegation is the responsibility of the Registered Nurse who originally delegated the task of nursing care. The following are examples of, but not limited to, situations where rescinding delegation is appropriate: (a) The unlicensed person demonstrates an inability to perform the task of nursing care safely; (b) The condition of the client has changed to a level where delegation to an unlicensed person is no longer safe; (c) The Registered Nurse determines that delegation and periodic supervision of the task and the unlicensed person is no longer necessary due to a change in client condition or because the task has been discontinued; (d) The Registered Nurse is no longer able to provide periodic supervision of the unlicensed person, in which case the registered nurse has the responsibility to pursue obtaining supervision with	• *Documentation must be included for delegations rescinded or transferred in accordance with OSBN OARs in Chapter 851, Division 047.* • *If a caregiver is no longer providing a task of nursing care or the supervision of the caregiver is transferred to another RN, documentation of this must be included in the file.*

the appropriate person or agency; (e) The skill of the unlicensed person, the longevity of the relationship and the client's condition in combination make delegation no longer necessary.	

Caregivers

Caregiver Rule Reference	*Interpretive Guideline*
333-536-0050(9) Personnel Records: (9) Personnel records for all caregiver, nursing staff, and employees shall include at a minimum the following: (a) Evidence of pre-employment screening; (b) Evidence that the in-home care agency has conducted a criminal records check on all subject individuals in accordance with OAR 333-536-0093. (A) The in-home care agency must ensure that a criminal records check has been conducted on all subject individuals employed by or volunteering for an agency on or after July 6, 2011. (B) If the screening indicates that a subject individual has been convicted for crimes against an individual or property, the agency shall make a determination of the individual's fitness to provide care to clients in accordance with OAR 333-536-0093. (c) Evidence that all position qualifications have been met, including required licensure; (d) Current position job description(s) signed by the individual(s); (e) Evidence of orientation, training, competency, and ongoing education; (f) Evidence of annual performance evaluations; and (g) Evidence of a valid driver's license with current auto insurance for each individual whose duties include transporting clients in motor vehicles.	• *Personnel Records must have at a minimum:* ➢ *Pre-employment screening documentation;* ➢ *A criminal record check and fitness test (if applicable);* ➢ *Evidence of position qualifications;* ➢ *A signed copy of the current job description;* ➢ *Orientation, training, competency, and ongoing education documentation;* ➢ *Documentation of annual performance evaluations; and* ➢ *A current copy of a valid driver's license with current auto insurance for each individual whose duties include transporting clients in motor vehicles.*
333-536-0070(3) Caregiver Orientation: Caregivers shall complete an agency-specific orientation, conducted by the agency administrator or designee, before independently providing services to clients. (a) The orientation shall include, but not be limited to, the following subject areas: (A) Caregivers' duties and responsibilities; (B) Clients' rights; (C) Ethics, including confidentiality of client information; (D) The agency's infection control policies;	• *Form or documentation must include all requirements (content) checked.* • *Documented as outlined in 333-536-0070(3)(b).* • *Can be on the same form as training but content, length and instructors must be independently documented from caregiver and medication training on the forms.* • *No competency evaluation required for orientation topics.*

(E) A description of the services provided by the agency; (F) Assignment and supervision of services; (G) Documentation of client needs and services provided; (H) The agency's policies related to medical and non-medical emergency response; (I) The roles of, and coordination with, other community service providers; (J) Information about what constitutes medication reminding and its specific limitations; and (K) Other appropriate subject matter based on the needs of the special populations served by the agency. (b) The content of the orientation, the date(s) and length, and the name(s) and signature(s) of the instructor(s) shall be clearly documented for each caregiver and maintained in personnel records.	
333-536-0070(4)(a-b) Caregiver Training: Date completed and includes at least: (A) Caregivers' duties and responsibilities; (B) Recognizing and responding to medical emergencies; (C) Dealing with adverse behaviors; (D) Nutrition and hydration, including special diets, meal preparation and service; (E) Appropriate and safe techniques in personal care tasks; (F) Methods and techniques to prevent skin breakdown, contractures, and falls; (G) Hand washing and infection control; (H) Body mechanics; (I) Maintenance of a clean and safe environment; (J) Fire safety and non-medical emergency procedures; (K) Assisting clients with self-directed or client representative-directed non-injectable medication administration; and (L) Providing basic non-injectable medication services as described in OAR 333-536-0075. (b) The content of the training, the date(s) and length, and name(s) and signature(s) of the instructors shall be clearly documented.	• *Form or documentation with all the required content.* • *Documentation must contain the content of the training, the date(s) and length, and name(s) and signature(s) of the instructors shall be clearly documented.* • *Surveyor may check training curriculums and materials to ensure all required topics are covered in the agency training.*
333-536-0070(4) Caregiver Training Competency Evaluation: Documentation of training and competency evaluation shall be included in the caregiver's personnel record.	• *Caregivers shall complete appropriate training and must have their competency evaluated after training is completed, and documented by the administrator or designee BEFORE independently providing*

	services to clients. • *Form or documentation with content, methods and date(s) completed.*
333-536-0075(10)(a) & (c) Medication Training: Date completed and includes at least: (A) Medication abbreviations; (B) Reading medication orders and directions; (C) Reading medication labels and packages; (D) Setting up medication labels and packages; (E) Administering non-injectable medications: (i) Pill forms, including identification of pills that cannot be crushed; (ii) Non-injectable liquid forms, including those administered by syringe or dropper and eye and ear drops; (iii) Suppository forms; and (iv) Topical forms. (F) Identifying and reporting adverse medication reactions, interactions, contraindications and side effects; (G) Infection control related to medication administration; and (H) Techniques and methods to ensure safe and accurate medication administration. (c)The content of the medication training, the dates and length of training, the identity of the qualified individual or qualified entity, evidence of successful return demonstrations, and the instructor's statement that the caregiver has been evaluated to be competent to provide the medication services described in this rule shall be clearly documented.	• *Medication training is required for Medication Services – for Basic, Intermediate, and Comprehensive licensure. The documentation needs to include all the topics, dates, and length and needs to include identity and signature of qualified individual or entity (as defined in rule).* • *Qualified Entity for IHC Medication Training: Prior to 04/2018: aQuire/IPCED Certs for 5 categories Med (306, 307, 308, 309 & 310 can substitute for training only NOT the return demonstration competency evaluation.* • *After 4/2018: Relias #s 301,302,305 and 308 can substitute for training only, NOT the return demonstration competency evaluation.* • *Training must be conducted by a Qualified Entity or Individual. Qualified individuals are defined in OAR 333-536-0005(23): "Qualified individual [QI]" means an individual who:* *(a) Has completed a Division approved training program [Currently there is not a division approved training program, QI must meet b or c below]; or* *(b) Is currently licensed as a registered nurse, practical nurse, physician assistant, or pharmacist; or* *(c) Is another health care professional not listed in subsection (23)(b) who has been approved by the Division to conduct training.*
333-536-0075(10) Medication Competency Evaluation: The content of the medication training, the dates and length of training, the identity of the qualified individual or qualified entity, evidence of successful return demonstrations, and the instructor's statement that the caregiver has been evaluated to be competent to provide the medication services described in this rule shall be clearly documented for each caregiver and maintained in the agency's personnel records.	• *Return demonstration competency evaluation documentation must include caregiver name, content, date, instructor's statement, and it must be signed and conducted by a Qualified Individual (the Qualified Entity is approved for medication training only they are not approved to conduct a return demonstration competency evaluation).* • *The return demonstration competency evaluation documentation can be on same form as medication training.*
333-536-0070(5) Continuing Caregiver Education:	• *Minimum 6 hours annually or 7 hours if the caregivers provide medication services; 7th*

Caregivers shall receive a minimum of six hours of education related to caregiver duties annually. If a caregiver provides medication administration to a client, one additional hour of education shall be required annually related to providing medication administration.	*hour of training must be related to medications.*
333-536-0070(6) Caregiver Selection and Review of Service Plan: (a) The skills of a caregiver must be matched with the care needs of a client. The administrator or designee must assign caregivers to specific clients based on the care needs of the clients and the skills of the caregivers. (b) The client's service plan must be reviewed with each caregiver before the initial delivery of client care. The date of the review(s), the signature or a unique electronic identifier such as an individual's log-in and password into a computer program or an electronic stamp of the agency administrator or designee and the list of assigned caregivers must be documented. (c) Caregivers must provide services to clients in accordance with the service plans.	• *Services provided to clients must match the skills of the assigned caregivers. Some tasks of personal care may require additional experience or agency training including: Hoyer or other lifting devices, Catheter/Colostomy care and hygiene, including proper line handling, bag positioning, storage, changing and emptying, and other non-delegated tasks of care.* • *The client record must include documentation that the caregiver reviewed the service plan or any service plan changes prior to providing services.* • *The services provided by the caregivers must match the services identified in the client's service plan.*
333-536-0093(6) Criminal Records Check Qualified Vendors: If Oregon DHS Background Check Unit is not used, the CRC vendor meets qualifying criteria in 333-536-0093(6)(b)(A): Accredited by the National Association of Professional Background Screeners (NAPBS) OR 333-536-0093(6)(b)(B): (i) Has been in business for at least 2 years; (ii) Has a current business license & private investigator license if required in the company's home state; and (iii) Maintains an errors and omissions insurance policy in an amount not less then $1 million.	• *All employees with direct contact with agency clients must have a background check conducted by a qualified vendor.* • *Must maintain and provide documentation of qualified vendor requirements listed in A or B. It's up to the agency to provide this proof.*
333-536-0093(2)&(13) Criminal Records Check Frequency: (2) An agency shall conduct a criminal records check before hiring an SI and before allowing an SI to volunteer to provide services on behalf of the agency, if an SI will have direct contact with a client of the agency. (13) On or after July 1, 2012 an agency shall ensure that a criminal records check is performed on an SI every three years from the date of the SI's last criminal records check in accordance with	• *Criminal records check must be conducted and completed before hire (prior to orientation and/or training) and every three years thereafter.*

these rules.	
333-536-0093(8) Criminal Records Check Requirements: A criminal records check must include the following: (a) Name and address history trace; (b) Verification that the SI's records have been correctly identified, via date of birth check and Social Security number trace; (c) A local criminal records check, including city and county records for SI's places of residence for the last seven years; (d) A nationwide multijurisdictional criminal database search, including state and federal records; (e) A nationwide sex offender registry search; (f) The name and contact information of the vendor who completed the records check; (g) Arrest, warrant and conviction data, including but not limited to: (A) Charge(s); (B) Jurisdiction; and (C) Date. (h) Source(s) for data included in the report.	• *Documentation of SI (caregiver) Name and Address history trace.* • *Documentation of SI date of birth and SS#.* • *Documentation of City/County records for the last 7 years.* • *Documentation of a nationwide multijurisdictional criminal database search, including state and federal records* • *Documentation of the Nationwide Sex Offender Registry Search.* • *Documentation of the name, contact information and state of business must be documented on the criminal records report.* • *Documentation of any arrest, warrant and conviction data, including but not limited to: Charge(s); (B) Jurisdiction; and (C) Date.* • *Report must include the sources for the data included in the report.* • *Surveyor will notate if the criminal records check is clear or if there are any convictions.*
333-536-0093(9) LEIE (List of Excluded Individuals and Entities): An agency shall perform and document a query of an SI with the National Practitioner Data Bank (NPDB) and the List of Excluded Individuals and Entities (LEIE).	• *Documentation of this check must be printed from the website [https://exclusions.oig.hhs.gov/] or listed on criminal records check report.* ****(may be noted as OIG [Office of Inspector General]).* • *The NPDB [National Practitioners Database] requirement is not currently enforced.*
333-536-0093(3) ORS 443.004(3) Criminal Records Check Convictions: An SI [Subject Individual] who has or will have direct contact with a recipient of in-home care services may not be employed or volunteer with an agency in any capacity if the criminal records check conducted reveals the SI has been convicted of a crime as described in ORS 443.004(3).	• *If the SI is convicted of a crime that is listed in ORS 443.004(3), the person is disqualified from being hired by the agency in any capacity.*
333-536-0093(4) Criminal Records Check Weighing Test: An agency shall have a policy on criminal records check requirements that shall include weighing test actions should the records check screening indicate that an SI has been convicted for crimes against an individual or property other than those	• *If crimes other than ORS 443.004(3), or if other potentially disqualifying conditions were identified, including any crimes against a person or property or any drug related crimes, the agency must conduct and document a weighing test that includes all*

identified in ORS 443.004(3). The policy must include the following provisions for performing a weighing test: (a) The agency shall consider circumstances regarding the nature of potentially disqualifying convictions and conditions including but not limited to: (A) The details of incidents leading to the charges of potentially disqualifying convictions or resulting in potentially disqualifying conditions; (B) The age of the SI at the time of the potentially disqualifying convictions or conditions; (C) Facts that support the convictions or potentially disqualifying conditions; and (D) Passage of time since commission of the potentially disqualifying convictions or conditions. (b) Other factors that should be considered when available include but are not limited to: (A) Other information related to criminal activity including charges, arrests, pending indictments and convictions. Other behavior involving contact with law enforcement may also be reviewed if information is relevant to other criminal records or shows a pattern relevant to criminal history; (B) Periods of incarceration; (C) Status of and compliance with parole, post-prison supervision or probation; (D) Evidence of alcohol or drug issues directly related to criminal activity or potentially disqualifying conditions; (E) Evidence of other treatment or rehabilitation related to criminal activity or potentially disqualifying conditions; (F) Likelihood of repetition of criminal behavior or behaviors leading to potentially disqualifying conditions, including but not limited to patterns of criminal activity or behavior; (G) Changes in circumstances subsequent to the criminal activity or disqualifying conditions including but not limited to: (i) History of high school, college or other education related accomplishments; (ii) Work history (employee or volunteer); (iii) History regarding licensure, certification or training for licensure or certification; or (iv) Written recommendations from current or past employers; (H) Indication of the SI's cooperation, honesty or the making of a false statement during the criminal records check process, including acknowledgment and acceptance of responsibility of criminal activity and potentially disqualifying conditions. (c) An agency shall consider the relevancy of an	*the elements in rule.*

SI's criminal activity or potentially disqualifying conditions to the paid or volunteer position, or to the environment in which the SI will work, especially, but not exclusively: (A) Access to medication; (B) Access to clients' personal information; (C) Access to vulnerable populations.	

Quality Assessment and Performance Improvement Program (QAPI)

QAPI Rule Reference	*Interpretive Guideline*
333-536-0090(1-4) QAPI Program: Establish and maintain an effective, agency wide quality assessment and performance improvement program that evaluates and monitors the quality, safety and appropriateness of services provided by the agency, and shall include at a minimum: A method to identify, analyze and correct adverse events; A method to select and track quality indicators by high risk, high volume, problem prone areas and by the effect on client safety and quality of care; The quality improvement activities shall be conducted by a committee comprised of, at a minimum, agency administrative staff, an agency caregiver, and if the agency is classified as an intermediate or comprehensive agency, an agency registered nurse; and Quality improvement activities shall be conducted and documented at least quarterly.	• *Meeting minutes need to reflect quarterly (90 days) meetings.* • *The meeting minutes must reflect the required committee members - Administrator, Registered Nurse (for Intermediate and Comprehensive Classifications) and an agency Caregiver (a person whose primary job is providing care in the home).* • *There should be minutes that reflect the identification of adverse events and problem prone areas and the corrections to avoid those events/areas in the future.* • *The meeting minutes should match the agency methods to identify, analyze and correct adverse events and what tools have been selected to track quality indicators by high risk, high volume, problem prone areas and by the effect on client safety and quality of care to the agency policy and procedures.*

Complaint and Grievance Process

Complaint/Grievance Process Rule Reference	*Interpretive Guideline*
333-536-0050(8)(i) Complaint Process: Ensuring the timely internal investigation of complaints, grievances, accidents, incidents, medication or treatment errors, and allegations of abuse or neglect involving individuals providing services for the agency. An agency shall maintain in its records documentation of the complaint or event, the investigation, the results, and actions taken;	• *The agency needs to provide documentation of the investigation for all types of complaints/grievances listed in rule.* • *Documentation must include at a minimum: complaint/event, the investigator, the results, and actions taken.* • *The surveyor will also review monitoring visits and caregiver notes for possible complaints, grievances, accidents, incidents, medication or treatment errors or allegations of abuse or neglect.* • *Instances of complaints, grievances, accidents, incidents, medication or treatment errors or allegations of abuse or neglect where the investigation is not*

	documented as required will result in a citation. • *The agency must gather complaints and give them to the surveyor. If they do not have them together in one place they will need to go through all pertinent electronic or physical files, gather them and provide them to surveyor.*
333-536-0050(8)(j) & 333-536-0005(1) Reporting Abuse/Neglect: Ensuring the timely reporting of allegations of abuse or neglect to the appropriate authority that includes but is not limited to the Department of Human Services, Oregon Health Authority, Public Health Division, or local law enforcement agency. "Abuse." (a) As it applies to an adult, includes but is not limited to: (A) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury. (B) Neglect that leads to physical harm through withholding of services necessary to maintain health and well-being. (C) Abandonment, including desertion or willful forsaking of a person or the withdrawal or neglect of duties and obligations owed a person. (D) Willful infliction of physical pain or injury. (E) Use of derogatory or inappropriate names, phrases or profanity, ridicule, harassment, coercion, threats, cursing, intimidation or inappropriate sexual comments or conduct of such a nature as to threaten significant physical or emotional harm to a person. (F) Wrongfully taking or appropriating money or property, of knowingly subjecting a person to harm by conveying a threat to wrongfully take or appropriate money or property, which threat reasonably would be expected to cause the person to believe that the threat will be carried out. (G) Sexual contact with a non-consenting person or with a person considered incapable of consenting to a sexual act as described in ORS 163.315. As used in this paragraph, "sexual contact" has the meaning given that term in ORS 163.305. (b) As is applies to a child, has the same meaning as "abuse" as that term is defined in ORS 419B.005.	• *If the agency learns of possible abuse or neglect as defined in rule, the agency must immediately report the information to the appropriate authorities.* • *The agency must document the reporting details, including an follow up or actions taken.*

Policies and Procedures

Policies and Procedures Rule Reference	*Interpretive Guideline*
333-536-0050(8)(b)&(f) Policies and Procedures: (b) Developing and implementing written and current policies and procedures necessary to direct the administrative, personnel, and client care operations of the agency, including but not limited to the requirements in these rules; (f) Ensuring that personnel and client care practices are consistent with the agency's written policies and procedures.	• *Agency must have written policies and procedures that cover all IHC rules listed in Chapter 333, Division 536.* • *Policies and procedures cannot just be a cut and paste copy of the rules alone. While policies can have some iteration of the rules, the procedures must be specific to the agency processes.* • *Policies and procedures should be clear, concise and free of conflicting information.* • *If policies or procedures reference a form, the form should be used and available for surveyor review.* • *The policies and procedures should match the actual practice of the agency. For example, if your policies and procedures state the agency only hires Certified Nursing Aides (CNAs) as caregivers, but your employee records contain caregivers who are not CNAs, your practice is out of compliance with the agency's documented policies and procedures.* • *Policies and procedures must be updated when Oregon Administrative Rules are revised, or the agency's practice has changed.* • *Other requirements specific to policies and procedures can be found in 333-536-0050(2)(D), 333-536-0055(2)(h)&(i), 333-536-0070(3)(D)&(H), 333-536-0075(4), 333-536-0075(8), 333-536-0080(4), and 333-536-0093(4).*
333-536-0050(7) Administrator Availability and Designee: An administrator or designee shall be accessible and available during all hours in which services are being provided to clients and must be able to be on site at the parent agency location within a timely manner as needed. An administrator shall assign, in writing, a qualified designee to act as administrator in his or her temporary absence.	• *The Administrator Designee must be listed in writing (sometimes included in the Policies and Procedures but isn't required to be).* • *The Administrator or Designee identified in writing must be accessible and available at the parent agency location in a timely manner. If neither the Administrator or Designee identified in writing is available at the time of survey, the agency may be cited.*