

**Oregon Health Authority
Public Health Division – Chapter 333
Divisions 76 and 77**

**BIRTHING CENTERS
Administrative Rules in Effect on November 2, 2025**

333-077-0010 (formerly 333-076-0450)

Birthing Centers: Definitions

- (1) "Free Standing Birth Center" ("Birthing Center" or "Center") means any health care facility (HCF), licensed for the primary purpose of performing low risk deliveries that is not a hospital, or in a hospital, and where births are planned to occur away from the mother's usual residence following normal, uncomplicated pregnancy.
- (2) "Division" means the Oregon Health Authority, Public Health Division.
- (3) "Low Risk Pregnancy" means a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care, and anticipation of a normal uncomplicated labor and birth, as defined by reasonable and generally accepted criteria of maternal and fetal health.
- (4) "Absolute risk factors" are those conditions that, if present, prohibit care in a birthing center.
- (5) "Patient audit" means review of the clinical record and/or physical inspection of a client.
- (6) "Reasonable and generally accepted criteria" means criteria or standards of care adopted by professional groups for maternal, fetal and neonatal health care, and generally accepted and followed by the care providers to whom they apply, and accepted by the Division as reasonable.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.086

History:

PH 121-2024, renumbered from 333-076-0450, filed 12/24/2024, effective 12/24/2024

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90, Renumbered from 333-076-0400

HD 26-1985, f. & ef. 10-28-85

333-077-0015 (formerly 333-076-0470)

Birthing Centers: Licensing

- (1) Application for a license to operate a Birthing Center must be in writing on a form provided by the Division, including demographic, ownership and administrative information. The form must specify such information required by the Division.
- (2) No health care facility licensed pursuant to the provisions of ORS Chapter 441, may in any manner or by any means assert, represent, offer, provide or imply that such facility is or may render care or services other than that which is permitted by or that is within the scope of the license issued to such facility by the Division nor may any service be offered or provided that is not authorized within the scope of the license issued to such facility or licensed practitioner providing services in the facility.
- (3) The Birthing Center license must be conspicuously posted in the area where clients are admitted.

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These rules are also posted on <http://www.healthoregon.org/hcrqirules> under 'Recently Filed New and Amended Rules'

(4) A license that has been suspended or revoked may be reissued after the Division determines that compliance with Health Care Facility laws has been achieved satisfactorily.

Statutory/Other Authority: ORS 441.015 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.015

History:

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333-076-0490

Birthing Centers: Submission of Plans

(1) Any party proposing to make certain alterations or additions to an existing health care facility or to construct new facilities must, before commencing such alteration, addition or new construction, submit plans and specifications to the Division for preliminary inspection and approval of recommendations with respect to compliance with Division rules. Submissions shall be in accord with, OAR 333-675-0000. Plans should also be submitted to the local building division having authority for review and approval in accordance with state building codes.

(2) Centers must keep the Division informed of any changes in ownership, organizational structure, procedures performed and privileges permitted and any information requested on the application form, in writing within 30 days of the change. Failure to notify the Division may result in revocation of license.

Statutory/Other Authority: ORS 441.060 & 442.015

Statutes/Other Implemented: ORS 441.060 & 442.015

History:

PH 15-2006, f. & cert. ef. 6-27-06

HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-077-0035 (formerly 333-076-0510)

Birthing Centers: Expiration and Renewal of License

Each license to operate a Birthing Center will expire on December 31 following the date of issue, and if a renewal is desired, the licensee must make application at least 30 days prior to the expiration date upon a form prescribed by the Division as described in OAR 333-076-0470.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.025

History:

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-077-0030 (formerly 333-077-0530)

Birthing Centers: Denial or Revocation of a License

(1) A license for any Birthing Center may be denied, suspended or revoked by the Division when the Division finds that there has been a substantial failure to comply with the provisions of Health Care Facility licensing law.

(2) A person or persons in charge of a Birthing Center must not permit, aid or abet any illegal act affecting the welfare of the license.

- (3) A license will be denied, suspended or revoked in any case where the State Fire Marshal certifies that there was failure to comply with all applicable laws, lawful ordinances and rules relating to safety from fire.
- (4) A license may be suspended or revoked for failure to comply with a Division order arising from a Center's substantial lack of compliance with the rules or statutes.

Statutory/Other Authority: ORS 441.030 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.030

History:

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-077-0045 (formerly 333-076-0550)

Birthing Centers: Return of Facility License

Each license certificate in the licensee's possession must be returned to the Division immediately on the suspension or revocation of the license, failure to renew the license by December 31, or if operation is discontinued by the voluntary action of the licensee.

Statutory/Other Authority: ORS 441.086 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.086

History:

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-076-0560

Birthing Centers: Classification

(1) Health care facilities licensed by the Division may neither assume a descriptive title or be held out under any descriptive title other than the classification title established by the Division and under which the facility is licensed.

(2) No change in the licensed classification of any health care facility, as set out in this rule, may be allowed by the Division unless such facility files a new application, accompanied by the required license fee, with the Division. If the Division finds that the applicant and facility comply with Health Care Facility laws and the regulations of the Division relating to the new classification for which application for licensure is made, the Division may issue a license for such classification.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: ORS 441.025 & 442.015

History:

PH 15-2006, f. & cert. ef. 6-27-06

HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-076-0570

Birthing Centers: Hearings

Upon written notification by the Division of revocation, suspension or denial to issue or renew a license; a written request by the Center for a hearing in accordance with ORS 183.310 to 183.500 may be granted by the Division.

Statutory/Other Authority: ORS 441.037 & 442.015

Statutes/Other Implemented: ORS 441.037 & 442.015

Rules in effect on November 2, 2025

These rules are also posted on <http://www.healthoregon.org/hcrqirules> under 'Recently Filed New and Amended Rules'

History:

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-076-0590**Birthing Centers: Adoption by Reference**

All rules, standards and publications referred to in this division are made a part thereof. Copies are available for inspection at the Division during office hours. Where publications are in conflict with the rules, the rules govern.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: ORS 441.086 & 442.015

History:

PH 15-2006, f. & cert. ef. 6-27-06

HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-077-0055 (formerly 333-76-0610)**Birthing Centers: Division Procedures**

Inspections and investigations:

(1) Complaints:

(a) Any person may make a complaint to the Division regarding violation of health care facility laws or regulations. A complaint investigation will be carried out as soon as practicable and may include but not be limited to, as applicable to facts alleged:

(A) Interviews of the complainant, client(s), witnesses, and Center management and staff;

(B) Observations of the client(s), staff performance, client environment and physical environment; and

(C) Review of documents and records.

(b) Copies of all complaint investigations will be available from the Division provided that the identity of any complainant and any client referred to in an investigation will not be disclosed without legal authorization.

(2) Inspections:

(a) The Division may, in addition to any inspections conducted pursuant to complaint investigations, conduct at least one general inspection of each Center to determine compliance with Health Care Facility laws during each calendar year and at such other times as the Division deems necessary;

(b) Inspections may include but not be limited to those procedures stated in subsection (1)(a) of this rule;

(c) The inspection may include a client audit;

(d) When documents and records are requested under sections (1) or (2) of this rule, the Center must make the requested materials available to the investigator for review and copying.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.086

History:

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90

333-077-0070 (formerly 333-76-0630)**Birthing Centers: Administration**

Rules in effect on November 2, 2025

These rules are also posted on <http://www.healthoregon.org/hcrqirules> under 'Recently Filed New and Amended Rules'

Each Center must have a governing body or person clearly identified as being legally responsible for setting of policies and procedures, and assuring that they are implemented.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.086

History:

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HD 2-1990, f. 1-8-90, cert. ef. 1-15-90, Renumbered from 333-076-0410

HD 26-1985, f. & ef. 10-28-85

333-076-0650

Birthing Centers: Service Restrictions

(1) Procedures permitted, including surgical procedures, must be limited to those directly pertaining to pregnancy, labor and delivery care of women experiencing low risk pregnancy. Procedures performed will be consistent with the individual practitioner's licensure and/or scope of practice. Tubal ligation and abortion must not be performed. Table I outlines absolute risk factors that, if present on admission to the birthing center for labor and delivery, would prohibit admission to the birthing center. Table II outlines absolute risk factors that, if they develop during labor and delivery, require transfer of the client to a higher level of care. Table III outlines absolute risk factors that, if they develop during the postpartum period in the mother or infant, would require transfer to a higher level of care. [Tables not included. See ED. NOTE.]

(2) General, spinal, caudal, and/or epidural anesthesia must not be administered in the Center.

(3) Labor shall not be induced, stimulated, or augmented with chemical agents during the first or second stages of labor.

(4) Chemical agents may be administered within the individual practitioner's scope of practice to inhibit labor, as a temporary measure, until referral/transfer of the client is complete.

[ED. NOTE: Tables referenced are available from the agency.]

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: ORS 441.025 & 442.015

History:

PH 15-2006, f. & cert. ef. 6-27-06

HD 2-1990, f. 1-8-90, cert. ef. 1-15-90, Renumbered from 333-076-0415

HD 26-1985, f. & ef. 10-28-85

333-077-0090 (formerly 333-076-0670)

Birthing Centers: Policies and Procedures

Each Center must have a detailed Policies and Procedures Manual in easily accessible form, that has been approved by the governing body or person. In order to be approved by the Division for licensing purposes, these policies and procedures must meet North American Registry of Midwives (NARM) standards. All the above noted policies must be made available to representatives of the Division on request, and subject to their approval. Failure of approval will be adequate reason for the finding of deficiencies that must be corrected for continuation of licensure. The policies must be implemented as applicable, and there must be documented evidence of implementation of the above noted policies. The policies and procedures that will be developed as applicable and implemented include:

(1) A detailed organizational chart that shows the governing body or person, and clearly delineates lines of authority, responsibility and accountability for each position included in the organization, including volunteers.

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- (2) Staffing — The governing body or person must ensure, through the policies and procedures, that there are adequate numbers of qualified and, where required, licensed or registered personnel on duty and immediately available to provide services intended for mothers and families, and to provide for safe maintenance of the Center.
- (3) Detail of procedures to be permitted, and by whom, and method of determining the qualifications and privileges of all personnel. Staff will be required to provide documented evidence of such qualifications. Such evidence must be maintained by the Center.
- (4) System for ensuring 24-hour coverage of the Center, including constant attendance by qualified attendants while a client is in the Center.
- (5) System for training and for continuing education for all personnel according to their assigned duties and evaluation of skills consistent with the individual practitioners' scopes of practice. All personnel providing direct client care must be trained in cardiopulmonary resuscitation (CPR) and there must be a record of current CPR certification. In addition there must be present at each birth one practitioner trained in care and resuscitation of the newborn.
- (6) System delineating how and when the Center will seek consultation with clinical specialists in obstetrics and pediatrics in order to ensure that all services, policies, and procedures meet North American Registry of Midwives (NARM) standards.
- (7) Protocol for referral or transfer to appropriate health care facilities all clients whose risk status exceeds that for "low risk pregnancy."
- (8) Procedures by which risk status will be assessed during the antepartal, intrapartal, and post partum period, and the identification of medical and social factors which exclude women, fetuses and newborns from the low-risk group; and for the annual review of these methods. Documentation of such assessments must be maintained in client's clinical records. Only those clients for whom prenatal and intrapartum history, physical examination, and laboratory screening procedures have demonstrated a low risk pregnancy and labor will be accepted into the Center for childbirth.
- (9) System by which the Center will ensure the presence and continuing maintenance, as recommended by the manufacturer(s), of equipment needed to provide low risk maternity care, and to initiate emergency procedures in life-threatening events to the mother or baby.
- (10) Plan and protocols for ensuring that emergency situations in either the mother or newborn are recognized in a timely fashion, and care is provided within the limits of the practitioner's scope of practice.
- (11) System delineating how emergency transportation will be promptly available for transport of the mother and/or newborn to a health care facility with the capacity for emergency care of women, in all the stages of labor, and newborns. The written policy must include a listing of situations for the mother and/or newborn that would have the potential to necessitate emergency transfer. The policy must also include the requirement that a transfer plan for each patient be developed.
- (12) Systems for ensuring the orientation and education of women and families registering for care at the Center so that they will be informed as to the benefits and risks of the services available to them at the Center and the qualifications and licensure status of practitioners at the Center. They must be fully informed of the risk criteria as defined in OAR 333-076-0650 and provide written consent. The client, as a part of the informed consent, must also agree in advance to transfer to another clinician or appropriate health care facility, should the need occur due to the development of unexpected risk factors after admission to the Center. The client must be informed of the benefits and risks of such a transfer.
- (13) System for the sterilization of equipment and supplies, unless only pre-packaged and pre-sterilized items are used.
- (14) System to ensure the performance of appropriate laboratory studies and to ensure that the results are available in a timely manner.

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- (15) System for the storage and administration of drugs. All medications must be prescribed and/or administered within the individual practitioner's licensure and/or scope of practice.
- (16) System to ensure the timely administration of Rh immune globulin to the mother, where applicable.
- (17) System to ensure the timely appropriate administration of Vitamin K to the newborn, according to rules of the Division.
- (a) The purpose of ORS 433.303 to 433.314 is to protect newborn infants against hemorrhagic disease of the newborn.
- (b) The Vitamin K forms suitable for use are forms of Vitamin K1 (Phytonadione), available in injectable or oral forms: as Mephyton for oral use, or as aquamephyton or konakion for injectable use. The Vitamin K dose is to be administered within the first 24 hours of delivery. Menadione (Vitamin K3) is not recommended for prophylaxis and treatment of hemorrhagic disease of the newborn.
- (c) The dose of any of the Vitamin K1 forms to be administered is one dose of 0.5 to 1.0 mg., if given by injection, or one dose of 1.0 to 2.0 mg. if given orally.
- (d) A parent may, after being provided a full and clear explanation, decline to permit the administration of Vitamin K based on religious tenets and practices. In this event, the parent must sign a form acknowledging his/her understanding of the reason for administration of Vitamin K and possible adverse consequences in the presence of a person who witnessed the instruction of the parent, and who must also sign the form. The form must become a part of the clinical record of the newborn infant.
- (18) System to ensure the timely and appropriate collection of blood from the newborn for testing by the Oregon State Public Health Laboratory, Newborn Screening Program, for the Metabolic Diseases listed in 333-024-0210.
- (19) System to ensure that pulse oximetry screening is performed on every newborn infant delivered at the Birthing Center before the infant is discharged in conformance with the following requirements:
- (a) The pulse oximetry screening must be performed using evidence-based guidelines such as those recommended by Strategies for Implementing Screening for Critical Congenital Heart Disease, AR Kemper et al., Pediatrics 2011;128(5): e1259–1267.
- (b) The Birthing Center must have policies and procedures based on the guidelines required by subsection (a) of this section for:
- (A) Determining what is considered a positive screening result; and
- (B) Determining what follow-up services, treatment or referrals must be provided if a newborn infant has a positive screening result.
- (c) A Federal Drug Administration (FDA) approved motion tolerant pulse oximeter must be used.
- (d) The pulse oximetry screening must be performed no sooner than 24 hours after birth or as close to discharge of the newborn infant as possible.
- (e) Before performing pulse oximetry screening on newborn infants, individuals must have received training on how to correctly operate the pulse oximeter and the policies and procedures associated with the screening. The Birthing Center must document this training.
- (f) If a newborn infant is admitted to a hospital as the result of a transfer from the Birthing Center before a pulse oximetry screening is performed, the hospital from which the newborn infant is discharged to home is responsible for performing the screening.
- (g) The Birthing Center must provide the following notifications and document them in the newborn infant's medical record:
- (A) Prior to the pulse oximetry screening, notify a parent or legal representative of the newborn about the reasons for the screening and the risks and consequences of not screening.
- (B) Following the pulse oximetry screening, notify the health care provider responsible for the newborn infant and the infant's primary care provider of the results of the screening.

(C) Following the pulse oximetry screening and prior to discharge, notify a parent or legal representative of the newborn infant of the screening result, an explanation of its meaning and, if it is a positive screening result, provide information about the importance of timely diagnosis and intervention.

(h) A parent or legal representative of a newborn infant may decline pulse oximetry screening and, if screening is declined, the Birthing Center must document the declination in the newborn infant's medical record.

(i) Following the pulse oximetry screening, the Birthing Center, in accordance with the applicable standard of care, must provide any appropriate follow-up services or treatment for the newborn infant if necessary or provide a referral to a parent or legal representative of the newborn for follow-up services or treatment if necessary.

(j) The Birthing Center must document in the newborn infant's medical record that the screening was performed, the screening result, the names of the health care providers who were notified of the screening result, and any follow-up services or treatment or referral for services or treatment.

(k) No newborn infant may be refused screening because of the inability of a parent or legal representative to pay for the screening.

(20) Protocol delineating the steps to ensure the prompt and safe evacuation of the Center in the event of emergency situations, such as fire. The Center must ensure the evaluation of staff in managing such situations by periodic drills for fire, and/or other emergencies. Such drills must be documented.

(21) System of infection control to address the prevention and early recognition of the possibility of infection, and timely and acceptable methods of control. This includes written documentation of the problem, and measures taken for control, and must at least meet the requirements of the rules of the Division.

Documentation must also include methods for the control and prevention of cross-infection between clients and services in accordance with 2003 Center for Disease Control and Prevention "Guidelines for Environmental Infection Control in Health-Care Facilities."

(22) System to be used for the prevention of Ophthalmia Neonatorum in the newborn OAR 333-019-0036(2). Prophylaxis for Gonococcal Ophthalmia Neonatorum:

(a) The practitioner attending the birth of an infant must, after evaluating the infant as being at risk and within two hours of delivery, instill appropriate prophylactic antibiotic ointment from single patient use applicators into each eye of the newborn infant;

(b) Parent(s) refusing to allow prophylaxis for their infant(s) must be informed, by the attending Health Care Provider, of the risks attendant to such action and must sign a witnessed affidavit to testify that they have been so informed and nonetheless refuse to allow prophylaxis.

(c) If Vitamin K and/or Gonococcal Ophthalmia Neonatorum Prophylaxis cannot be administered by the individual delivering the newborn, methods must be described to ensure that these services are arranged by referral.

(23) System to ensure that appropriate vital records are filed according to the rules of the Division.

(24) System for a semi-annual clinical record audit to evaluate the care process and outcome.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.025

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These rules are also posted on <http://www.healthoregon.org/hcrqirules> under 'Recently Filed New and Amended Rules'

333-077-0130 (formerly 333-076-0690)

Birth Centers: Health and Medical Records

Health and Clinical Records must be developed according to procedures outlined in the Policy and Procedures Manual as a legal record and an instrument for the continuity of care and must include:

- (1) Contents — The records of each client must contain:
 - (a) Demographic data, initial prenatal physical examination, laboratory tests and evaluation of risk status;
 - (b) Continuous periodic prenatal examination and evaluation of risk status;
 - (c) A signed informed consent (refer also to OAR 333-076-0670(12));
 - (d) History, physical examination and risk assessment on admission to the Center in labor (including assessment of mother and fetus);
 - (e) Continuous assessment of the mother and fetus during labor and delivery;
 - (f) Labor summary;
 - (g) The emergency transport plan for the client;
 - (h) Physical assessment of newborn, including Apgar scores and vital signs;
 - (i) Post partum evaluation of the mother;
 - (j) Discharge summary for mother and newborn;
 - (k) Documentation of consultation, referral, and/or transfer;
 - (l) Signed documents as may be required by law; and
 - (m) Records of newborn and stillborn infants must include, in addition to the requirement for medical records, the following information:
 - (A) Date and hour of birth, birth weight and length of infant, period of gestation, sex, and condition of infant on delivery;
 - (B) Mother's name;
 - (C) Record of ophthalmic prophylaxis and Vitamin K administration or refusal of same; and
 - (D) Progress notes including:
 - (i) Temperature, weight and feeding data;
 - (ii) Number, consistency and color of stools;
 - (iii) Urinary output;
 - (iv) Condition of eyes and umbilical cord;
 - (v) Condition and color of skin; and
 - (vi) Motor behavior.
- (2) All entries in a client's labor record must be dated, timed, and authenticated. Verification of an entry requires use of a unique identifier, i.e., signature, code, thumbprint, voice print or other means, that allows identification of the individual responsible for the entry.
- (3) A single signature or authentication of the responsible practitioner on the clinical record does not suffice to cover the entire content of the record.
- (4) The completion of the clinical record must be the responsibility of the attending practitioner.
- (5) The Center will ensure that the prenatal and intrapartum records are available at the time of admission and in the event of transfer to the care of another clinician or health care facility.
- (6) Storage — The records will be stored in such a way as to minimize the chance of their destruction by fire or other source of loss or damage and to ensure prevention of access by unauthorized persons.
- (7) Records are the property of the Center, and will be kept confidential unless released by the permission of the client. An exception is that they may be reviewed by representatives of the Division, and will be provided in copy form to such representatives on request.

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(8) All clinical records must be kept for a period of at least twenty-one years after the date of last discharge. Original clinical records may be retained on paper, microfilm, electronic or other media.

(9) If a Center changes ownership all clinical records in original, electronic, or microfilm form must remain in the Center, and it must be the responsibility of the new owner to protect and maintain these records.

(10) If a Birthing Center must be closed, its clinical records may be delivered and turned over to any other health care facility in the vicinity willing to accept and maintain the same as provided in section (8) of this rule.

(11) If a qualified clinical record practitioner, RHIA (Registered Health Information Administrator) or RHIT (Registered Health Information Technician) is not the Director of the Clinical Records Department, the Division may require the Center to obtain periodic and at least annual consultation from a qualified clinical records consultant, RHIA/RHIT. The visits of the clinical records consultant must be of sufficient duration and frequency to review clinical record systems and assure quality records of the clients. Contract for such services must be available to the Division.

Statutory/Other Authority: ORS 441.025 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.025

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HD 26-1985, f. & ef. 10-28-85

333-077-0220 (formerly 333-076-0710)

Birthing Centers: Physical Facility

(1) Design — The Center may be an adaptation of a house. It must include birthing rooms of adequate size to meet the needs to accomplish the procedures specified in the Policies and Procedures and must meet applicable codes for ordinary construction and for water supply and sewage disposal. The building and equipment must be kept clean and in good repair. The Center must include:

- (a) Toilet facilities for staff, mothers and families;
- (b) Bath facilities;
- (c) Hand washing facilities and single use towel dispensers adjacent or closely available to all examining or birth rooms;
- (d) Examination areas;
- (e) Laundry facilities (unless laundry is done elsewhere);
- (f) Kitchen facilities;
- (g) Adequate storage areas for emergency equipment;
- (h) Separate storage for clean/sterile supplies and equipment;
- (i) Storage areas for laboratory equipment and sterilizing, if applicable;
- (j) Space for resuscitation of the newborn; and
- (k) Reception and family facilities.

(2) Client Environment:

- (a) There must be provided for each client a good bed, mattress and pillow with protective coverage, and necessary bed coverings;
- (b) No towels, wash cloths, bath blankets, or other linen which comes directly in contact with the client will be interchangeable from one client to another unless it is first laundered;
- (c) The use of torn or unclean bed linen is prohibited; and

(d) After the discharge of any client, the bed, bed furnishings, bedside furniture and equipment must be thoroughly cleaned and disinfected prior to reuse. Mattresses must be professionally renovated when necessary.

(3) Provision must be made for the safe disposal of any bodily wastes that result from procedures performed in accordance with Centers for Disease Control and Prevention recommendations and state law.

(4) Fire and Safety — State and local fire and life-safety codes apply with specific attention to demonstration of adequate ingress and egress of occupants, placement of smoke alarms, emergency lighting, fire extinguishers or sprinkler systems, fire escape routes, and fire reporting plans. The Center must have an emergency plan in effect on premises available to all staff. There must be evidence of an annual fire inspection.

(5) Emergency Access — Hallways and doorways must be so sized and arranged as to ensure the reasonable access of equipment in the event of the need for emergency transport.

(6) Emergency preparedness:

(a) The health care facility shall develop, maintain, update, train, and exercise an emergency plan for the protection of all individuals in the event of an emergency, in accordance with the regulations as specified in Oregon Fire Code (OAR 837-040).

(A) The health care facility shall conduct at least two drills every year that document and demonstrate that employees have practiced their specific duties and assignments, as outlined in the emergency preparedness plan.

(b) The emergency plan shall include the contact information for local emergency management. Each facility shall have documentation that the local emergency management office has been contacted and that the facility has a list of local hazards identified in the county hazard vulnerability analysis.

(c) The summary of the emergency plan shall be sent to the Authority within one year of the filing of this rule. New facilities that have submitted licensing documents to the state before this provision goes into effect will have one year from the date of license application to submit their plan. All other new facilities shall have a plan prior to licensing. The Authority shall request updated plans as needed.

(d) The emergency plan shall address all local hazards that have been identified by local emergency management and may include, but is not limited to, the following:

(A) Chemical emergencies;

(B) Dam failure;

(C) Earthquake;

(D) Fire;

(E) Flood;

(F) Hazardous material;

(G) Heat;

(H) Hurricane;

(I) Landslide;

(J) Nuclear power plant emergency;

(K) Pandemic;

(L) Terrorism; or

(M) Thunderstorms.

(e) The emergency plan shall address the availability of sufficient supplies for staff and patients to shelter in place or at an agreed upon alternative location for a minimum of two days, in coordination with local emergency management, under the following conditions:

(A) Extended power outage;

(B) No running water;

- (C) Replacement of food or supplies is unavailable;
- (D) Staff members do not report to work as scheduled; and
- (E) The patient is unable to return to the pre-treatment shelter.
- (f) The emergency plan shall address evacuation, including:
 - (A) Identification of individual positions' duties while vacating the building, transporting, and housing residents;
 - (B) Method and source of transportation;
 - (C) Planned relocation sites;
 - (D) Method by which each patient will be identified by name and facility of origin by people unknown to them;
 - (E) Method for tracking and reporting the physical location of specific patients until a different entity resumes responsibility for the patient; and
 - (F) Notification to the Authority about the status of the evacuation.
- (g) The emergency plan shall address the clinical and medical needs of the patients, including provisions to provide:
 - (A) Storage of and continued access to medical records necessary to obtain care and treatment of patients, and the use of paper forms to be used for the transfer of care or to maintain care on-site when electronic systems are not available.
 - (B) Continued access to pharmaceuticals, medical supplies, and equipment, even during and after an evacuation; and
 - (C) Alternative staffing plans to meet the needs of the patients when scheduled staff members are unavailable. Alternative staffing plans may include, but is not limited to, on-call staff, the use of travelers, the use of management, or the use of other emergency personnel.
- (h) The emergency plan shall be made available as requested by the Authority and during licensing and certification surveys. Each plan will be re-evaluated and revised as necessary or when there is a significant change in the facility or population of the health care facility.

Statutory/Other Authority: ORS 441.020 & 442.015

Statutes/Other Implemented: 442.015 & ORS 441.020

History:

PH 121-2024, renumbered from 333-076-0710, filed 12/24/2024, effective 12/24/2024

PH 13-2008, f. & cert. ef. 8-15-08

PH 15-2006, f. & cert. ef. 6-27-06

HD 2-1990, f. 1-8-90, cert. ef. 1-15-90, Renumbered from 333-076-0430

HD 26-1985, f. & ef. 10-28-85

**BIRTHING CENTERS HIGH RISK FACTORS
ADMISSION - TABLE I**

ABSOLUTE RISK FACTORS - If present at the time of admission to the birthing center, the following conditions would necessitate transfer of the client to a higher level of care:
Current substance abuse which has the potential to adversely affect labor and/or the infant
Quadriplegia
Hypertension >150/100 on at least two occasions
For this pregnancy, Type I Diabetes, other diabetes requiring insulin to maintain acceptable control, or Type II Diabetes
Thrombosis, active/current
Severe anemia, <9 hemoglobin
Uncontrolled seizure disorder
Life-threatening congenital defects in fetus. This does not include documented lethal anomalies
<p>History of previous uterine wall surgery, including Caesarean section, if one or more of the following risk factors is present:</p> <ul style="list-style-type: none"> -Conception occurred < 12 months following that surgery or uterine procedure; -Absence of ultrasound to rule out placenta previa and/or placental attachment to the surgical site; -History of two or more Caesarean sections without a prior successful vaginal delivery; -History of myomectomy which invaded the endometrium; -History of a known uterine perforation; -History of Caesarean section which included classical incision; -History of Caesarean section and complications including postoperative infection, diabetes, or steroid use; -Absence of signed, detailed informed consent

NOTE: Any woman with previous uterine wall surgery must be evaluated for the presence of risk factors, and must go through a thorough informed consent process. The information given to the woman must include an explanation of the risk, including non-absolute risks, of a vaginal birth after Caesarean section, and an explanation of the contingency plan in place should transport be necessary. If transport becomes necessary, the birthing center should notify the receiving facility when the transport is imminent.

Need for Caesarean delivery this birth

Multiple gestation

Intrauterine growth restriction without reassuring bio-physical profile of greater than or equal to 8 out of 10

No previous prenatal care or written prenatal records available

Abnormal fetal surveillance studies

Fetal presentation other than vertex, when known

Rising antibody titre - types known to affect fetal well-being; significant Rh sensitization

Amniotic fluid index >30 at term

Amniotic fluid index <5 without reassuring labor progress, without reassuring fetal heart tones and/or abnormal non-stress test

Abnormal bleeding

Need for chemical and/or pharmacological induction of labor

Need for general or conduction anesthesia

Eclampsia; preeclampsia with lab abnormalities

Low-lying placenta within 2 cm. or less of cervical os; vasa previa; complete placenta previa; abruptio placenta

Genital herpes, primary; secondary uncoverable at onset of labor

Labor or premature rupture of membranes at <36 weeks; pregnancy >43 weeks or >42 weeks with abnormal non-stress test

Chorioamnionitis

Thick meconium-stained amniotic fluid without reassuring Doppler heart tones

Known pre-term fetal demise

**BIRTHING CENTERS - HIGH RISK FACTORS
INTRAPARTUM - TABLE II**

ABSOLUTE RISK FACTORS - If any of the following conditions develop during labor and delivery, the client shall be transferred to a higher level of care.
Presence or development of Table I (Admission) risk factors
Failure to progress in active labor with strong contractions and/or maternal/fetal compromise
Abnormal fetal heart tone (FHT) pattern unresponsive to treatment; inability to auscultate fetal heart tones unless birth is imminent
Thick meconium-stained amniotic fluid without reassuring Doppler heart tones and birth is not imminent
Hypertension >150/100 on at least two occasions
Abnormal bleeding
Prolapsed umbilical cord
Fetal presentation other than vertex, when known, and birth is not imminent
Multiple gestation when birth is not imminent
Amniotic fluid index <5 without reassuring labor progress or without reassuring fetal heart tones or abnormal non-stress test
Persistent fever of equal to or greater than 101 degrees Fahrenheit (oral) or indication of serious infection with the potential to harm the mother or the fetus
Development of severe medical or surgical problem

BIRTHING CENTERS HIGH RISK FACTORS

TABLE III - POSTPARTUM

MOTHER

ABSOLUTE RISK FACTORS - If the mother develops any of the following during in the postpartum period, the mother shall be transferred to a higher level of care:
Abnormal bleeding unresponsive to treatment and/or symptoms of hypovolemia
Need for transfusion
Retained placenta or incomplete placenta, with bleeding; suspected placenta accreta; retained placenta >3 hours
OTHER: Hypertension >150/100 on at least two occasions; shock, unresponsive to treatment; laceration requiring repair in a hospital; enlarging hematoma; development of preeclampsia or eclampsia; signs of serious infection.

BIRTHING CENTERS HIGH RISK FACTORS

TABLE III - POSTPARTUM

INFANT

ABSOLUTE RISK FACTORS - If the infant develops any of the following during the postpartum period, the infant shall be transferred to a higher level of care:
Apgar problems <5 at 5 minutes or <7 at 10 minutes
Inability to maintain axillary temperature between 97 degrees Fahrenheit and 100 degrees Fahrenheit at 2 hours
Hypotonia > 10 minutes
Tremors, seizures, or hyperirritability
Life-threatening congenital defects in fetus. This does not include documented lethal abnormalities ¹
Respiratory or cardiac irregularities (examples: abnormal capillary refill time, disturbance of rate or rhythm; grunting or retracting after 30 minutes postpartum, need for oxygen > 30 minutes without improvement; cyanosis, central and persistent)
Signs/symptoms of infection

¹ In the presence of known and documented lethal fetal abnormalities, the denial of admission and the requirements to transfer do not apply