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# PERMANENT ADMINISTRATIVE ORDER

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CHAPTER 333
**OREGON HEALTH AUTHORITY**
**PUBLIC HEALTH DIVISION**

FILING CAPTION: Workplace Violence Prevention Safety Requirements in Healthcare Settings and Administrative Updates

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RULES:
333-027-0001, 333-027-0046, 333-027-0060, 333-027-0115, 333-027-0125, 333-027-0170, 333-035-0120, 333-035-0125, 333-035-0165, 333-035-0167, 333-035-0220, 333-035-0300, 333-071-0260, 333-071-0400, 333-071-0420, 333-071-0423, 333-071-0425, 333-500-0025, 333-505-0030, 333-505-0036, 333-505-0045, 333-535-0015

AMEND: 333-027-0001

RULE TITLE: Compliance with Federal Law

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-027-0001: Removes outdated language that no longer applies.

RULE TEXT:
(1) Every home health agency subject to ORS 443.014 to 443.105 must comply with the Conditions of Participation governing home health agencies prescribed by the Centers for Medicare and Medicaid Services (CMS), under 42 CFR Part 484, adopted by reference.
(2) Although a naturopathic physician may prescribe services and supplies under a plan of care pursuant to ORS 443.065, those services and supplies ordered by the naturopathic physician are not eligible for reimbursement by CMS.
(3) In addition to the requirements of 42 CFR Part 484, home health agencies licensed in Oregon must also comply with the rules in OAR 333-027-0000 through 333-027-0190.

STATUTORY/OTHER AUTHORITY: ORS 443.085

STATUTES/OTHER IMPLEMENTED: ORS 443.014 - 443.090

AMEND: 333-027-0046

RULE TITLE: Geographic Service Area

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-027-0046: Amendments to this rule allow greater flexibility for a home health agency to serve a larger service area when serving a historically underserved population.

RULE TEXT:
(1) As used in this rule, "underserved area or population" means an area in which residents have a shortage of available home health services or a group of persons who face economic, racial, cultural, linguistic, religious, sexual orientation, gender-identity, or age-related barriers to home health services.
(2) A home health agency serves a geographic service area that is equal to or less than 60 miles from the physical location of the agency.
(3) A branch office provides services to the parent agency's location within a portion of the total geographic area served by the parent agency.
(4) The Oregon Health Authority (Authority) may permit a home health agency providing care at branch offices, if:
(a) All branch offices are operating under the same Medicare Certification number;
(b) All branch offices provide the same level of care and range of care and services offered by the parent home health agency certified by the Centers for Medicare and Medicaid Services (CMS); and
(c) The branch offices are located within a 60-mile radius of the parent home health agency applying for licensure.
(5) The Authority may waive the geographical restrictions specified in this rule in accordance with OAR 333-027-0170, including but not limited to, if the parent home health agency proposes to provide home health services to an underserved area or population of the state and adequately demonstrates the ability to manage and control the services.
(6) A home health agency that moves its physical location must:
(a) Apply for a new license in accordance with OAR 333-027-0010; and
(b) Ensure that the services it provides to patients is within 60 miles from the new physical location.

STATUTORY/OTHER AUTHORITY: ORS 443.085

STATUTES/OTHER IMPLEMENTED: ORS 443.075

AMEND: 333-027-0060

RULE TITLE: Administration of Home Health Agency

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-027-0060: The rule is amended to update terms relating to personnel or staff. The rule requires that home health agency employees be notified about the availability of personnel safety training which must be documented in personnel records. The rule further requires a home health agency to establish, and review annually, policies relating to personnel safety requirements and potential threat or disruptive behavior flagging systems.

RULE TEXT:

(1) An agency shall clearly set forth in writing the organization, services provided, administrative control, and lines of authority for the delegation of responsibility to the patient care level. An agency shall not delegate administrative and supervisory functions to another agency, individual, or organization.

(2) An agency shall ensure that:

(a) A clinical manager is employed who is responsible for the oversight of all patient care services and personnel and that the clinical manager is available during all operating hours;

(b) A professional policy-making committee is established in accordance with ORS 443.065; and

(c) All patient complaints are reviewed including documentation and resolution.

(3) If an agency chooses to provide professional students with a practicum in home health, the agency must ensure that:

(a) A contract between the agency and the accredited educational institution is in effect and includes at a minimum, a description of:

(A) Program objectives;

(B) Program coordination;

(C) Student supervision;

(D) Adherence to agency policy; and

(E) Conformance with applicable professional practice laws, rules, and regulations.

(b) The governing body shall be informed about the contract specified in subsection (3)(a) prior to its implementation.

(c) The agency maintains documentation of each practicum and the student's activities, supervision, and the evaluation of these activities.

(d) The agency maintains documentation of patient care services provided by the student.

(4) An agency's governing body shall assume full legal and fiscal responsibility for the agency's operation. The agency's governing body shall provide for effective communication with administration of the agency and the owner of the agency.

(5) An agency's governing body shall:

(a) Employ a qualified administrator, unless exempted under ORS 443.025;

(b) Regularly monitor the performance of the administrator; and

(c) Ensure there is a quality assessment and performance improvement program established and maintained in accordance with OAR 333-027-0160.

(6) The administrator shall identify a qualified alternate, designated in writing by the administrator and the governing body to assume responsibilities and obligations of the agency during the administrator's absence. The clinical manager may be designated to serve in this role.

(7)(a) The agency shall develop personnel policies which must be appropriate to the agency, be documented, and include:

(A) Hours of work;

(B) Orientation that is appropriate to the classification of the employee;

(C) An inservice program that provides ongoing education to ensure that skills of personnel are maintained for the responsibilities assigned and ensures that personnel are educated in their responsibility in infection control;

(D) Employee notification about the availability of personnel safety training provided in accordance with OAR 333-027-

0115;
(E) Work performance evaluations;
(F) Employee health program;
(G) A tuberculosis infection control plan that includes provisions for employee assessment and screening for protecting patient and employees from tuberculosis in accordance with OAR 333-019-0041; and
(H) Provisions for the completion of criminal records checks in accordance with ORS 443.004 and OAR 333-027-0064.
(b) Personnel records shall include job descriptions, personnel qualifications, evidence of any required licensure or certification, evidence of orientation and performance evaluations, evidence of a completed criminal records check and fitness determination, and evidence of personnel safety training notification.
(8) An agency shall provide health care interpreter services to a patient who prefers to communicate in a language other than English in accordance with ORS 413.559 and OAR 950-050-0160.
(9) An agency contracting with individual personnel or public or private entities for home health care services shall maintain written contracts and shall clearly designate:
(a) That patients are accepted for care only by the primary agency;
(b) The services to be provided;
(c) The rights and responsibilities of the contracting individual or entity in the coordination, supervision, and evaluation of the care or service provided;
(d) The obligation to comply with all applicable agency policies;
(e) The party with responsibility for development and revisions of the plan of care, patient assessment, progress reports, and patient care conferences, scheduling of visits or hours, and discharge planning;
(f) Appropriate documentation of services provided on record forms provided by the agency; and
(g) The terms of the agreement and basis for renewal or termination.
(10) The professional policy-making committee appointed by the agency shall:
(a) Be composed of personnel associated with the agency and that meet the requirements in ORS 443.065.
(b) Establish in writing and review annually, the agency's policies governing scope of services, admission and discharge policies, personnel safety program requirements in accordance with OAR 333-027-0115, potential threat or disruptive behavior flagging systems in accordance with OAR 333-027-0125, medical supervision, plans of treatment, emergency care, clinical records, personnel qualifications, and quality assessment and performance improvement.
(c) Meet as needed to advise the agency on other professional issues.
(d) Participate with personnel in the annual evaluation of the agency's program.
(11) The agency shall document the professional-policy making committee's systematic involvement and effective communication with the governing body and the management of the agency.

STATUTORY/OTHER AUTHORITY: ORS 443.085

STATUTES/OTHER IMPLEMENTED: ORS 443.014, ORS 443.055, ORS 443.065, ORS 43.085, ORS 413.559, ORS 413.561, ORS 441.201, ORS 443.190, ORS 443.195

ADOPT: 333-027-0115

RULE TITLE: Personnel Safety Program Requirements

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-027-0115: New rule is adopted requiring a home health agency to establish, implement, and maintain a workforce violence prevention program. Minimum requirements are specified including information that must be collected, the development and implementation of plan to obtain necessary patient history from a hospital when the patient is referred to receive home health services, keeping personnel apprised of information collected, the provision of annual training on personnel safety, conducting quarterly safety assessments, providing information to verify the identity of a patient, providing a way by which personnel can perform safety checks, and establishing and implementing policies and procedures. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Hazards" means potentially unsafe or dangerous conditions in or around the home health care setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance use disorder, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of timely law enforcement or emergency response capability.

(b) "Home health care setting" means a place of temporary or permanent residence of an individual where home health care services are furnished to the individual.

(c) "Safety check" means the process by which personnel can access, review, and apply safety-related information collected by the agency in accordance with this rule, and includes a mechanism for personnel to directly contact the agency to report safety concerns.

(2) Effective May 1, 2026, an agency shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:

(a) Intake risk assessment. An agency must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:

(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior where home health care services are provided to a patient;

(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by personnel;

(C) Possible pest infestations, for example, rodents or insects; and

(D) Whether the patient is willing to securely store any weapons that are present in the home health care setting before any visit from personnel.

(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to an agency, the agency must develop and implement a plan to obtain any known patient history of violence within the last 12 months from the hospital as part of continuity of care.

(c) Personnel notification. The agency must have a protocol, and implement the protocol, to share all information collected under subsections (2)(a) and (b) of this rule with personnel assigned to provide home health care services to the patient.

(d) Training. An agency shall provide annual training on personnel safety. The training must be consistent with training for home health care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration and must include the following:

(A) Recognizing hazards that are commonly found by personnel where home health care services are provided to a patient; and

(B) How to manage hazards that are identified.

(C) This training may be incorporated as part of the mandated requirements under ORS 654.414(4).

(e) Quarterly safety assessments. An agency must conduct quarterly safety assessments with personnel who have been

assigned to provide home health care services. A safety assessment may consist of the same criteria required under ORS 654.414(2) and (3).
(f) Patient identification. An agency must provide personnel with information that may be used to verify the identity of a patient prior to an initial home health care visit.
(g) Safety checks. An agency must provide a mechanism by which personnel can perform safety checks, including but not limited to use of a mobile application to access relevant safety-related information identified under subsections (2)(a) and (b) of this rule, use of communication devices that allow personnel to transmit one-way or two-way messages, or regular check-ins.
(h) Policy development. An agency shall establish and implement policies and procedures that allow personnel to:
(A) Perform data entry and chart updates at a time and place outside the location where home health care services are provided; and
(B) Be accompanied by an escort, including but not limited to another employee, when there are concerns about the safety or security of the setting where home health care services are provided to the patient.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 443.085

STATUTES/OTHER IMPLEMENTED: ORS 443.065, ORS 443.085, ORS 443.190, ORS 443.195

ADOPT: 333-027-0125

RULE TITLE: Potential Threat or Disruptive Behavior Flagging Systems

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-027-0125: New rule requires a home health agency to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that home health agency personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.

(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior.

(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.

(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel.

(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence.

(2) Effective May 1, 2026, an agency shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags.

(3) Each agency must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging system must address, at a minimum, the following:

(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags.

(b) Requirements for new and revised EHR flags and visual flags that include:

(A) The reasons for initiating or revising the flag; and

(B) Specific recommended actions that agency providers and personnel should take when interacting with a flagged individual.

(c) For EHR flags:

(A) Designating authorized staff to initiate an EHR flag.

(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.

(C) Provider and personnel responsibilities when an EHR flag is present.

(D) Evaluating and identifying potential threats of violence or disruptive behavior.

(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.

(F) Reviewing EHR flags every 12 months at a minimum, and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.
(H) Safety protocols and precautions for engaging with patients with an EHR flag.
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the patient, such as a caregiver or support person, may request review and removal of an EHR flag.
(d) For visual flags, education and training for authorized staff on:
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;
(B) Consistent approaches to initiating a visual flag; and
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.
(4) Providers and personnel of an agency may not take any of the following actions based solely on the presence of an EHR flag:
(a) Deny home health services to which the patient would otherwise be eligible.
(b) Make decisions regarding the patient's access to care.
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health or safety of an employee, patient, caregiver, support person, or the public.
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.
(g) Punish or penalize the patient.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 443.085

STATUTES/OTHER IMPLEMENTED: ORS 443.065, ORS 443.085, ORS 441.201

AMEND: 333-027-0170

RULE TITLE: Waivers

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-027-0170: The rule is amended to require additional information when a home health agency is requesting a waiver from an administrative rule requirement. The request for a waiver must include information on the possible impacts to persons with different backgrounds and cultures, persons with limited English proficiency, households with lower incomes, and persons based on their gender identity and sexual orientation. The facility would also need to specify how the impact was determined and what would be proposed steps to mitigate the impact on disproportionately affected populations.

RULE TEXT:

(1) While all agencies are required to maintain continuous compliance with these rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. A request for a waiver from a rule must be submitted to the Oregon Health Authority (Authority) in writing and include the following information:

(a) Identification of the specific rule for which a waiver is requested;

(b) The special circumstances relied upon to justify the waiver;

(c) What alternatives were considered, if any, and why alternatives (including compliance) were not selected;

(d) Information demonstrating that the proposed waiver is desirable to maintain or improve the health and safety of the patients, to meet the individual and aggregate needs of patients, and will not jeopardize patient health and safety;

(e) For an initial waiver request or any request to renew a waiver, a description of the following:

(A) Possible impacts that the proposed waiver may have on persons from different backgrounds and cultures, including but not limited to individuals of color, individuals with disabilities, individuals with limited English proficiency, people or households with lower incomes, and individuals who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary, or another minority gender identity or another sexual orientation;

(B) How the impact was determined; and

(C) Proposed steps to mitigate the impact on disproportionately affected populations; and

(f) The proposed duration of the waiver.

(2) Upon finding that the agency has satisfied the conditions of this rule, the Authority may grant a waiver.

(3) An agency may not implement a waiver until it has received written approval from the Authority.

(4) During an emergency the Authority may waive a rule that an agency is unable to meet, for reasons beyond the agency's control. If the Authority waives a rule under this section, it shall issue an order, in writing, specifying which rules are waived, which agencies are subject to the order, and how long the order shall remain in effect.

STATUTORY/OTHER AUTHORITY: ORS 443.085

STATUTES/OTHER IMPLEMENTED: ORS 443.085

AMEND: 333-035-0120

RULE TITLE: Definitions

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-035-0120: Amends the definition of 'Patient Family Unit' in an effort to align language used in the definition of hospice program and language used by the Centers for Medicare and Medicaid Services, Conditions of Participation by referencing "medical prognosis”.

RULE TEXT:

As used in OAR chapter 333, division 35, the following definitions apply:

(1) "Accreditation" means a designation by an accrediting organization that a hospice program has met standards that have been developed to indicate a quality program.

(2) "Administrator" means a hospice employee responsible for the administrative functions and day-to-day operations of the hospice program.

(3) "Authority" means the Oregon Health Authority, Public Health Division.

(4) "CMS" means Centers for Medicare and Medicaid Services.

(5) "Certification" means a state agency's official recommendations and findings to CMS regarding a hospice program's compliance with federal CMS regulations.

(6) "Conditions of Participation" mean the applicable federal regulations that hospice programs are required to comply with to participate in the federal Medicare and Medicaid programs.

(7) "Hospice aide" means a person:

(a) Certified by the Oregon State Board of Nursing as a certified nursing assistant (CNA) under ORS 678.442;

(b) Who has successfully completed a training program and competency evaluation in accordance with 42 CFR 418.76(a); or

(c) Who has successfully completed a competency evaluation in accordance with 42 CFR 418.76(c).

(8) "Hospice program" means a coordinated program of home and inpatient care, available 24 hours a day, that utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient-family unit experiencing a life-threatening disease with a limited medical prognosis. A hospice program is an institution for purposes of ORS 146.100.

(9) "Hospice services" means items and services provided to a patient-family unit by a hospice program or by other individuals or community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include home care, inpatient care for acute pain and symptom management or respite, and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of a patient-family unit during the final stages of illness, dying and the bereavement period.

(10)(a) "Interdisciplinary team" means a group of individuals working together in a coordinated manner to provide hospice care. An interdisciplinary team includes, but is not limited to, the patient-family unit, the patient's attending physician or clinician and one or more of the following hospice program personnel who are trained and experienced to provide hospice care:

(A) Physician;

(B) Physician associate;

(C) Nurse practitioner;

(D) Nurse;

(E) Nurse's aide or hospice aide;

(F) Occupational therapist;

(G) Physical therapist;

(H) Trained lay volunteer;

(I) Clergy or spiritual counselor;

(J) Credentialed mental health professional such as psychiatrist, psychologist, psychiatric nurse or social worker; or

(K) Naturopathic physician.
(b) The interdisciplinary team is not the same as the interdisciplinary group as that term is defined under 42 CFR 418.56; however, interdisciplinary team members may be included in the interdisciplinary group meetings. The purpose of the interdisciplinary team is to include the patient, patient's family, and the patient's attending physician or clinician when formulating a plan of care to ensure that the full range of needs of the patient and family are met.
(11) "Medicare Certification Number" means the unique identification number, also referred to as the Medicare Provider Number, assigned to a qualifying hospice program by CMS.
(12) "Nurse's aide" means a CNA certified by the Oregon State Board of Nursing under ORS 678.442.
(13) "Palliative care" has the meaning given that term in ORS 413.273.
(14) "Parent hospice program" means the program that provides supervision and administrative control to multiple locations providing care that are within a 60-mile radius from the parent hospice program's physical location.
(15) "Patient-family unit" includes an individual who has a life-threatening disease with a limited medical prognosis and all others sharing housing, common ancestry or a common personal commitment with the individual.
(16) "Person" includes individuals, organizations and groups of organizations.
(17) "Survey" means an inspection of an applicant for a hospice program license or a hospice program to determine the extent to which the applicant or hospice program is in compliance with state hospice program statutes, these rules and CMS Conditions of Participation.
(18) "These rules" means OAR 333-035-0110 through 333-035-0300.

STATUTORY/OTHER AUTHORITY: ORS 443.860

STATUTES/OTHER IMPLEMENTED: ORS 443.850, 443.867

AMEND: 333-035-0125

RULE TITLE: Application for Licensure and Fees

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-035-0125: The rule is amended by removing vague language relating to 'sufficient staff' and clarifies that a hospice program needs to have documentation that demonstrates it maintains a workforce capable of meeting the demands of hospice services.

RULE TEXT:

(1) A person may not establish, conduct or maintain a hospice program providing hospice services, or hold itself out to the public as a hospice program, without obtaining a license from the Oregon Health Authority (Authority).

(2)(a) A person applying for a new or renewal license to operate a hospice program shall submit a complete application on a form prescribed by the Authority, accompanied by the fee specified in ORS 443.860.

(b) A complete application for an initial license includes, but is not limited to:

(A) Documentation of written policies and procedures, including any forms and curricula to direct all administrative, personnel, and patient care operations;

(B) Documentation that patient care and documentation systems have been developed; and

(C) Documentation demonstrating that the hospice program maintains a workforce of qualified and trained employees or contractors capable of meeting hospice service demands, with personnel records properly established for each employee or contractor.

(3) The Authority may deem an application incomplete if it does not include the information required by the Authority, is not accompanied by the appropriate fee, or at the time of initial survey fails to comply with subsection (2)(b) of this rule.

(4) The Authority may reject an application that is incomplete.

(5)(a) Within 30 days of the change, a hospice program must inform the Authority in writing of any change in:

(A) Ownership;

(B) Ownership category (for example, corporation, partnership, sole proprietorship);

(C) Administrator;

(D) Business name;

(E) Medicare certification number;

(F) Primary and multiple locations;

(G) Physical location; or

(H) Mailing address.

(b) If ownership of a hospice program changes, the hospice program must submit a new license application indicating change of ownership along with the required fee.

(c) If a parent hospice program moves 30 miles or more from its current physical location, the parent hospice program must apply for a new license and pay the required fee.

(6) The Authority may issue a civil penalty for failure to timely notify the Authority of any changes under section (5) of this rule or suspend, revoke or deny the license.

(7) A hospice program may provide palliative care in addition to hospice services as defined in these rules. A hospice program providing palliative care is not subject to licensure as an in-home care agency under ORS 443.867.

(8) A hospice program licensed in a bordering state must be licensed in Oregon to provide care to patients located in Oregon. The hospice program must apply and be licensed in accordance with these rules. The hospice program is subject to these rules including, the geographic service area restrictions specified in OAR 333-035-0160.

(9) A hospice program license is nontransferable.

(10) Licensure fees are not prorated and are non-refundable.

STATUTORY/OTHER AUTHORITY: ORS 443.860

STATUTES/OTHER IMPLEMENTED: ORS 443.860, 443.867

ADOPT: 333-035-0165

RULE TITLE: Personnel Safety Program Requirements

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-035-0165: New rule is adopted requiring a hospice program to establish, implement, and maintain a workforce violence prevention program. Minimum requirements are specified including information that must be collected, the development and implementation of plan to obtain necessary patient history from a hospital when the patient is referred to receive home health services, keeping personnel apprised of information collected, the provision of annual training on personnel safety, conducting quarterly safety assessments, providing information to verify the identity of a patient, providing a way by which personnel can perform safety checks, and establishing and implementing policies and procedures. Policies and procedures must be reviewed annually. The rule further requires that hospice program employees be notified about the availability of personnel safety training which must be documented in personnel records. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Hazards" means potentially unsafe or dangerous conditions in or around the home health care setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance use disorder, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of timely law enforcement or emergency response capability.

(b) "Home health care setting" means a place of temporary or permanent residence of an individual where hospice services are furnished to the individual.

(c) "Safety check" means the process by which personnel can access, review, and apply safety-related information collected by the agency in accordance with this rule, and includes a mechanism for personnel to directly contact the agency to report safety concerns.

(2) Effective May 1, 2026, a hospice program shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:

(a) Intake risk assessment. A hospice program must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:

(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior where hospice services are provided to a patient;

(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by personnel;

(C) Possible pest infestations, for example, rodents or insects; and

(D) Whether the patient is willing to securely store any weapons that are present in the home health care setting before any visit from personnel.

(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to a hospice program, the hospice program must develop and implement a plan to obtain any known patient history of violence within the last 12 months from the hospital as part of continuity of care.

(c) Personnel notification. The hospice program must have a protocol, and implement the protocol, to share all information collected under subsections (2)(a) and (b) of this rule with personnel assigned to provide hospice services to the patient.

(d) Training. A hospice program shall provide annual training on personnel safety. The training must be consistent with training for home health care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration and must include the following:

(A) Recognizing hazards that are commonly found by personnel where hospice services are provided to a patient; and

(B) How to manage hazards that are identified.

(C) This training may be incorporated as part of the mandated requirements under ORS 654.414(4).

(e) Quarterly safety assessments. A hospice program must conduct quarterly safety assessments with personnel who have been assigned to provide hospice services. A safety assessment may consist of the same criteria required under ORS 654.414(2) and (3).
(f) Patient identification. A hospice program must provide personnel with information that may be used to verify the identity of a patient prior to an initial hospice visit.
(g) Safety checks. A hospice program must provide a mechanism by which personnel can perform safety checks, including but not limited to use of a mobile application to access relevant safety-related information identified under subsections (2)(a) and (b) of this rules, use of communication devices that allow the employee to transmit one-way or two-way messages, or regular check-ins.
(h) Policy development. A hospice program shall establish in writing and implement policy and procedures on personnel safety program requirements. The policy and procedures must be reviewed annually and include at a minimum:
(A) Allowing personnel to perform data entry and chart updates at a time and place outside the location where hospice services are provided;
(B) Allowing personnel to be accompanied by an escort, including but not limited to another employee, when there are concerns about the safety or security of the setting where hospice services are provided to the patient;
(C) Employee notification about the availability of personnel safety training provided in accordance with subsection (2)(d) of this rule; and
(D) Documenting in personnel records evidence of personnel safety training notification.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 443.860

STATUTES/OTHER IMPLEMENTED: ORS 443.860, ORS 443.190, ORS 443.195

ADOPT: 333-035-0167

RULE TITLE: Potential Threat or Disruptive Behavior Flagging Systems

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-035-0167: New rule requires a hospice program to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that hospice program personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.

(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior.

(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.

(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel.

(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence.

(2) Effective May 1, 2026, a hospice program shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags.

(3) Each hospice program must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging systems must address, at a minimum, the following:

(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags.

(b) Requirements for new and revised EHR flags and visual flags that include:

(A) The reasons for initiating or revising the flag; and

(B) Specific recommended actions that agency providers and personnel should take when interacting with a flagged individual.

(c) For EHR flags:

(A) Designating authorized staff to initiate an EHR flag.

(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.

(C) Provider and personnel responsibilities when an EHR flag is present.

(D) Evaluating and identifying potential threats of violence or disruptive behavior.

(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.

(F) Reviewing EHR flags every 12 months at a minimum and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.
(H) Safety protocols and precautions for engaging with patients with an EHR flag.
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the patient, such as a caregiver or support person, may request review and removal of an EHR flag.
(d) For visual flags, education and training for authorized staff on:
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;
(B) Consistent approaches to initiating a visual flag; and
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.
(4) Providers and personnel of a hospice program may not take any of the following actions based solely on the presence of an EHR flag:
(a) Deny hospice services to which the patient would otherwise be eligible.
(b) Make decisions regarding the patient's access to care.
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health and safety of an employee, patient, caregiver, support person, or the public.
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.
(g) Punish or penalize the patient.
(5) Written protocols and procedures must be established pursuant to section (3) of this rule and be reviewed annually.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 443.860

STATUTES/OTHER IMPLEMENTED: ORS 443.860, ORS 441.201

AMEND: 333-035-0220

RULE TITLE: Complaints

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-035-0220: This rule has been amended due to the passage of SB 965 (2023), clarifying the confidentiality provisions for persons making a complaint and the procedures for employees reporting possible violations of rules.

RULE TEXT:

(1) Any person may make a complaint verbally or in writing to the Oregon Health Authority (Authority) regarding an allegation as to the care or services provided by a hospice program or violations of any hospice program laws or regulations.

(2) The identity of a person making a complaint and any personally identifiable information, as that is defined in ORS 432.005 is confidential and not subject to disclosure under ORS 192.311 to 192.478.

(3) The Authority may investigate after receipt of a complaint in accordance with OAR 333-035-0230.

(4) An employee or contract provider with knowledge of a violation of ORS chapter 443 or these rules, shall use the reporting procedures established by the hospice program before notifying the Authority or other state agency of the inappropriate care or violation, unless the employee or contract provider:

(a) Believes a patient's health or safety is in immediate jeopardy; or

(b) Files a complaint in accordance with section (1) of this rule.

(5) If the complaint involves an allegation of criminal conduct or an allegation that is within the jurisdiction of another local, state, or federal agency, the Authority may refer the matter to that agency.

STATUTORY/OTHER AUTHORITY: ORS 443.860, ORS 443.013

STATUTES/OTHER IMPLEMENTED: ORS 443.860, ORS 443.013

AMEND: 333-035-0300

RULE TITLE: Waivers

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-035-0300: The rule is amended to require additional information when a hospice program is requesting a waiver from an administrative rule requirement. The request for a waiver must include information on the possible impacts to persons with different backgrounds and cultures, persons with limited English proficiency, households with lower incomes, and persons based on their gender identity and sexual orientation. The facility would also need to specify how the impact was determined and what would be proposed steps to mitigate the impact on disproportionately affected populations.

RULE TEXT:

(1) While all hospice programs are required to maintain continuous compliance with these rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. A request for a waiver from a rule must be submitted to the Oregon Health Authority (Authority) in writing and include the following information:

(a) Identification of the specific rule for which a waiver is requested;

(b) The special circumstances relied upon to justify the waiver;

(c) What alternatives were considered, if any, and why alternatives (including compliance) were not selected;

(d) Information demonstrating that the proposed waiver is desirable to maintain or improve the health and safety of the patients, to meet the individual and aggregate needs of patients, and will not jeopardize patient health and safety;

(e) For an initial waiver request or any request to renew a waiver, a description of the following:

(A) Possible impacts that the proposed waiver may have on persons from different backgrounds and cultures, including but not limited to individuals of color, individuals with disabilities, individuals with limited English proficiency, people or households with lower incomes, and individuals who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary, or another minority gender identity or another sexual orientation;

(B) How the impact was determined; and

(C) Proposed steps to mitigate the impact on disproportionately affected populations; and

(f) The proposed duration of the waiver.

(2) Upon finding that the hospice program has satisfied the conditions of this rule, the Authority may grant a waiver.

(3) A hospice program may not implement a waiver until it has received written approval from the Authority.

(4) During an emergency the Authority may waive a rule that a hospice program is unable to meet, for reasons beyond the hospice program's control. If the Authority waives a rule under this section, it shall issue an order, in writing, specifying which rules are waived, which hospice programs are subject to the order, and how long the order shall remain in effect.

STATUTORY/OTHER AUTHORITY: ORS 443.860

STATUTES/OTHER IMPLEMENTED: ORS 443.860

AMEND: 333-071-0260

RULE TITLE: Waivers

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-071-0260: The rule is amended to require additional information when a special inpatient care facility is requesting a waiver from an administrative rule requirement. The request for a waiver must include information on the possible impacts to persons with different backgrounds and cultures, persons with limited English proficiency, households with lower incomes, and persons based on their gender identity and sexual orientation. The facility would also need to specify how the impact was determined and what would be proposed steps to mitigate the impact on disproportionately affected populations.

RULE TEXT:

(1) While all special inpatient care facilities (SICFs) are required to maintain continuous compliance with the Oregon Health Authority's (Authority) rules, these requirements do not prohibit the use of alternative concepts, methods, procedures, techniques, equipment, facilities, personnel qualifications or the conducting of pilot projects or research. A request for a waiver from a rule must be submitted to the Authority in writing and include the following information:

(a) Identification of the specific rule for which a waiver is requested;

(b) The special circumstances relied upon to justify the waiver;

(c) What alternatives were considered, if any, and why alternatives (including compliance) were not selected;

(d) Information demonstrating that the proposed waiver is desirable to maintain or improve the health and safety of the patients, and will not jeopardize patient health and safety;

(e) For an initial waiver request or any request to renew a waiver, a description of the following:

(A) Possible impacts that the proposed waiver may have on persons from different backgrounds and cultures, including but not limited to individuals of color, individuals with disabilities, individuals with limited English proficiency, people or households with lower incomes, and individuals who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary, or another minority gender identity or another sexual orientation;

(B) How the impact was determined; and

(C) Proposed steps to mitigate the impact on disproportionately affected populations; and

(f) The proposed duration of the waiver.

(2) Upon finding that the SICF has satisfied the conditions of this rule, the Authority may grant a waiver.

(3) An SICF may not implement a waiver until it has received written approval from the Authority.

(4) During an emergency, the Authority may waive a rule that an SICF is unable to meet, for reasons beyond the SICF's control. If the Authority waives a rule under this section, it shall issue an order, in writing, specifying which rules are waived, which SICFs are subject to the order, and how long the order will remain in effect.

STATUTORY/OTHER AUTHORITY: ORS 441.025

STATUTES/OTHER IMPLEMENTED: ORS 441.025

AMEND: 333-071-0400

RULE TITLE: Organization Policies

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-071-0400: The rule makes clarifying changes to rule text. The rule further requires that a special inpatient care facility is required to develop and implement policies and procedures relating to potential threats of violence and disruptive behavior flagging systems that must be reviewed annually. The rule also requires freestanding hospice facilities to develop and implement a personnel safety program that meets specified requirements and that must be reviewed annually.

RULE TEXT:

(1) A special inpatient care facility's (SICF's) internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.

(2) An SICF shall adopt and maintain clearly written definitions of its organization, authority, responsibility, relationships and scope of services offered.

(3) An SICF shall adopt, maintain and follow written policies that include but are not limited to:

(a) Patient admission and transfer policies that address:

(A) Types of clinical conditions not acceptable for patient admission;

(B) Constraints imposed by limitations of services, staff coverage or physical facilities. No patient shall be admitted to a bed in any room, other than one regularly designated as a bedroom or ward;

(C) Emergency patient admissions;

(D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.640, 109.670, and 109.675;

(E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098; and

(F) A process for the internal transfer of patients from one level or type of care to another, if applicable;

(b) Patient discharge planning and termination of services in accordance with OAR 333-505-0055;

(c) Patient rights;

(d) Housekeeping;

(e) All patient care services provided by the facility;

(f) Preventive maintenance program for all aspects of the facility's physical plant, operations, and equipment used in patient care and patient environment;

(g) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403;

(h) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with ORS 413.273;

(i) Procedures for ensuring that an SICF provides health care interpreter services to a patient who prefers to communicate in a language other than English in accordance with ORS 413.559 and OAR 950-050-0160;

(j) In accordance with OAR 333-071-0425, protocols and procedures for implementing and using potential threats of violence and disruptive behavior flagging systems. These protocols and procedures must be reviewed on an annual basis; and

(k) For an SICF classified as a freestanding hospice facility, personnel safety program requirements in accordance with OAR 333-071-0423. These requirements must be reviewed on an annual basis.

(4) In addition to the policies described in section (3) of this rule, an SICF shall, in accordance with the Patient Self-Determination Act, 42 CFR 489.102, adopt policies and procedures that require (applicable to all capable individuals 18 years of age or older who are receiving health care in the facility):

(a) Providing to each adult patient, including emancipated minors, not later than five days after an individual is admitted

as an inpatient, but in any event before discharge, the following in written form, without recommendation:
(A) Information on the rights of the individual under Oregon law to make health care decisions, including the right to accept or refuse medical treatment and the right to execute directives and powers of attorney for health care;
(B) Information on the policies of the facility with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;
(C) A copy of the advance directive form set forth in ORS 127.529;
(D) The name of a person who can provide additional information concerning the forms for directives;
(b) Documenting in a prominent place in the individual's medical record whether the individual has executed a directive;
(c) Compliance with ORS chapter 127 relating to directives for health care; and
(d) Educating the staff and the community on issues relating to directives.
(5) An SICF's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.
(6) Patient care policies shall be evaluated triennially and rewritten as needed, and presented to the governing body or a designated administrative body for approval triennially. Documentation of the evaluation is required.
(7) An SICF shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.

STATUTORY/OTHER AUTHORITY: ORS 441.025

STATUTES/OTHER IMPLEMENTED: ORS 147.401, ORS 413.273, ORS 441.025, ORS 413.559, ORS 413.561, ORS 441.051, ORS 441.054, ORS 441.201, ORS 443.190, ORS 443.195

AMEND: 333-071-0420

RULE TITLE: Personnel

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-071-0420: Vague terms have been removed and clarified by stating that a special inpatient care facility must maintain a workforce that meets service demands. Additionally, language has been added stating that a freestanding hospice facility must notify all personnel of the availability of personnel safety training that must be documented in personnel records.

RULE TEXT:

(1) A special inpatient care facility (SICF) shall:

(a) Maintain a workforce of qualified and trained personnel capable of meeting the service demands of the SICF, and equipment to provide effective patient care and all other related services;

(b) Have written personnel policies and procedures that are available to personnel;

(c) Provide orientation for new employees;

(d) Have an annual continuing education plan;

(e) Have a job description for each position which delineates the qualifications, duties, authority and responsibilities inherent in each position;

(f) Provide an annual work performance evaluation for each employee with appropriate records maintained; and

(g) Have an employee health screening program for the purpose of protecting patients and employees from communicable diseases, including but not limited to requiring tuberculosis testing for employees in accordance with OAR 333-071-0450.

(2) In addition to the requirements specified in section (1) of this rule, an SICF classified as a rehabilitation hospital shall:

(a) Have a medical director with training or experience in rehabilitation who provides services in the facility for a minimum of 20 hours per week;

(b) Maintain a workforce of qualified physical therapists, occupational therapists, speech-language pathologists or audiologists based on the rehabilitative services offered capable of meeting service demands;

(c) Maintain a workforce of qualified personnel available when needed to evaluate each patient, initiate a plan of treatment and supervise supportive personnel when furnishing rehabilitation services. The number of qualified personnel is based on the type of patients treated and the frequency, duration and complexity of the treatment ordered; and

(d) An individual that directs the rehabilitation services offered that has the necessary knowledge, experience and capabilities to properly supervise and administer the services.

(3) In addition to the requirements specified in section (1) of this rule, an SICF classified as a freestanding hospice facility shall notify all personnel about the availability of personnel safety training provided in accordance with OAR 333-071-0423 and document notification in personnel records.

(4) An SICF shall restrict the work of employees with restrictable diseases in accordance with OAR 333-019-0010.

(5) The actions taken by an SICF under this rule shall be fully documented for each employee.

STATUTORY/OTHER AUTHORITY: ORS 441.025, ORS 431.110, ORS 433.004, ORS 433.332

STATUTES/OTHER IMPLEMENTED: ORS 441.025, ORS 433.004, ORS 433.329, ORS 443.195

ADOPT: 333-071-0423

RULE TITLE: Personnel Safety Program Requirements

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-071-0423: New rule is adopted requiring a freestanding hospice facility to establish, implement, and maintain a workforce violence prevention program. Minimum requirements are specified including information that must be collected, the development and implementation of plan to obtain necessary patient history from a hospital when the patient is referred to receive home health services, keeping personnel apprised of information collected, the provision of annual training on personnel safety, conducting quarterly safety assessments, providing information to verify the identity of a patient, providing a way by which personnel can perform safety checks, and establishing and implementing policies and procedures. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Hazards" means potentially unsafe or dangerous conditions in or around the home health care setting, including but not limited to the presence of uncontrolled animals, persistent or periodic presence of individuals with history of aggressive behavior or substance use disorder, elevated rate of criminal activity, poor or unreliable cell phone coverage, and lack of timely law enforcement or emergency response capability.

(b) "Home health care setting" means a place of temporary or permanent residence of an individual where hospice services are furnished to the individual.

(c) "Safety check" means the process by which personnel can access, review, and apply safety-related information collected by the agency in accordance with this rule, and includes a mechanism for personnel to directly contact the agency to report safety concerns.

(2) Effective May 1, 2026, a special inpatient care facility (SICF) classified as a freestanding hospice facility shall establish, implement, and maintain a workforce violence prevention program that includes, but is not limited to, the following requirements:

(a) Intake risk assessment. The freestanding hospice facility must collect information necessary to identify and assess health and safety-related risks and hazards in a home health care setting, including but not limited to:

(A) Any act or threat of physical violence, harassment, intimidation, assault, homicide or any other threatening behavior where hospice services are provided to a patient;

(B) Presence of pet(s) and if any, whether the pet(s) can be secured away from the area where care is provided, if requested by personnel;

(C) Possible pest infestations, for example, rodents or insects; and

(D) Whether the patient is willing to securely store any weapons that are present in the home health care setting before any visit from hospice personnel.

(b) Hospital discharge coordination. When a patient is discharged from a hospital and referred to a freestanding hospice facility, the facility must develop and implement a plan to obtain any known patient history of violence within the last 12 months from the hospital as part of continuity of care.

(c) Personnel notification. The freestanding hospice facility must have a protocol, and implement the protocol, to share all information collected under subsections (2)(a) and (b) of this rule with personnel assigned to provide hospice services to the patient.

(d) Training. The freestanding hospice facility shall provide annual training on personnel safety. The training must be consistent with training for home health care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration and must include the following:

(A) Recognizing hazards that are commonly found by personnel where hospice services are provided to a patient; and

(B) How to manage hazards that are identified.

(C) This training may be incorporated as part of the mandated requirements under ORS 654.414(4).

(e) Quarterly safety assessments. A freestanding hospice facility must conduct quarterly safety assessments with personnel who have been assigned to provide hospice services. A safety assessment may consist of the same criteria required under ORS 654.414(2) and (3).
(f) Patient identification. A freestanding hospice facility must provide personnel with information that may be used to verify the identity of a patient prior to an initial hospice visit.
(g) Safety checks. A freestanding hospice facility must provide a mechanism by which personnel can perform safety checks, including but not limited to use of a mobile application to access relevant safety-related information identified under subsections (2)(a) and (b) of this rule, use of communication devices that allow personnel to transmit one-way or two-way messages, or regular check-ins.
(h) Policy development. A freestanding hospice facility shall establish in writing and implement policy and procedures that allow personnel to:
(A) Perform data entry and chart updates at a time and place outside the location where hospice services are provided; and
(B) Be accompanied by an escort, including but not limited to another employee, when there are concerns about the safety or security of the setting where hospice services are provided to the patient.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 441.025, ORS 443.860

STATUTES/OTHER IMPLEMENTED: ORS 441.025, ORS 443.860, ORS 442.015, ORS 443.190, ORS 443.195

ADOPT: 333-071-0425

RULE TITLE: Potential Threat or Disruptive Behavior Flagging Systems

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-071-0425: New rule requires a special inpatient care facility to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.

(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior.

(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.

(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel.

(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence.

(2) Effective May 1, 2026, a special inpatient care facility (SICF) shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags.

(3) An SICF must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging system must address, at a minimum, the following:

(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags.

(b) Requirements for new and revised EHR flags and visual flags that include:

(A) The reasons for initiating or revising the flag; and

(B) Specific recommended actions that agency providers and personnel should take when interacting with a flagged individual.

(c) For EHR flags:

(A) Designating authorized staff to initiate an EHR flag.

(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.

(C) Provider and personnel responsibilities when an EHR flag is present.

(D) Evaluating and identifying potential threats of violence or disruptive behavior.

(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.

(F) Reviewing EHR flags every 12 months at a minimum and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.
(H) Safety protocols and precautions for engaging with patients with an EHR flag.
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the patient, such as a caregiver or support person, may request review and removal of an EHR flag.
(d) For visual flags, education and training for authorized staff on:
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;
(B) Consistent approaches to initiating a visual flag; and
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.
(4) Providers and personnel of an SICF may not take any of the following actions based solely on the presence of an EHR flag:
(a) Deny services to which the patient would otherwise be eligible.
(b) Make decisions regarding the patient's access to care.
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health or safety of an employee, patient, caregiver, support person, or the public.
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.
(g) Punish or penalize the patient.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 441.025

STATUTES/OTHER IMPLEMENTED: ORS 441.025, ORS 441.020, ORS 441.201

AMEND: 333-500-0025

RULE TITLE: Endorsement of Satellite Operations

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-500-0025: Specifies that a satellite of a hospital must comply with the potential threat or disruptive behavior flagging systems.

RULE TEXT:
(1) The Oregon Health Authority (Authority) may endorse, under a hospital's license, a satellite or mobile satellite of a hospital.
(2) In order for a satellite to be endorsed under a hospital's license, the applicant or licensee shall pay the appropriate fee and provide evidence to the Authority that:
(a) The satellite meets the requirements in OAR chapter 333, divisions 500 through 535;
(b) The services at the satellite are integrated with the hospital;
(c) The financial operations of the satellite are integrated with the hospital;
(d) The hospital and the satellite have the same governing body;
(e) The satellite is under the ownership and control of the hospital;
(f) Staff at the satellite have privileges at the hospital;
(g) Medical records of the satellite are integrated with the hospital into a unified system;
(h) The satellite is in compliance with OAR 333-505-0045 relating to potential threat or disruptive behavior flagging systems;
(i) The facility is not subject to certificate of need requirements in ORS 442.315 to 442.347; and
(j) If the satellite is intended to provide emergency medical services, the satellite can comply with OAR 333-500-0027.
(3) A hospital applying for an emergency medical services satellite endorsement must also submit for its emergency department, the information described in OAR 333-500-0027(1)(e), for the previous six months.
(4) A satellite shall be subject to a plans review and must pass life safety code requirements.
(5) In order for a mobile satellite to be endorsed under a hospital's license, the applicant or licensee shall pay the appropriate fee and provide evidence to the Authority that:
(a) The mobile satellite is operated in whole or in part by the hospital through lease, ownership or other arrangement;
(b) The services at the mobile satellite are integrated with the hospital;
(c) The financial operations of the mobile satellite are integrated with the hospital;
(d) The mobile satellite is physically separate from the hospital and other buildings on the hospital campus by at least 20 feet; and
(e) It meets the 2000 NFPA 101 Life Safety Code for mobile units.
(6) A mobile satellite shall keep and provide to the Authority and the Fire Marshal upon request, a log that shows where the mobile satellite is located every day of the year, and its use. A copy of the log shall be kept in the mobile satellite at all times.
(7) A hospital that has a satellite that provides inpatient services that is endorsed under its license as of October 1, 2009, may continue to have that satellite endorsed under its license. On or after October 1, 2009, a satellite must meet the definition of satellite in OAR 333-500-0010 and comply with all other rules related to satellites in order to have a satellite endorsed under a hospital license.
(8) Nothing in these rules is meant to:
(a) Prevent a satellite as defined in OAR 333-500-0010 from providing outpatient medical services; or
(b) Permit the endorsement of satellite under a hospital license as a means to circumvent the certificate of need laws in ORS chapter 442 and OAR chapter 333, divisions 545 through 670.
(9) The Authority may revoke the endorsement of a satellite at any time if it determines a hospital or its satellite:
(a) Is not complying with this rule or OAR 333-500-0027, as applicable; or
(b) Is unable to ensure the safety of patients at the satellite.

STATUTORY/OTHER AUTHORITY: ORS 441.025, ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 441.020, ORS 441.201

AMEND: 333-505-0030

RULE TITLE: Organization, Hospital Policies

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-505-0030: Text has been added requiring a hospital to develop necessary policies and procedures that includes a plan to share with home health agencies or hospice programs any known patient history of violence within the last 12 months, when a patient has been referred to receive home health or hospice services. Specifies that the hospital must also adopt and maintain protocols and procedures for implementing and using a potential threat or disruptive behavior flagging system that must be reviewed on an annual basis. Minor change was also made to align the meaning of the term POLST with OAR chapter 333, division 270.

RULE TEXT:

(1) A hospital's internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.

(2) A hospital shall adopt and maintain clearly written definitions of its organization, authority, responsibility and relationships.

(3) A hospital shall adopt, maintain and follow written patient care policies that include but are not limited to:

(a) Admission and transfer policies that address:

(A) Types of clinical conditions not acceptable for admission;

(B) Constraints imposed by limitations of services, physical facilities or staff coverage;

(C) Emergency admissions;

(D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.640, 109.670, and 109.675;

(E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098;

(F) A process for the internal transfer of patients from one level or type of care to another; and

(G) A plan to share with home health or hospice agencies any known patient history of violence within the last 12 months, when a patient is referred to receive home health or hospice services;

(b) Discharge, termination of services, and release from emergency department policies in accordance with OAR 333-505-0055 and OAR 333-520-0070;

(c) Patient rights, including but not limited to compliance with OAR 333-505-0033;

(d) Housekeeping;

(e) Mandatory use of identification badges for health care practitioners providing direct patient care which must include the practitioner’s name and professional title in accordance with ORS 441.096. The policy must also identify the size of badges to be used;

(f) All patient care services provided by the hospital;

(g) Maintenance of the hospital's physical plant, equipment used in patient care and patient environment;

(h) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403; and

(i) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with ORS 413.273.

(4) In addition to the policies described in section (3) of this rule, a hospital shall:

(a) In accordance with 42 CFR 489.102, ORS 127.649, and ORS 127.652, adopt and maintain written policies and procedures concerning a patient's right to accept or refuse medical or surgical treatment and the right to formulate an advance directive or appoint a health care representative; and

(b) In accordance with OAR 333-505-0045, adopt and maintain protocols and procedures for implementing and using potential threat or disruptive flagging systems. These protocols and procedures must be reviewed on an annual basis.

(5) A hospital may not condition the provision of treatment on a patient having a physician order or portable order for life-sustaining treatment (POLST) as that term is defined in OAR chapter 333, division 270 and ORS 127.663, an advance directive as defined in ORS 127.505, a form appointing a health care representative under ORS 127.510, or any instruction relating to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.
(6) A hospital's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.
(7) Patient care policies shall be evaluated triennially and rewritten as needed and presented to the governing body or a designated administrative body for approval triennially. Documentation of the evaluation is required.
(8) A hospital shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.

STATUTORY/OTHER AUTHORITY: ORS 441.025, ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.273, ORS 441.025, ORS 441.051, ORS 441.054, ORS 441.048, ORS 441.096, ORS 441.201

AMEND: 333-505-0036

RULE TITLE: Hospital Requirements During Emergency Impacting Standard of Care

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-505-0036: Makes minor changes to text to align with language used in the Oregon Crisis Care Guidance and makes a minor change to text to align the meaning of the term POLST with OAR chapter 333, division 270.

RULE TEXT:

(1) This rule does not circumvent or supersede Centers for Medicare and Medicaid Services (CMS) requirements to meet the needs of the facility and care of patients.

(2) For purposes of this rule:

(a) "Crisis standards of care" means policies or standards adopted by a hospital to be implemented during an emergency to make triage decisions, such as but not limited to Oregon Health Authority (Authority) adopted crisis standards of care and related tools.

(b) "Emergency" includes but is not limited to a federal emergency declaration, Governor's declared emergency, a determination by the state Public Health Director under ORS 431A.015(1), an epidemic as that is defined in ORS 431A.005, or any other unforeseen event that results in an increased need for scarce hospital resources or a significant reduction of health care staff.

(c) "Hospital" has the meaning given that term in ORS 442.015, but does not include a Special Inpatient Care Facility as that term is defined under OAR 333-071-0205.

(d) "Support person" has the meaning given that term in OAR 333-505-0033.

(e) "Triage decisions" means the decisions necessary to provide equitable prioritization of critical care resources for patients during an emergency.

(3) When a hospital is making triage decisions because of an emergency the hospital must:

(a) Within 24 hours provide notice to the Authority at mailbox.hclc@odhsoha.oregon.gov, or in another manner as directed by the Authority.

(b) Within 24 hours inform the public by at a minimum posting information on its website and at the hospital in multiple conspicuous locations that the hospital is making triage decisions because of an emergency. The information must be posted in the five most common spoken languages in the county where the hospital is located. This information is accessible on the Secretary of State's website: https://www.oregon.gov/languages/Pages/common-language-county.aspx.

(c) Post the crisis standard of care the hospital is using to make triage decisions on its website in the five most common spoken languages in the county where the hospital is located.

(d) For each patient that is subject to a triage decision, communicate the outcome of the triage decision to the patient, their support person, or the individual legally authorized to act on behalf of the patient, in an accessible format, language they understand and in a culturally responsive manner to the extent possible, including how the triage decision was made, and immediately provide a copy of the crisis standard of care used to make the triage decision.

(e) Document for each patient that is subject to a triage decision:

(A) The patient’s medical record number.

(B) The hospital’s name and location.

(C) The patient’s date of birth.

(D) The patient’s race, ethnicity, preferred spoken or signed language and preferred written language, disability, sexual orientation and gender identity in accordance with OAR chapter 950, division 30.

(E) Whether, at the time of presentation at the hospital, the patient was using a personal ventilator or other personal medical treatment equipment or resources.

(F) The patient’s home address, whether they are unhoused, or whether their housing status is unknown.

(G) The patient's care preferences, as documented in an advanced directive, physician order or portable order for life-sustaining treatment (POLST), or as communicated by a health care representative, support person, or a family member.
(H) The patient's triage prioritization and clinical outcome.
(4) A hospital must provide the documentation required in section (3) of this rule to the Authority upon request.

Note: The Oregon Health Authority's Interim Crises Care Tool can be found at www.healthoregon.org/hflc.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 441.025

STATUTES/OTHER IMPLEMENTED: ORS 441.025

ADOPT: 333-505-0045

RULE TITLE: Potential Threat or Disruptive Behavior Flagging Systems

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Adopt 333-505-0045: New rule requires a hospital to develop and implement protocols and procedures for implementing and using a flagging system to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals. Clarifies that the flagging system includes both electronic health record (EHR) flags and visual flags. Requires that visual flags, when used, be clear, respectful, and non-stigmatizing to promote safety and provide neutral alerts. Specifies minimum criteria for EHR flags and visual flags. Requires that EHR flags be reviewed annually and updated as determined necessary. Prescribes that hospital personnel may not take certain actions based solely on the fact that a person has been flagged. Defines terms. Makes provisions of the rule effective May 1, 2026.

RULE TEXT:

(1) As used in this rule:

(a) "Authorized staff" means the personnel who are responsible for creating and tracking electronic health record flags.

(b) "Disruptive behavior" includes physically aggressive, harassing, or destructive behavior.

(c) "Electronic health record (EHR) flag" means an alert generated within the electronic health record of a patient that notifies providers that a patient may pose a potential safety risk to themselves or to others due to the patient's history of violent or disruptive behavior.

(d) "Flagging system" means a system used to identify, communicate, monitor and manage potential threats of violence or disruptive behavior by patients or other individuals, including caregivers or support persons, who may encounter health care providers and personnel.

(e) "Visual flags" means paper-based physical cues, including wristbands, signage, color-coded indicators, symbols and other visible cues built within the care environment to facilitate immediate recognition of potential threats of violence or disruptive behavior without having to access an electronic health record. Visual flags, when used, must communicate essential information in a clear, respectful, and non-stigmatizing manner to promote safety and provide neutral alerts or reminders that guide appropriate action without assigning negative labels or implying violence.

(2) Effective May 1, 2026, a hospital shall implement flagging systems with the capabilities and functions to communicate potential threats of violence or disruptive behavior to providers and personnel using EHR flags and visual flags.

(3) Each hospital must establish and implement written protocols and procedures for implementing and using flagging systems. The flagging system must address, at a minimum, the following:

(a) Criteria and process for initiating flags, continuing flags, inactivating flags, and reactivating EHR flags and visual flags.

(b) Requirements for new and revised EHR flags and visual flags that include:

(A) The reasons for initiating or revising the flag; and

(B) Specific recommended actions that hospital providers and personnel should take when interacting with a flagged individual.

(c) For EHR flags:

(A) Designating authorized staff to initiate an EHR flag.

(B) Training and education requirements for personnel authorized to initiate an EHR flag, including training on identifying and preventing bias in the assignment of such flags, and instruction on reducing unconscious bias to ensure that EHR flags are not unfairly or disproportionately applied to individuals belonging to groups subjected to historical and contemporary discrimination.

(C) Provider and personnel responsibilities when an EHR flag is present.

(D) Evaluating and identifying potential threats of violence or disruptive behavior.

(E) Consistent practices for assigning, tracking, monitoring, and documenting information in the EHR flag.

(F) Reviewing EHR flags every 12 months at a minimum and updating EHR flags, as necessary, for purposes of determining whether to remove or maintain a flag.
(G) Communication and collaboration about flagged conduct or behaviors recorded in an EHR.
(H) Safety protocols and precautions for engaging with patients with an EHR flag.
(I) Patient privacy in relation to personnel safety, including compliance with state and federal privacy laws when communicating information through the electronic health record regarding an EHR flag.
(J) Requiring that every flag-related action, including but not limited to initiation or reactivation, be supported by documentation for the action.
(K) Establishing a process by which a patient, or a person authorized to make health care decisions on behalf of the patient, such as a caregiver or support person, may request review and removal of an EHR flag.
(d) For visual flags, education and training for authorized staff on:
(A) Identifying circumstances and assessing behaviors and actions of patients and other individuals that may increase risk for potential violence or disruptive behavior;
(B) Consistent approaches to initiating a visual flag; and
(C) Safety protocols and precautions to take when encountering patients or other individuals when a visual flag is present.
(4) Providers and personnel of a hospital may not take any of the following actions based solely on the presence of an EHR flag:
(a) Deny services to which the patient would otherwise be eligible.
(b) Make decisions regarding the patient's access to care.
(c) Prevent or restrict the right of the patient to file a complaint with the appropriate federal or state agency concerning the patient's right to privacy.
(d) Deny or restrict the patient's right to access or obtain the patient's protected health information.
(e) Contact, report or disclose information to law enforcement, unless it is necessary to prevent or lessen serious or imminent threat to the health or safety of an employee, patient, caregiver, support person, or the public.
(f) Deny, restrict or withhold medical or nonmedical care that is appropriate for the patient.
(g) Punish or penalize the patient.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 441.025

STATUTES/OTHER IMPLEMENTED: ORS 441.025, ORS 441.020, ORS 441.201

AMEND: 333-535-0015

RULE TITLE: Physical Environment

NOTICE FILED DATE: 11/24/2025

RULE SUMMARY: Amend 333-535-0015: Adds a requirement that hospitals undergoing new construction or when a hospital is altering or renovating the emergency department, it must install a bullet-resistant intake area where patients are registered. Minimum construction elements are specified.

RULE TEXT:

(1) Any person proposing to construct a new hospital, or proposing to make certain alterations or additions to an existing hospital, must, before commencing new construction, alterations, or additions, comply with OAR chapter 333, division 675 and these rules.

(2) Only the portion of an existing hospital that is being altered or renovated and any impacted ancillary areas required to ensure full functionality of the hospital must meet the requirements in sections (3) through (7) of this rule.

(3) An applicant or a licensed hospital must comply with the 2018, Facility Guidelines Institute (FGI), Guidelines for Design and Construction of Hospitals, and the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities, adopted by reference, including all references to part, subpart, sections, subsections, paragraphs, subparagraphs and appendices except as specified in sections (4) through (7) of this rule. References in FGI to "and/or" mean "or."

(4) The following chapters, sections, paragraphs, subparagraphs or appendices of the 2018, FGI, Guidelines for Design and Construction of Hospitals are deleted in their entirety:

(a) Subsection A.1.2-2.1.2.1;

(b) Subsection 1.2-2.1.2.3;

(c) Section 1.2-8;

(d) Section 1.2-9;

(e) Paragraph (2)(b) in subsection 2.1-2.8.2.1;

(f) Subsection 2.1-2.8.10.2;

(g) Subparagraphs (2)(b)(vi) and (3)(b)(v) in subsection 2.1-5.1.2.2;

(h) Paragraph (b) in subsection A2.1-7.2.4;

(i) Paragraph (2) in subsection A2.1-8.3.3.1;

(j) Subsections 2.2-3.1.2 through 2.2-3.1.2.8;

(k) Subsection 2.2-3.1.8.17;

(l) Paragraph (4) in subsection A2.2-3.3.1.1;

(m) Paragraphs (1) and (2) in subsection 2.2-3.10.8.14;

(n) Chapter 2.3;

(o) Chapter 2.4; and

(p) Subsection 2.7-3.1.2.

(5) The following amendments or additions are made to the 2018, FGI, Guidelines for Design and Construction of Hospitals, as adopted and incorporated by reference. All references to part, subpart, sections, paragraphs, subparagraphs and appendices relate to the 2018, FGI, Guidelines for Design and Construction of Hospitals.

(a) Amend section 1.1-2 to read: "New Construction. Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with any of the following scopes of work shall be considered new construction and shall comply with the requirements in the Guidelines for Design and Construction of Hospitals:"

(b) Amend subsection 1.1-3.1.1.2 to read: "Major renovation projects. Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with either of the following scopes of work shall be considered a major renovation and shall comply with the requirements for new construction in the Guidelines for Design and Construction of Hospitals to the extent possible as determined by the authority having jurisdiction: (1) A series of planned changes and updates to the physical plant of an existing facility. (2) A renovation project that includes modification of an entire building or an

entire area in a building to accommodate a new use or occupancy."
(c) Amend subsection 1.1-3.1.2.1 to read: "Where major structural elements make total compliance impractical or impossible, exceptions shall be considered in accordance with the Oregon Administrative Rules specific to the physical environment of the type of hospital under consideration."
(d) Amend subsection 1.1-3.1.2.2 to read: "Minor renovation or replacement work shall be permitted to be exempted from the requirements in Section 1.1-3.1.1 (Compliance Requirements) provided they meet the criteria specified in OAR chapter 333, division 675 and do not reduce the level of health and safety in an existing facility."
(e) Amend subsection 1.1-3.1.4 to read: "Temporary Waivers. When parts of an existing facility essential to continued overall facility operation cannot comply with particular standards during a renovation project, a temporary waiver of those standards shall be permitted as determined by the authority having jurisdiction if patient care and safety will not be jeopardized as a result. Reference Oregon Administrative Rules specific to the physical environment of the type of hospital under consideration."
(f) Amend section 1.1-8 to include the following codes and standards:
(A) "ASHRAE 62.1: The Standards for Ventilation and Indoor Air Quality (2016)."
(B) "Building Industry Consulting Services International (BICSI) Standards (2018)."
(C) "NFPA 50: Standard for Bulk Oxygen Systems at Consumer Sites (2001)."
(D) "NFPA 99: Health Care Facilities Code (2012 as adopted by CMS)."
(E) "NFPA 101: Life Safety Code (2012 as adopted by CMS)."
(g) Amend paragraph (a) in subsection A1.2-2.1.1 to read: "(a) All projects, large and small, require a functional program to guide the design. The length and complexity of the functional program will vary greatly depending on project scope."
(h) Amend subsection 1.2-2.1.2.1 to read: "The governing body shall be responsible for having a functional program developed, documented, and updated. The governing body may delegate documentation of the functional program to consultants with subject matter expertise. The governing body shall review and approve the functional program."
(i) Add subsection 1.2-2.2.7.4 to read: "A description of the following: (a) Special design feature(s); (b) Occupant load, numbers of staff, patients, visitors and vendors; (c) Issue of privacy/confidentiality for patient; (d) In treatment areas, describe: (A) Types of procedures; (B) Design considerations for equipment; (C) Requirements where the circulation patterns are a function of asepsis control; and (D) Highest level of sedation, if applicable."
(j) Amend subsection 1.2-4.1.1.2 to read: "To support this goal, an interdisciplinary team shall develop a safety risk assessment (SRA). A copy of the SRA shall accompany instruction documents submitted to the Oregon Health Authority, Facility Planning and Safety program."
(k) Add paragraphs (1) through (4) and amend subsection 1.2-4.6.1 to read: "Behavioral and Mental Health Elements of the Safety Risk Assessment. The SRA report shall identify areas where patients at risk of mental health injury and suicide will be served. Elements of the assessment shall include but not be limited to: (1) A statement explaining the psychiatric population groups served; (2) A discussion of the capability for staff visual supervision of patient ancillary areas and corridors; (3) A discussion of the risks to patients, including self-injury, and the project solutions employed to minimize such risks; and (4) A discussion of building features and equipment, including items which may be used as weapons, that is intended to minimize risks to patients, staff and visitors."
(l) Amend paragraph (d) in subsection A1.2-5.4.5 to read: "(d) In facilities with multi-bed rooms, family consultation rooms or grieving rooms, in addition to family lounges, should be provided to permit patients and families to communicate privately."
(m) Amend 1.2-6.1.1 to read: "General. The planning and design of new hospitals and the retrofitting of existing hospitals shall conform to the Guidelines and all applicable codes and regulations with respect to exterior environmental sound and interior sound within all occupied building spaces. Documentation by a Licensed Acoustic Engineer of compliance with acoustic criteria, shall be accepted as equivalency to the requirements of Table 1.2-4 Noise Reduction Coefficient (NRC) and Table 1.2-6 Sound Transmission Class (STC.)"
(n) Amend paragraph (1) in subsection 2.1-2.3.1.1 to read: "(1) All patient care areas designated for care of patients of size shall meet the requirements in this section. The Oregon Health Authority will complete a review when specifically

cross-referenced from a FGI facility type requirement section or when identified in the project submission documents."
(o) Amend subsection 2.1-2.4.1 to read: "The special patient care room requirements in this section shall apply to all facilities that provide these rooms. See facility chapters for other specific requirements. Requirements for other types of special patient care rooms are located in the facility chapters. Where monolithic ceilings are provided in airborne infection isolation (AII) rooms or seclusion rooms, the NRC standards listed in Table 1.2-4 are not required."
(p) Amend paragraph (2)(a) in subsection 2.1-2.8.2.1 to read: "(a) At least one hand-washing station shall be provided within 20 feet and not through a door. See section 2.1-7.2.2.8 (Hand-washing stations) for requirement."
(q) Amend paragraph (1) in subsection 2.1-2.8.7.3 to read: "(1) At least one hand-washing station shall be provided for every four patient care stations or fewer."
(r) Amend subparagraph (2)(d) in subsection 2.1-2.8.8.1 to read: "(d) Lighting. Task-specific lighting levels, measured at the worksurface only, for health care settings recommended in the U.S. Pharmacopeia-National Formulary shall be used to design lighting."
(s) In subsection 2.1-2.8.8.2:
(A) Amend the title to read: "Work areas for preparing and dispensing medication. Facilities shall be reviewed below for each area as applicable as either subparagraph (1) or as subparagraph (2) if only dispensing."
(B) Amend paragraph (1) to read: "(1) Medication preparation room or area"
(C) Amend subparagraph (1)(a) to read: "(a) This room or area shall be under direct or indirect (example, camera) visual control of the nursing staff."
(D) Amend subparagraph (1)(b) to read: "(b) This room or area shall contain the following:"
(E) Amend subparagraph (1)(b)(ii) to read: "(ii) Hand-washing station unless located within an operating room, c-section room, Class 3 imaging, or sterile core of surgical department. Where hand-washing station is omitted in the sterile core, a hand sanitation dispenser shall be provided."
(F) Amend subparagraph (1)(b)(iii) to read: "(iii) Lockable refrigerator where refrigerated medications are used."
(G) Amend subparagraph (1)(c) to read: "(c) Where a medication preparation room or area is used to store one or more self-contained medication-dispensing units, the room shall be designed with space to prepare medication when the self-contained medication dispensing unit(s) are present."
(H) Amend subparagraph (2)(c) to read: "(c) A hand-washing station shall be located next to stationary medication-dispensing units or stations unless the medication-dispensing unit, station, or cart is located within an operating room, c-section room, Class 3 imaging, or sterile core of surgical department. Where hand-washing station is omitted in the sterile core, a hand sanitation dispenser shall be provided."
(t) Amend subsection 2.1-2.8.10.1 to read: "Ice-making equipment shall be of the self-dispensing type."
(u) Amend paragraph (1) in subsection 2.1-2.8.12.3 to read: "(1) Hand-washing station."
(v) Amend subsection 2.1-2.8.14.2 to read: "Environmental services room shall be a minimum of 35 square feet. Each environmental services room shall be provided with the following: (1) Service sink or floor-mounted mop sink; (2) Provisions for storage of supplies and housekeeping equipment; (3) Hand-washing station or hand sanitation dispenser."
(w) Amend subparagraph (1)(a) in subsection 2.1-4.1.2.6 to read: "(a) Terminal sterilization is not required for waste that is incinerated on-site or when services for regulated medical/bio-hazard waste disposal services will be contracted through a vendor."
(x) Add paragraph (3) to subsection 2.1-4.2.3.1 to read: "(3) Pharmacy clean/sterile compounding rooms accessed from an ante room need not comply with Table 1.2-4: Minimum Design Room-Average Sound Absorption Coefficients."
(y) Amend subsection 2.1-4.2.8.7 to read: "A hand-washing station(s) shall be provided within each separate room where open medication is prepared for administration except where prohibited by OAR chapter 855, division 045; USP 797 or USP 800. Where a hand-wash station is prohibited in the compounding room, a hand-wash station(s) shall be provided in an anteroom."
(z) Add paragraph (5) to subsection 2.1-4.3.1.3 to read: "(5) All offered dietary services shall comply with Oregon Health Authority Food Sanitation Rules, chapter 333, division 150 and other authorities having jurisdiction."

(aa) Add subparagraphs (2)(a) through (c) in subsection 2.1-5.2.2.2 to read: "(a) Washers/extractors. Washers/extractors shall be located between the soiled linen receiving and clean process areas. Washers/extractors shall provide a temperature of at least 160 degrees Fahrenheit for a minimum of 25 minutes or include use of a chemical disinfectant; (b) Dryers; (c) Supply storage. Storage shall be provided for laundry supplies."
(bb) In subsection 2.1-5.4.1.3:
(A) Add subparagraphs (1)(a)(i) and (ii) to read: "(i) Wall base shall be integral and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects. (ii) Shall have hand sanitation dispenser in or adjacent to interior regulated waste storage spaces."
(B) Amend subparagraph (2)(a) to read: "(a) Illumination per Illuminating Engineering Society of North America (IES) standards."
(C) Add paragraph (4) to read: "(4) Regulated waste management shall be in accordance with the requirements of OAR chapter 333, division 056."
(cc) Amend subsection 2.1-6.2.7.1 to read: "Storage. A designated area located out of the required corridor width and directly accessible to the entrance shall be provided for storage of at least one wheelchair."
(dd) Amend subparagraph (3)(b) in subsection 2.1-7.2.2.8 to read: "(b) For newly constructed or newly installed countertops that require a substrate, marine-grade plywood (or equivalent material) with an impervious seal shall be required. Existing countertops shall be fully sealed/caulked and in good repair."
(ee) Add paragraph (4) to subsection 2.1-7.2.2.11 to read: "(4) All imaging facilities and radiation producing equipment installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."
(ff) Add subsection 2.1-7.2.2.15 to read: "Work Surfaces: Work Areas. Where a work space, work area, work counter, or work surface is provided, it shall have a minimum of 4 square feet (.37 square meter) of contiguous clear surface for each person programmed to work in the space at the same time. A mobile cart meeting these requirements shall be permitted."
(gg) Add subparagraphs (xi) through (xvi) to subparagraph (7)(a) in subsection 2.1-7.2.3.1 to read: "(xi) Bathing and toilet rooms. (xii) Soiled workrooms and soiled hold rooms. (xiii) Environmental services rooms. (xiv) Pharmacy clean and anterooms. (xv) Emergency department trauma rooms. (xvi) Emergency department exam/treatment rooms."
(hh) Amend paragraph (2) in subsection 2.1-8.3.3.1 to read: "Stored fuel is required and storage capacity shall permit continuous operation for at least 96 hours. An Extended Stay Center shall provide fuel for emergency power to meet longest expected patient stay."
(ii) Amend subsection 2.1-8.3.5.2 to read: "Electronic health record system servers and centralized storage. This equipment shall be provided with an uninterruptible power supply and connected to the essential electrical system."
(jj) Amend paragraph (2) in subsection 2.1-8.4.2.5 to read: "(2) Heated potable water distribution system serving patient care areas shall be under constant recirculation to provide continuous hot water at each hot water outlet and shall meet the standards specified in Table A2.1-a."
(kk) In subsection 2.1-8.4.2.6:
(A) Amend subparagraph (1)(a) to read: "(a) Where sanitary or storm drainage piping is installed above the ceiling of, or exposed in, operating and delivery rooms, procedure rooms, trauma rooms, nurseries, central kitchens, sterile processing facilities, Class 2 and 3 imaging rooms, electronic mainframe rooms (TSERs and TECs), main switchgear and electrical rooms, electronic data processing areas, or electric closets, the piping shall have special provisions (e.g., double wall containment piping or oversized drip pans) to protect the space below from leakage and condensation."
(B) Add subparagraph (1)(c) to read: "(c) FM 1680 compliant no-hub couplings shall be acceptable in lieu of standards specified in paragraphs (a) and (b)."
(ll) Amend subparagraph (5)(a)(i) in subsection 2.2-2.2.4.4 to read: "(i) The ceiling shall be monolithic. The NRC standards listed in Table 1.2-4 are not required."
(mm) Add subparagraph (2)(c)(v) in subsection 2.2-2.2.4.6 to read: "(v) Hidden alcoves are prohibited."
(nn) In subsection 2.2-3.1.3.3:

(A) Amend paragraph (1) to read (1)(a).
(B) Add paragraph (1)(b) and subparagraphs (i) and (ii) to read: (1)(b) Bullet-resistant construction including glazing, doors, and walls shall be provided at all emergency department intake areas where patients are registered. (i) The intake area shall provide UL 752 level 3 protection. (ii) Ballistic protection shall extend from the floor to a height of 7 feet, 0 inches at exposed glazing, doors and walls of the intake area. (iii) Ballistic protection shall extend at exposed walls adjacent to the intake area, from the floor to a height of 7 feet, 0 inches. Protection shall be provided at the exposed intake area sidewalls. (iv) Level of ballistic protection at walls shall meet or exceed required glazing protection."
(C) Amend paragraph (3) to read: "(3) The triage area, room or bay shall be a minimum of 80 square feet and shall include the following:"
(oo) Add paragraph (4) to subsection 2.2-3.1.4.2 to read: "Where monolithic ceilings are provided in airborne infection isolation (AII) rooms, secure holding rooms, or flex behavioral health rooms (flex between secure hold and regular treatment) and are located in the emergency department, the NRC standards listed in Table 1.2-4 are not required."
(pp) Amend subsection 2.2-3.1.4.3 to read: "Secure holding room. If psychiatric services are provided, a secure holding room shall be provided and it shall meet the following requirements. (1) The location of the secure holding room(s) shall facilitate staff observation and monitoring of patients in these areas. (2) The secure holding room shall have a minimum clear floor area of 60 square feet (5.57 square meters) with a minimum wall length of 7 feet (2.13 meters) and a maximum wall length of 11 feet (3.35 meters). (3) This room shall be designed to prevent injury to patients. (a) All finishes, light fixtures, vents and diffusers, and sprinklers shall be impact-, tamper-, and ligature-resistant. (b) There shall not be any electrical outlets, medical gas outlets, or similar devices. (c) There shall be no sharp corners, edges, or protrusions, and the walls shall be free of objects or accessories of any kind. (d) Patient room doors shall swing out and shall have hardware on the exterior side only. (e) A small impact-resistant view panel or window shall be provided in the door for discreet staff observation of the patient. (4) Door openings shall be provided in accordance with Section 2.1-7.2.2.3 (2)(a)(i) (Door openings—Minimum for patient rooms and diagnostic and treatment areas…)."
(qq) Amend paragraph (4) in subsection 2.2-3.1.8.2 to read: "(4) Visual observation of all traffic into and within the unit shall be provided from the nurse station through direct or indirect visual observation."
(rr) Amend subsection 2.2-3.1.8.12 to read: "A soiled workroom(s) shall be provided for the exclusive use of the emergency department in accordance with Section 2.1-2.8.12 (Soiled Workroom or Soiled Holding Room)."
(ss) Amend paragraph (4) in subsection 2.2-3.2.8.2 to read: "(4) Soiled workroom. A soiled workroom shall be provided in accordance with Section 2.1-2.8.12 (Soiled Workroom or Soiled Holding Room)."
(tt) Add subparagraphs (4)(a) through (c) to subsection 2.2-3.3.1.1 to read: "(a) Unrestricted area: Any area of the surgery department that is not defined as semi-restricted or restricted. These areas shall include a central control point for designated personnel to monitor the entrance of patients, personnel, and materials into the semi-restricted areas; staff changing areas; a staff lounge; offices; waiting rooms or areas; pre- and postoperative patient care areas; and access to procedure rooms (e.g., endoscopy procedure rooms, laser treatment rooms). Street clothes are permitted in these areas. Public access to unrestricted areas may be limited based on the facility's policy and procedures. (b) Semi-restricted area: Peripheral areas that support surgical services. These areas shall include storage for equipment and clean and sterile supplies; work areas for processing instruments; sterile processing facilities; hand scrub stations; corridors leading from the unrestricted area to the restricted area of the surgical suite; and entrances to staff changing areas, pre- and postoperative patient care areas, and sterile processing facilities. The semi-restricted area of the surgical suite is entered directly from the unrestricted area past a nurse station or from other areas. Semi-restricted areas have specific HVAC design requirements associated with the intended use of the space (see Part 3: ANSI/ASHRAE/ASHE 170: Ventilation of Health Care Facilities). Personnel in the semi-restricted area shall wear surgical attire and cover all head and facial hair. Access to the semi-restricted area shall be limited to authorized personnel and patients accompanied by authorized personnel. (c) Restricted area: A designated space contained within the semi-restricted area and accessible only through a semi-restricted area. The restricted area includes operating and other rooms in which operative or other invasive procedures are performed. Restricted areas have specific HVAC design requirements associated with the intended use of the space (see Part 3: ASHRAE/ASHE 170). Personnel in the restricted area shall

wear surgical attire and cover head and facial hair. Masks shall be worn when the wearer is in the presence of open sterile supplies or of persons who are completing or have completed a surgical hand scrub. Only authorized personnel and patients accompanied by authorized personnel shall be admitted to this area."
(uu) Add paragraph (3) in subsection 2.2-3.3.2.1 to read: "(3) Procedure rooms where monolithic ceilings are required or provided, the NRC standards listed in Table 1.2-4 are not required."
(vv) In subsection 2.2-3.3.10.3:
(A) Amend paragraph (1) to read: "(1) A changing area that includes the following shall be provided for patients. (a) Toilet(s); (b) Space for changing or gowning."
(B) Add paragraph (3) to read: "(3) Individual, lockable storage shall be provided for patients' belongings."
(ww) In subsection 2.2-3.4.1.2, add the following paragraphs to read: "(1) Class 2 imaging shall include electrophysiology procedures and cardiac catheterization labs unless the facility chooses to identify and design them as Class 3 imaging. (2) Imaging Services for which an anesthesia machine is used only to immobilize the patient (for the benefit of the imaging exam) shall be permitted in Class 1 imaging rooms in which the following criteria are met: (a) Anesthesia is provided exclusively for the benefit of the patient (for example, to assuage anxiety or claustrophobia) or to combat patient motion that may interfere with exam results. (b) The imaging room shall provide a clearance of 4 feet around all sides of a freestanding imaging device, including a patient table/bed/couch, gantry, or assembly. Omission of this clearance shall be permitted on the side(s) of an imaging device that is mounted to/placed against a wall. (c) The imaging room meets the Class 2 electrical receptacle requirements of Table 2.1-1 (Electrical Receptacles for Patient Care Areas in Hospitals). (d) The imaging room meet the Class 2 nurse call requirements of Table 2.1-2 (Locations for Nurse Call Devices in Hospitals). (e) The imaging room meets the Class 2 medical gas and vacuum system requirements of Table 2.1-3 (Oxygen, Vacuum, Medical Air, WAGD, and Instrument Air Systems). (f) Compliance with NFPA 99 and ASHRAE 170 requirements for anesthetizing locations is required no matter the imaging classification. Conformance includes but is not limited to ASHRAE 170 article 7.1(a)(7), ASHRAE 170 Table 7.1 note m and p, NFPA 99 articles 5.1.5.16, 5.1.4.8.7, 5.1.9.3, 6.4.2.2.4.2, 6.3.2.2.11.1."
(xx) In subsection 2.2-3.4.1.3:
(A) Add subparagraph (1)(c)(i) to read: "(i) A minimum of 1 foot 6 inches between the view window and the outside partition edge shall be provided."
(B) Add subparagraph (1)(d) to read: "(d) The control room shall be physically separated from the Class 2 or Class 3 imaging room with walls and a door. The door shall not be required where the control room serves only one imaging room that is built, maintained, and controlled the same as the imaging room and does not contain system components identified in 2.2-3.4.2.5."
(yy) Amend subparagraph (1)(a) in subsection 2.2-3.4.2.5 to read: "(a) For Class 2 and Class 3 imaging rooms considered new construction or major renovation, the system component room shall not open into the imaging room or any restricted space."
(zz) In subsection 2.2-3.4.10.2:
(A) Amend paragraph (1) to read: "(1) Patient toilet rooms shall be immediately accessible to sub-waiting rooms or areas and patient changing rooms where provided."
(B) Amend subparagraph (3)(a) to read: "(a) Patient toilet rooms reserved for nuclear imaging patients shall be provided immediately accessible to sub-waiting rooms or areas and nuclear imaging rooms."
(aaa) Amend paragraph (2) in subsection 2.2-3.5.8.15 to read: "(2) Each examination room shall be equipped with a hand-washing station and a work counter."
(bbb) Amend subsection 2.2-3.10.2.4 to read: "Patient privacy. Space shall be available to accommodate provisions for patient privacy including when patients are examined or treated and body exposure is required. Privacy must be provided for the use of a bedpan or commode during dialysis, initiating and discontinuing treatment when the vascular access is placed in an intimate area, for physical exams, and for sensitive communications. There shall be sufficient numbers of privacy screens or other methods of visual separation available and used to afford patients full visual privacy when indicated."

(ccc) Add subparagraphs (1)(a) and (b) to subsection 2.2-3.10.2.5 to read: "(a) Wrist blade controls are not considered to be operable without the use of the hands. (b) Exception: Home training room hand-wash stations may be trimmed with residential style, ADA compatible controls."
(ddd) Add subsection 2.2-3.10.2.6 to read: "Body Fluid Disposal Sink. A fluid disposal sink shall be provided in each hemodialysis treatment area or room. Sink design including signage and location shall be constructed to prevent cross-contamination of the hand washing station."
(eee) Add subsection 2.2-3.10.2.7 to read: "Emergency Equipment. Emergency cart and equipment storage located close to the patient treatment area, readily accessible by staff, and not located in an exit path."
(fff) In subsection 2.2-3.10.3.2:
(A) Amend paragraph (3) to read: "(3) Separate sink with identifying signage that it is for fluid disposal."
(B) Add paragraph (4) to read: "(4) Emergency nurse call."
(ggg) Amend reference to subsections 2.2-3.10.4 – 2.2.3.10.7 to read:
(A) "2.2-3.10.4 Special Patient Care Rooms."
(B) "2.2-3.10.4.1 Isolation Room."
(C) "2.2-3.10.4.1.1 An isolation room shall be provided for Hepatitis B positive (HBV+) patients to prevent contact transmission of HBV+ blood spills and other body fluids. The isolation room shall meet the following requirements: (1) Provides a door and walls that go to the floor, but not necessarily the ceiling, and allows for visual monitoring of the patient; (2) Accommodates only one patient; (3) A hand washing station; and (4) A separate sink shall be provided within the isolation room for fluid disposal. Sink design including signage and location shall be constructed to prevent cross-contamination of the hand washing station."
(D) "2.2-3.10.4.1.2 The isolation room shall have a minimum clear floor area of 120 square feet."
(E) "2.2-3.10.4.1.3 The isolation room shall allow for direct observation of the patient by staff from a patient care staff station. Direct observation must include patient face and insertion point."
(F) "2.2-3.10.5 – 2.2-3.10.7 Reserved".
(hhh) Amend paragraph (2) in subsection 2.2-3.10.8.2 to read: "(2) The nurse station(s) shall be no higher than 3 feet 8 inches and be designed to provide direct visual observation of all individual dialysis treatment bays. Direct observation must include patient face and insertion point."
(iii) Amend subsection 2.2-3.10.8.12 to read: "Soiled holding room. A soiled holding room shall be provided in accordance with Section 2.1-2.8.12 (Soiled Workroom or Soiled Holding Room)."
(jjj) Amend subsection 2.2-3.10.8.14 to read: "An environmental services room shall be provided that meets the requirements in Section 2.1-2.8.14 (Environmental Services Room)."
(kkk) Amend subsection 2.2-3.10.8.19 to read: "An equipment repair and breakdown room shall be provided, and be equipped with the following: (1) Hand-washing station; (2) Treated water outlet for equipment maintenance and drain or clinical service sink for equipment connection and testing; (3) Work counter; (4) Storage cabinet."
(lll) Add paragraph (3) under subsection 2.2-3.11.2.1 to read: "(3) Where monolithic ceilings are provided in endoscopy procedure rooms, the NRC standards listed in Table 1.2-4 are not required."
(mmm) Amend subparagraph (1)(a) in subsection 2.2-3.11.10.3 to read: "(a) Patient changing areas. Provisions for storing patients' belongings. Individual, lockable storage shall be provided."
(nnn) Amend subparagraph (1)(c) in subsection 2.2-3.13.10.3 to read: "(c) Provisions for hanging patients' clothing and individual, lockable storage for securing valuables."
(ooo) Amend paragraph (1) in subsection 2.5-2.2.2.6 to read: "(1) Each patient shall have access to a toilet room without having to enter a corridor."
(ppp) Amend subsection 2.5-2.3.2.1 to read: "Capacity. (1) The maximum number of beds per room shall be one unless the necessity of a two-bed arrangement has been demonstrated. Two beds per room shall be permitted where approved by the authority having jurisdiction. (2) Where renovation work is undertaken and the present capacity is more than one bed, the maximum room capacity shall be two beds."
(qqq) Amend subsection 2.5-2.3.2.3 to read: "Patient toilet room. (1) Each patient shall have direct access to a toilet

room. (2) One toilet room shall serve no more than two patient bedrooms and no more than four patients. (3) The toilet room shall contain a toilet and a hand-washing station. (4) Toilet room doors: (a) Where indicated by the safety risk assessment, toilet room doors shall be equipped with keyed locks that allow staff to control access to the toilet room. (b) Where a swinging door is used, the door to the toilet room shall swing outward or be double-acting."
(rrr) Amend subsection 2.5-2.3.4 to read: "Outdoor Areas. An outdoor activity area shall be provided with a minimum of 50 square feet per patient but not less than 400 total square feet, see Section 2.5-2.2.3 (General Psychiatric Patient Care Unit—Outdoor Areas) for requirements."
(sss) Amend paragraph (1) in subsection 2.6-2.2.8.1 to read: "(1) The support areas noted shall be provided in or readily accessible to each patient care unit and meet the requirements in Section 2.2-2.2.8 (Support Areas for Medical/Surgical Patient Care Units) as amended in this section."
(ttt) Amend subsection 2.7-3.1.3.1 to read: "Children's hospitals shall have facilities for the services they provide that meet the requirements in Section 2.2-3.1.3 (Emergency Department) as amended by the children's hospitals-specific emergency department requirements in this section."
(uuu) Amend subsection 2.7-3.1.3.6 to read: "Treatment room. Treatment rooms shall meet the requirements in Section 2.2-3.1.3.6(5) (Pediatric treatment rooms)."
(vvv) Add subsection 2.8-1.1.1.4 to read: "This chapter shall not be reviewed for Class 1 imaging mobile/transportable medical units that are to be used for less than 180 calendar days in a consecutive 12-month period while the permanent equipment and imaging space is receiving renovation or replacement work. Interim life safety measures shall be implemented and made available for review and inspection upon request. Documents shall record the arrival date and removal date of the trailer. A copy of these record documents shall be with the trailer for duration of placement."
(www) Amend subsection 2.8-1.3.7.4 to read: "Applicable local and state requirements. All imaging facilities and radiation producing equipment installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."
(xxx) Amend subsection 2.8-3.1.2 to read: "All mobile/transportable medical units shall be provided with a hand-washing station in accordance with Section 2.1-2.8.7 (Hand-Washing Station). For Class 1 imaging units that are not already provided with a hand-washing station, a hand-sanitation dispenser shall be provided instead."
(6) The following chapters, sections, paragraphs, subparagraphs or appendices of the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities are deleted in their entirety:
(a) Subsection A1.2-2.1.2.1;
(b) Subsection 1.2-2.1.2.3;
(c) Section 1.2-8;
(d) Section 1.2-9;
(e) Paragraph (b) in subsection A2.1-3.6;
(f) Subsection 2.1-3.8.10.2;
(g) Subparagraphs (2)(b)(vi) and (3)(b)(v) in subsections 2.1-4.3.2.2;
(h) Paragraph (7) in subsection A2.1-7.2.2.8;
(i) Subsection 2.4-6.2.2 through A2.4-6.2.3;
(j) Subsection A2.7-3.1.1.4;
(k) Subsection A2.10-3.4.1; and
(l) Chapter 2.8;
(m) Subsection 2.11-3.2.7.1 through 2.11-3.2.7.5;
(n) Subsection 2.11-3.2.9.1 through 2.11-3.2.9.10; and
(o) Subsection 2.11-3.2.10.
(7) The following amendments or additions are made to the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities, as adopted and incorporated by reference. All references to part, subpart, sections, paragraphs, subparagraphs and appendices relate to the 2018, FGI, Guidelines for Design and Construction of Outpatient Facilities.
(a) Amend section 1.1-2 to read: "Project submittal criteria shall comply with OAR chapter 333, division 675. Projects

with any of the following scopes of work shall be considered new construction and shall comply with the requirements in the Guidelines for Design and Construction of Outpatient Facilities:"
(b) Amend subsection 1.1-3.1.1.2 to read: "Major renovation projects. Project submittal criteria shall comply with OAR chapter 333, division 675. Projects with either of the following scopes of work shall be considered a major renovation and shall comply with the requirements for new construction in the Guidelines for Design and Construction of Outpatient Facilities to the extent possible as determined by the authority having jurisdiction: (1) A series of planned changes and updates to the physical plant of an existing facility, (2) A renovation project that includes modification of an entire building or an entire area in a building to accommodate a new use or occupancy."
(c) Amend subsection 1.1-3.1.2.1 to read: "Where major structural elements make total compliance impractical or impossible, exceptions shall be considered in accordance with the Oregon Administrative Rules specific to the physical environment of the type of health care facility under consideration."
(d) Amend subsection 1.1-3.1.2.2 to read: "Minor renovation or replacement work shall be permitted to be exempted from the requirements in Section 1.1-3.1.1 (Compliance Requirements) provided they meet the criteria specified in OAR chapter 333, division 675 and do not reduce the level of health and safety in an existing facility."
(e) Amend paragraph (a) in subsection A1.2-2.1.1 to read: "(a) All projects, large and small, require a functional program to guide the design. The length and complexity of the functional program will vary greatly depending on project scope."
(f) Amend subsection 1.2-2.1.2.1 to read: "The governing body shall be responsible for having a functional program developed, documented, and updated. The governing body may delegate documentation of the functional program to consultants with subject matter expertise. The governing body shall review and approve the functional program."
(g) Add new subsection 1.2-2.2.7.4 to read: "A description of the following: (a) Special design feature(s); (b) Occupant load, numbers of staff, patients, visitors and vendors; (c) Issue of privacy/confidentiality for patient; (d) In treatment areas, describe: (A) Types of procedures; (B) Design considerations for equipment; (C) Requirements where the circulation patterns are a function of asepsis control; and (D) Highest level of sedation, if applicable; (e) For Outpatient Surgery facilities, the functional program must also describe: (A) Level of medical gas system per NFPA 99; and (B) Type of central electrical system."
(h) Amend subsection 1.2-4.1.1.2 to read: "To support this goal, an interdisciplinary team shall develop a safety risk assessment (SRA). A copy of the SRA shall accompany construction documents submitted to the Oregon Health Authority, Facility Planning and Safety program."
(i) Add paragraphs (1) through (4) and amend subsection 1.2-4.6.1 to read: "Behavioral and Mental Health Elements of the Safety Risk Assessment. The SRA report shall identify areas where patients at risk of mental health injury and suicide will be served. Elements of the assessment shall include but are not limited to: (1) A statement explaining the psychiatric population groups served; (2) A discussion of the capability for staff visual supervision of patient ancillary areas and corridors; (3) A discussion of the risks to patients, including self-injury, and the project solutions employed to minimize such risks; and (4) A discussion of building features and equipment, including items which may be used as weapons, that is intended to minimize risks to patients, staff and visitors."
(j) Amend subsection 1.2-6.1.1 to read: "General. The planning and design of new outpatient facilities and the retrofitting of existing outpatient facilities shall conform to the Guidelines and all applicable codes and regulations with respect to exterior environmental sound and interior sound within all occupied building spaces. Documentation by a Licensed Acoustic Engineer of compliance with acoustic criteria, shall be accepted as equivalency to the requirements of Table 1.2-4 NRC and Table 1.2-6 STC."
(k) Amend subsection 2.1-2.1.1.1 to read: "All patient care areas designated for care of patients of size shall meet the requirements in this section. The Oregon Health Authority will complete a review when specifically cross-referenced from a FGI facility type requirement section or when identified in the project submission documents."
(l) Add subparagraph (3)(f) to subsection 2.1-3.2.1.2 to read: "(f) Work counter that complies with 2.1-7.2.2.15 (Work Surfaces)."
(m) Add paragraph (3) to subsection 2.1-3.2.2.1 to read: "(3) Procedure rooms where monolithic ceilings are required or provided, the NRC standards listed in Table 1.2-4 are not required."

(n) Add paragraph (4) to subsection 2.1-3.2.2.7 to read: "(4) Provision for in-room storage of supplies and equipment used in procedure room. May be fixed cabinets or movable cart(s)."
(o) Amend paragraph (12) in subsection 2.1-3.2.2.8 to read: "(12) Soiled holding. A dedicated soiled hold room or space for holding soiled materials shall be provided that is separate from the clean storage area."
(p) Amend paragraph (4) in subsection 2.1-3.2.2.10 to read: "(4) Storage for patients' belongings. Provisions shall be made for securing patients' personal effects during procedures. Individual, lockable storage shall be provided."
(q) Amend subsection 2.1-3.2.3.8:
(A) Subparagraph (1)(b) to read: "(b) Sharing of these support areas with other clinical services in the facility shall be permitted. An ambulatory surgical center (ASC) that is Medicare-certified must be distinct from any other health care facility or office-based physician practice as required in 42 CFR 416.2 and 42 CFR 416.44(a)(2) and (b)"; and
(B) Paragraph (12) to read: "(12) Soiled workroom meeting requirements in 2.1-3.8.12. A room for holding soiled material shall be provided that is separate from the clean storage area."
(r) Amend paragraph (4) in subsection 2.1-3.2.3.10 to read: "(4) Storage for patients' belongings. Provisions shall be made for securing patients' personal effects during surgery. Individual, lockable storage shall be provided."
(s) Amend subsection 2.1-3.5.1.2 to read: "To differentiate the design and construction requirements needed to achieve the environmental controls and other requirements that support the amount of intervention to be provided, imaging rooms shall be classified as described in Table 2.1-5 (Classification of Room Types for Imaging Services). (1) Class 2 imaging shall include electrophysiology procedures and cardiac catheterization labs unless the facility chooses to identify and design them as Class 3 imaging. (2) Imaging Services for which an anesthesia machine is used only to immobilize the patient (for the benefit of the imaging exam) shall be permitted in Class 1 imaging rooms in which the following criteria are met: (a) Anesthesia is provided exclusively for the benefit of the patient (for example, to assuage anxiety or claustrophobia) or to combat patient motion that may interfere with exam results. (b) The imaging room shall provide a clearance of 4 feet around all sides of a freestanding imaging device, including a patient table/bed/couch, gantry, or assembly. Omission of this clearance shall be permitted on the side(s) of an imaging device that is mounted to/placed against a wall. (c) The imaging room meets the Class 2 electrical receptacle requirements of Table 2.1-1 (Electrical Receptacles for Patient Care Areas in Outpatient Facilities). (d) The imaging room meet the Class 2 nurse call requirements of Table 2.1-3 (Locations for Nurse Call Devices in Outpatient Facilities). (e) The imaging room meets the Class 2 medical gas and vacuum system requirements of Table 2.1-2 (Station Outlets for Oxygen, Vacuum, Medical Air, WAGD, and Instrument Air Systems in Outpatient Facilities). (f) Compliance with NFPA 99 and ASHRAE 170 requirements for anesthetizing locations is required no matter the imaging classification. Conformance includes but is not limited to ASHRAE 170 article 7.1(a)(7), ASHRAE 170 Table 7.1 note m and p, NFPA 99 articles 5.1.5.16, 5.1.4.8.7, 5.1.9.3, 6.4.2.2.4.2, 6.3.2.2.11.1."
(t) In subsection 2.1-3.5.1.3:
(A) Amend subparagraph (1)(c) to read: "(c) Shielded view window. The control alcove or room shall include a shielded view window designed to provide a full view of the examination/procedure table and the patient at all times, including a full view of the patient during imaging activities (e.g., when the table is tilted or the chest X-ray is in use). Where protected alcoves with view windows are required, a minimum of 1 foot 6 inches between the view window and the outside partition edge shall be provided."
(B) Amend subparagraph (1)(d) to read: "(d) The control room shall be physically separated from the Class 2 or Class 3 imaging room with walls and a door. The door shall not be required where the control room serves only one imaging room that is built, maintained, and controlled the same as the imaging room and does not contain system components identified in 2.1-3.5.2.5."
(u) Amend paragraph (3) in subsection 2.1-3.5.2.1 to read: "(3) Where imaging procedures meeting Class 3 criteria are performed, a room(s) that meets the requirements for the applicable imaging suite and for an operating room (see Section 2.1-3.2.3) shall be provided. These imaging rooms shall comply with the following: (a) Be sized to accommodate the personnel and equipment planned to be in the room during procedures. (b) Have a minimum clear floor area of 600 square feet (55.74 square meters) with a minimum clear dimension of 20 feet (6.10 meters). (c) Where renovation work

is undertaken and it is not possible to meet the above minimum standards, these rooms shall have a minimum clear floor area of 500 square feet (46.50 square meters) with a minimum clear dimension of 20 feet (6.10 meters). (d) Fixed encroachments into the minimum clear floor area. Fixed encroachments shall be permitted to be included when determining the minimum clear floor area for an operating room as long as: (i) There are no encroachments into the sterile field. (ii) The encroachments do not extend more than 12 inches (30.5 centimeters) into the minimum clear floor area outside the sterile field. (iii) The encroachment width along each wall does not exceed 10 percent of the length of that wall."

(v) Amend paragraph (1)(a) in subsection 2.1-3.5.2.5 to read: "(a) For Class 2 and Class 3 imaging rooms considered new construction or major renovation, the system component room shall not open into the imaging room or any restricted space."

(w) Add paragraph (5) to subsection 2.1-3.5.4.4 to read: "(5) Where patients change in the mammography room, privacy shall be provided."

(x) In subsection 2.1-3.5.10.2:

(A) Amend paragraph (1) to read: "(1) Patient toilet rooms shall be immediately accessible to sub-waiting rooms or areas and patient changing rooms where provided."

(B) Amend subparagraph (3)(a) to read: "(a) Patient toilet rooms reserved for nuclear imaging patients shall be provided immediately accessible to sub-waiting rooms or areas and nuclear imaging rooms."

(y) Add new subsection 2.1-3.6.2.4 to read: "Hybrid imaging/therapy systems. Where external beam radiation therapy systems are combined with a concurrent imaging option (for example, CT or MRI), the full design criteria for both contributing imaging/therapy devices shall be applied to the hybrid service."

(z) Amend subsection A2.1-3.6.8.16 to read: "Other support areas for radiation therapy. In addition to the optional support areas in the main text, the following support areas may be needed to support radiation therapy services: (a) Dosimetry equipment area or storage for calibration phantoms. (b) Workstation/nutrition station."

(aa) Add new subsection 2.1-3.6.8.17 to read: "Additional Support Areas. (1) Control room or area: (a) All external beam radiation therapy treatment and simulator rooms shall have a control room or area. (b) Control room shall have visual and audio contact with patient in the treatment room. Visual contact may be direct or by video link. (2) Treatment planning and record room, if provided, shall be sized to meet manufacturers' dosimetry system requirements. (3) Consultation room shall be provided for radiation therapy suite."

(bb) Amend subsection 2.1-3.8.2.5 to read: "Hand-wash station shall be provided within 20 feet, not through a door. See section 2.1-7.2.2.8 (Hand-washing stations) for requirements."

(cc) Amend paragraph (1) in subsection 2.1-3.8.7.3 to read: "(1) At least one hand-washing station shall be provided for every four patient care stations or fewer."

(dd) Amend subparagraph (2)(d) in subsection 2.1-3.8.8.1 to read: "(d) Lighting. Task-specific lighting levels, measured at the worksurface only, for health care settings recommended in the U.S. Pharmacopeia-National Formulary shall be used to design lighting."

(ee) Amend subsection 2.1-3.8.8.2 to read: "Work areas for preparing and dispensing medication. Facilities shall be reviewed below for each area as applicable as either subparagraph (1) or as subparagraph (2) if only dispensing. (1) Medication preparation room or area (a) This room or area shall be under direct or indirect (example, camera) visual control of the nursing staff. (b) This room or area shall contain the following: (i) work counter; (ii) Hand-washing station unless located within an operating room, Class 3 imaging, or sterile core of surgical department. Where hand-washing station is omitted in the sterile core, a hand sanitation dispenser shall be provided; (iii) Lockable refrigerator where refrigerated medications are used; (iv) Locked storage for controlled drugs; (v) Sharps containers, where sharps are used (c) Where a medication preparation room or area is used to store one or more self-contained medication dispensing units, the room shall be designed with space to prepare medication when the self-contained medication-dispensing unit(s) is present. (d) Where a medication preparation room is used to compound sterile preparations, it shall meet the requirements in USP-NF General Chapter <797> “Pharmaceutical Compounding—Sterile Preparations.”"

(ff) Amend subsection 2.1-3.8.10.1 to read: "Ice-making equipment shall be of the self-dispensing type."

(gg) Amend paragraph (1) in subsection 2.1-3.8.12.3 to read: "(1) Hand-washing station."
(hh) Amend paragraph (2) in subsection 2.1-4.1.2.3 to read: "(2) Additional hand-washing stations shall be provided within 20 feet of each workstation where specimens or reagents are handled."
(ii) Amend subparagraph (1)(a) in subsection 2.1-4.1.2.5 to read: "Terminal sterilization is not required for waste that is incinerated on-site or when services for regulated medical/bio-hazardous waste disposal services will be contracted through a vendor."
(jj) Add paragraph (2) in subsection 2.1-4.1.8.1 to read: "(2) Refrigeration for storage of reagents, controls and patient specimens as necessary."
(kk) Add paragraph (3) in subsection 2.1-4.2.3.1 to read: "(3) Pharmacy clean/sterile compounding rooms accessed from an ante room need not comply with Table 1.2-4: Minimum Design Room-Average Sound Absorption Coefficients."
(ll) Amend subsection 2.1-4.2.8.7 to read: "A hand-washing station(s) shall be provided within each separate room where open medication is prepared for administration except where prohibited by OAR chapter 855, division 045; USP 797 or USP 800. Where a hand-wash station is prohibited in the compounding room, a hand-wash station(s) shall be provided in an anteroom."
(mm) Amend paragraph (2) in subsection 2.1-4.3.2.4 to read: "(2) Clean/sterile medical/surgical supply receiving room or area. A room or area shall be provided for receiving/unpacking clean/sterile supplies received from outside the department or facility. This room or area may not be located inside clean storage."
(nn) Amend paragraph (1) in subsection 2.1-4.4.2.1 to read: "(1) This area shall be large enough to accommodate the following: (a) Washer/extractor(s). Washers/extractors shall provide a temperature of at least 160 degrees Fahrenheit for a minimum of 25 minutes or include use of a chemical disinfectant. (b) Dryer. (c) Supply storage. Storage shall be provided for laundry supplies. (d) Any plumbing equipment needed to meet the temperature requirements in Section 2.1-8.4.2.5(4) (Water temperature)."
(oo) Add subparagraphs (1)(b) through (1)(e) in subsection 2.1-5.2.1.3 to read: "(b) Wall base shall be integral and coved with the floor, tightly sealed to the wall, and constructed without voids that can harbor insects. (c) The regulated waste storage spaces shall have lighting and exhaust ventilation, be safe from weather, animals and unauthorized entry. (d) Regulated waste management shall be in accordance with the requirements of OAR chapter 333, division 056. (e) Refrigeration requirements for such holding facilities, if provided, shall comply with local and state regulations."
(pp) Amend subsection 2.1-5.3.1.2 to read: "Environmental services room provisions. Environmental services room shall be a minimum of 35 square feet. Each environmental services room shall be provided with the following: (1) Service sink or floor-mounted mop sink; *(2) Provisions for storage of supplies and housekeeping equipment; (3) Hand-washing station or hand sanitation dispenser."
(qq) Amend paragraph (2) in subsection 2.1-7.2.2.1 to read: "(2) Corridors used for stretcher and gurney transport shall have a minimum corridor or aisle width of 6 feet (1.83 meters). This requirement is not applicable to birth centers (see 2.4-7.2.1.1) or renal dialysis centers (see 2.10-3.2.1.5)."
(rr) In subsection 2.1-7.2.2.8:
(A) Amend subparagraph (1)(b) to read: "(b) The number and placement of hand sanitation dispensers shall be determined by an infection control risk assessment (ICRA)."
(B) Amend subparagraph (3)(b) to read: "For newly constructed or newly installed countertops that require a substrate, marine-grade plywood (or an equivalent material) with an impervious seal shall be required. Existing countertops shall be fully sealed/caulked and in good repair."(C) Add paragraph (8) to read: "(8) Mirrors are not permitted at scrub, clinical or other staff use hand-wash stations, with the exception of staff toilets."
(ss) Add paragraph (4) in subsection 2.1-7.2.2.11 to read: "(4) All imaging facilities and radiation producing equipment installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."
(tt) Add subsection 2.1-7.2.2.15 to read: "Work Surfaces. Work areas. Where a work space, work area, work counter, or work surface is provided, it shall have a minimum of 4 square feet (.37 square meter) of contiguous clear surface for each person programmed to work in the space at the same time. A mobile cart meeting these requirements shall be

permitted."
(uu) Add subparagraphs (6)(a)(ix) through (xii) in subsection 2.1-7.2.3.1 to read: "(ix) Protective environment rooms; (x) Bathing and toilet rooms; (xi) Soiled workrooms and soiled hold rooms; (xii) Environmental services room; (xiii) Pharmacy clean and anterooms."
(vv) Add subparagraph (1)(c)(ix) in subsection 2.1-7.2.3.2 to read: "(ix) Bathing and toilet rooms."
(ww) Add paragraph (4) in subsection 2.1-8.2.1.2 to read: "(4) Extended Stay Centers".
(xx) Amend subsection 2.1-8.7.1 and add paragraph (2) to read: "(1) Where an outpatient facility is located on more than one floor or on a floor other than an entrance floor at grade level, at least one elevator shall be provided. (2) Installation and testing of elevators shall comply with the Oregon Elevator Code."
(yy) Add subsection A2.1-8.7.1 to read: "Consideration should be given to dedicating and separating elevator types by function, such as those for the public, patients, staff, and materials (for example, clean versus soiled flows), as the diverse uses affect both operational efficiency and cross-contamination and infection control issues."
(zz) Amend subsection 2.1-8.7.5.1 and add paragraph (2) to read: "(1) Elevator call buttons and controls shall not be activated by heat or smoke. (2) Each elevator, except those for material handling, shall be equipped with an independent keyed switch for staff use for bypassing all landing button calls and responding to car button calls only."
(aaa) Amend section 2.2-3.8.11.3 to read: "A clean workroom may be shared with other clinical services in the same building, in accordance with state and federal regulations."
(bbb) Amend subsection 2.2-3.10.2.2 to read: "This patient toilet room shall be permitted to serve waiting areas in clinics with five or fewer examination rooms."
(ccc) Amend paragraph (1) to subsection 2.2-4.3.3.1 to read: "(1) Provision of an area instead of a room shall be permitted to meet the requirements in sections 2.1-4.3.3.1 (A room for breakdown...) and 2.1-4.3.3.2 (A room for on-site storage...). Breakdown area may not be located in clean workroom or clean storage."
(ddd) Amend subsection 2.2-5.2.3 to read: "Location of storage for hazardous waste (red bag trash) and sharps shall be behind a closed door. An exam room shall not be used for cumulated storage of hazardous waste and sharps."
(eee) Amend subsection 2.4-1.2 to read: "Functional Program. See section 1.2-2 and 2.1-1.2 (Functional Program) for requirements."
(fff) Amend subsection 2.4-2.2.4 to read: "Privacy. Windows or doors within a normal sightline that would permit observation into the room shall be designed for mother and newborn privacy. See 2.1-3.1.2 (Patient Privacy) for additional requirements."
(ggg) Amend subsection 2.4-2.2.6 to read: "Bathrooms. Each birthing room shall have direct access to a private bathroom that meets the requirements in 2.1-3.10.2 (Patient Toilet Room(s)) and includes the following:"
(hhh) Amend subsection 2.4-2.2.6.1 to read: "Hand-washing station. See Section 2.1-7.2.2.8 (Hand-washing stations) and Section 2.1-8.4.3.2 (Hand-washing station sinks) for requirements."
(iii) Amend subsection 2.4-2.2.6.3 to read: "Shower or tub. See Section 2.1-8.4.3.3 (Showers and tubs) for requirements."
(jjj) Add subsection 2.4-2.2.7 to read: "Documentation and Charting. Accommodations for written or electronic documentation shall be provided in the birthing room or at a nurse station. See Section 2.1-3.8.3 (Documentation Area) for requirements."
(kkk) Amend subsection 2.4-2.8.7 to read: "Hand-Washing Stations. Hand-washing stations shall be located in, next to, or directly accessible to staff work area(s) and not through a door."
(lll) Amend subsection 2.4-2.8.10.2 to read: "Ice shall be served from self-dispensing ice-makers."
(mmm) Amend subsection 2.4-2.8.11 to read: "Clean Workroom or Clean Work Area. A clean work area or clean workroom shall be provided in accordance with Section 2.1-3.8.11 (Clean Workroom or Clean Supply Room)."
(nnn) Amend subsection 2.4-2.8.13.4 to read: "Emergency equipment storage. See Section 2.1-3.8.13.4 (Emergency equipment storage) for requirements."
(ooo) Amend subsection 2.4-2.8.14 to read: "Environmental Services Room. An environmental services room that meets the requirements in Section 2.1-5.3.1.2 (Environmental services room provisions) shall be provided for the exclusive use of the birth center."

(ppp) Amend reference to subsections 2.4-4.1 – 2.4-4.3 to read: "2.4-4.1 – 2.4-4.2 Reserved".
(qqq) Add subsection 2.4-4.3 to read: "Sterile Processing".
(rrr) Add subsection 2.4-4.3.1 to read: "Facilities for On-Site Sterile Processing. Where sterile processing is performed on-site, see Section 2.1-4.3 (Sterile Processing) for requirements."
(sss) Add subsection 2.4-4.3.2 to read: "Support Areas for Birthing Centers Using Off-Site Sterile Processing. For Birthing Centers where sterile processing services are provided off-site, see Section 2.1-4.3.3 (Support Areas for Outpatient Facilities Using Off-Site Sterile Processing) for requirements."
(ttt) Add paragraph (3) in subsection 2.4-4.5.2.1 to read: "(3) Shall meet the requirements of the Oregon Food Sanitation Rules OAR 333-150-0000."
(uuu) Amend subsection 2.4-6.2 to read: "Public Areas. Public areas shall be provided in accordance with Section 2.1-6.2 (Public Areas)."
(vvv) Amend subsection 2.4-7.1 to read: "Building Codes. The birth center shall be permitted to fall under the business occupancy provisions of applicable life safety and building codes. Building design and construction shall comply with local, state, and federal guidelines."
(www) Amend subsection 2.4-7.2 to read: "Architectural Details and Surfaces. See Section 2.1-7.2 (Architectural Details, Surfaces, and furnishings) for requirements."
(xxx) Amend section 2.4-8 to read: "Building Systems. See Section 2.1-8 (Building Systems) for requirements."
(yyy) Amend subsection 2.4-8.3.1 to read: "Lighting. (1) The birthing room shall provide lighting capable of providing at least 70 foot-candles in the delivery and newborn care area(s). (2) Exam light(s) shall be provided for each birthing room."
(zzz) Amend subsection 2.4-8.7 to read: "Elevators. Where elevators are provided, elevator cars shall have minimum inside dimensions of 5 feet 8 inches (1.73 meters) wide by 7 feet 6 inches (2.29 meters) deep. Installation and testing of elevators shall comply with the Oregon Elevator Code."
(aaaa) Amend paragraph (1) in subsection 2.5-3.2.3.1 to read: "(1) A dedicated triage space. The triage space or bay shall be a minimum 80 square feet."
(bbbb) Amend subsection 2.5-3.2.3.3 to read: "Hand-washing station. The triage area(s) shall be directly accessible to a hand-washing station(s) that complies with Section 2.1-3.8.7 (Hand-Washing Station). Hand-wash stations shall be provided in each triage room if rooms are provided."
(cccc) Amend subsection 2.5-3.3.3.1 to read: "Visual observation of all traffic into and within the unit shall be provided from the nurse station through direct or indirect visual observation."
(dddd) Amend subsection 2.7-1.2.3 and add paragraph (2) to read: "Shared Services. (1) If the outpatient surgery facility is part of an acute care hospital or other medical facility, services shall be permitted to be shared to minimize duplication as acceptable to authorities having jurisdiction. (2) If the facility is an ASC: An ASC is a distinct entity and must be separate and distinguishable from any other health care facility or office-based physician practice. Medicare-certified ASCs are subject to specific requirements related to sharing spaces with another health care facility or office-based physician practice. An ASC that is Medicare-certified must be distinct from any other health care facility or office-based physician practice as required in 42 CFR 416.2 and 42 CFR 416.44(a)(2) and (b)."
(eeee) Add subsection 2.7-3.1.1.5 to read: "Areas in the outpatient surgery facility. (1) Unrestricted area: Any area of the surgery facility that is not defined as semi-restricted or restricted. These areas shall include a central control point for designated personnel to monitor the entrance of patients, personnel, and materials into the semi-restricted areas; staff changing areas; a staff lounge; offices; waiting rooms or areas; pre- and postoperative patient care areas; and access to procedure rooms (e.g., endoscopy procedure rooms, laser treatment rooms). Street clothes are permitted in these areas. Public access to unrestricted areas may be limited based on the facility's policy and procedures. (2) Semi-restricted area: Peripheral areas that support surgical services. These areas shall include storage for equipment and clean and sterile supplies; work areas for processing instruments; sterile processing facilities (if on-site sterile processing is provided); hand scrub stations; corridors leading from the unrestricted area to the restricted area; and entrances to staff changing areas, pre- and postoperative patient care areas, and sterile processing facilities. The semi-restricted area is entered

directly from the unrestricted area past a nurse station or from other areas. Semi-restricted areas have specific HVAC design requirements associated with the intended use of the space (see Part 3: ANSI/ASHRAE/ASHE 170: Ventilation of Health Care Facilities). Personnel in the semi-restricted area shall wear surgical attire and cover all head and facial hair. Access to the semi-restricted area shall be limited to authorized personnel and patients accompanied by authorized personnel. (3) Restricted area: A designated space contained within the semi-restricted area and accessible only through a semi-restricted area. The restricted area includes operating and other rooms in which operative or other invasive procedures are performed. Restricted areas have specific HVAC design requirements associated with the intended use of the space (see ANSI/ASHRAE/ASHE 170: Ventilation of Health Care Facilities). Personnel in the restricted area shall wear surgical attire and cover head and facial hair. Masks shall be worn when the wearer is in the presence of open sterile supplies or of persons who are completing or have completed a surgical hand scrub. Only authorized personnel and patients accompanied by authorized personnel shall be admitted to this area."

(ffff) Add paragraphs (1) and (2) to subsection 2.9-3.2.1 to state: "(1) The endoscopy procedure room shall meet the requirements in Section 2.1-3.2.2 (Procedure Room) as amended in this section. (2) Where monolithic ceilings are provided in Endoscopy Procedure Rooms, the NRC standards listed in Table 1.2-4 are not required."

(gggg) Amend 2.9-3.10.3.2 to read: "Provisions shall be made for securing patients' personal effects. Individual, lockable storage shall be provided."

(hhhh) Add subsection 2.10-1.1.4 to read: "Fire suppression sprinkler systems are required in Medicare certified dialysis facilities housed in multi-story buildings construction Types II(000), III(200), or V(000), as defined in the 2012 edition of NFPA 101 Life Safety Code, Table 21.1.6.1, and those housed in high-rise buildings over 75 feet in height."

(iiii) Amend subsection 2.10-3.1 to read: "Examination Room. Where an exam room is provided, it shall meet the requirements in Section 2.1-3.2.1 (Examination room)."

(jjjj) Add subsection 2.10-3.2.1.4 to read: "Emergency Equipment. Emergency cart and equipment storage shall be located close to the patient treatment area, readily accessible by staff, and not located in an exit path. Emergency equipment shall also comply with 2.1-3.8.13.4 (Emergency equipment storage)."

(kkkk) Add subsection 2.10-3.2.1.5 to read: "Emergency transport of patient. Corridors, doorways, and stairways serving the unit shall be sized to allow at least one exit route for emergency medical personnel to transport a patient by stretcher to an ambulance. The identified corridor(s) shall be 44 inches minimum clear and any doors within the identified route shall have a minimum 42 inches door leaf width."

(llll) Add subsection 2.10-3.2.1.6 to read: "Patient Scale. Provide dedicated space for a patient scale."

(mmmm) Amend subsection 2.10-3.2.4 to read: "Patient Privacy. Space shall be available to accommodate provisions for patient privacy including when patients are examined or treated and body exposure is required. Privacy must be provided for the use of a bedpan or commode during dialysis, initiating and discontinuing treatment when the vascular access is placed in an intimate area, for physical exams, and for sensitive communications. There shall be sufficient numbers of privacy screens or other methods of visual separation available and used to afford patients full visual privacy when indicated."

(nnnn) Amend subsection 2.10-3.2.5.1 to read: "Hand-washing stations shall be provided in accordance with Section 2.1-3.8.7 (Hand-Washing Station). (1) Hand-washing stations shall be trimmed with fittings that are operable without use of the hands. Note: wrist blade controls are not considered to be operable without the use of the hands. (2) Exception: Home training room hand-wash stations may be trimmed with residential style controls."

(oooo) Add subsection 2.10-3.2.6 to read: "Body Fluid Disposal Sink".

(pppp) Add subsection 2.10-3.2.6.1 to read: "A fluid disposal sink shall be provided in each hemodialysis treatment area or room. Sink design including signage and location shall be constructed to prevent cross-contamination of the hand washing stations."

(qqqq) Amend subsection 2.10-3.3.2.3 to read: "Separate sink with identifying signage that it is for fluid disposal".

(rrrr) Add subsection 2.10-3.3.2.4 to read: "Emergency nurse call".

(ssss) Amend subsection 2-10-3.4.1 to read: "Airborne Infection Isolation (AII) Room. If the ICRA calls for an airborne infection isolation (AII) room, an AII rooms shall be provided."

(tttt) Amend subsection 2.10-3.4.1.3 to read: "The AII room shall allow for direct observation of the patient by staff during treatment. Direct observation must include patient face and insertion point."
(uuuu) Add subsection 2.10-3.4.2 to read: "Isolation Room".
(vvvv) Add subsection 2.10-3.4.2.1 to read: "An isolation room shall be provided for Hepatitis B positive (HBV+) patients to prevent contact transmission of HBV+ blood spills and other body fluids. The room shall meet the following requirements: (1) Provides a door and walls that go to the floor, but not necessarily the ceiling, and allows for visual monitoring of the patient; (2) Accommodates only one patient; (3) A hand washing station; and (4) A separate sink shall be provided within the isolation room for fluid disposal. Sink design and location shall be constructed to prevent cross-contamination of the hand washing station."
(wwww) Add subsection 2.10-3.4.2.2 to read: "The isolation room shall have a minimum clear floor area of 120 square feet."
(xxxx) Add subsection 2.10-3.4.2.3 to read: "The isolation room shall allow for direct observation of the patient by staff from a patient care staff station. Direct observation must include patient face and insertion point."
(yyyy) Amend subsection 2.10-3.8.2.2 to read: "The nurse station(s) shall be no higher than 3 feet 8 inches, designed to provide direct visual observation of all dialysis patient care stations. Direct observation must include patient face and insertion point."
(zzzz) Amend subsection 2.10-5.2 to read: "Waste Management. See Section 2.1-5.2 (Waste Management) for requirements. Hand-washing station or hand sanitizer shall be provided within or adjacent to biohazardous waste storage area."
(aaaaa) Amend reference to 2.10-6.3.1 – 2.10-6.3.2 to read: "2.10-6.3.1 Reserved".
(bbbbb) Add subsection 2.10-6.3.2 to read: “Interview Space. See Section 2.1-6.3.2 (Interview space) for requirements)."
(ccccc) Amend section 2.10-7 to read: "Architectural Details, Surfaces, and Furnishings. See Section 2.1-7 (Architectural Details, Surfaces, and furnishings) for requirements."
(ddddd) Add subsection 2.10-8.3.1 to read: "General. For electrical system requirements, see Section 2.1-8.3 (Electrical Systems) and additional requirements in this section."
(eeeee) Add subsection 2.10-8.3.2 to read: "Reserved."
(fffff) Add subsection 2.10-8.3.3 to read: "Emergency Electrical Power. (1) Provisions shall be made to allow connection to an alternate power source. The point of connection shall be immediately accessible to the exterior. The alternate power source shall provide on-going power for the lighting and continued provision of dialysis services. (2) Power may be provided by an on-site generator or by means of a hitching post for connection to a portable generator provided under contract by others. Hitching post, if provided, must be located to allow connection without the need to leave a door or doors open during use."
(ggggg) Add reference to subsections 2.10-8.3.4 – 2.10-8.3.5 to read: "Reserved."
(hhhhh) Add subsection 2.10-8.3.6 to read: "Electrical Receptacles. One of the eight required receptacles shall be a dedicated GFI circuit on emergency power for the dialysis machine. Hospital grade electrical outlets shall be provided for all dialysis equipment connections."
(iiiii) Amend subsection 2.11-3.2.1.1 to read: "Space for a clear path of escape for staff. Furniture shall be selected and placed so that the staff member is always between the patient and the escape path or by providing two exit doors."
(jjjjj) Amend subsection 2.11-3.2.1.2 to read: "A staff assist device to communicate with other staff, internal or external, when assistance is needed. Integrated communication systems (such as Vocera) are acceptable."
(kkkkk) Amend subsection 2.11-3.2.4 to read: "Consultation Room(s) These rooms are used for one-on-one counseling or therapy."
(lllll) Amend subsection 2.11-3.2.4.2 to read: "Each consultation room shall include a staff assist device to allow staff to communicate with other staff members, internal or external, when assistance is needed. Integrated communication systems (such as Vocera) are acceptable."
(mmmmm) Amend subsection 2.11-3.2.5.2 to read: "Staff assist device. Each group room shall include a staff assist device to allow staff to communicate with other staff members, internal or external, when assistance is needed.

Integrated communication systems (such as Vocera) are acceptable."
(nnnnn) Amend subsection 2.11-3.2.7 to read: “Seclusion Rooms are not allowed in outpatient psychiatric centers.”
(ooooo) Amend paragraph (2) in subsection 2.11-3.2.8.2 to read: "(2) This toilet room shall be permitted to be shared by patients using other activity spaces."
(ppppp) Amend subsection 2.11-3.2.9 to read: “Electroconvulsive Therapy is not allowed in outpatient psychiatric centers.”
(qqqqq) Amend subsection 2.11-3.8.8 to read: "Where provided, see section 2.1-3.8.8 (Medication Safety Zones) for requirements."
(rrrrr) Amend subsection 2.11-3.8.9 to read: "Where provided, location of a kitchenette(s) by the large group room(s) shall be permitted."
(sssss) Amend subsection 2.11-3.8.11 to read: "Clean Workroom or Work Area or Clean Supply Room or Area - Where an exam room is provided, a clean workroom or work area meeting the requirements of 2.1-3.8.11.2 (Clean Workroom) or a clean supply room or area meeting the requirements of 2.1-3.8.11.3 (Clean Supply Room) shall be provided. Use of an area instead of a room shall be allowed providing area is under direct staff supervision or that storage is lockable."
(ttttt) Amend subsection 2.11-3.8.12 to read: "Soiled Holding Room – Where an examination room is provided or when biohazardous waste is generated, a soiled holding room meeting the requirements of 2.1-3.8.12 (Soiled Workroom or Soiled Holding Room) shall be provided."
(uuuuu) Amend subsection 2.11-3.8.13 to read: "Where an exam room is included, patient wheelchair storage shall be provided in accordance with Section 2.1-3.8.13.3 (Wheelchair storage and parking space)."
(vvvvv) Amend subsection 2.11-5.2 to read: "Waste Management - See Section 2.1-5.2.1 (Waste Collection and Storage Facilities) for requirements. Section 2.1-5.2.1.3 only required when an examination room provided or biohazardous waste is generated."
(wwwww) Amend subsection 2.11-6.2.3.1 to read: "The waiting area shall be under staff control."
(xxxxx) Amend subsection 2.11-6.2.3.2 to read: "Where the outpatient psychiatric center has a dedicated pediatrics service, a separate, controlled area for pediatric patients shall be provided unless temporal separation is provided between adult and pediatric services (not seen at same or possible overlapping times)."
(yyyyy) Amend subsection 2.11-7.1.2 to read: "Observation of all public areas, including corridors, shall be provided."
(zzzzz) Amend subsection 2.11-7.1.2.1 to read: "This can be accomplished by electronic surveillance."
(aaaaaa) Amend subsection 2.12-1.2.1.2 to read: "Support areas may be shared in accordance with state and federal regulations."
(bbbbbb) Add 2.13-1.1.1.4 to read: “This chapter shall not be reviewed for Class 1 imaging mobile/transportable medical units that are to be used for less than 180 calendar days in a consecutive 12-month period while the permanent equipment and imaging space is receiving renovation or replacement work. Interim life safety measures shall be implemented and made available for review and inspection upon request. Documents shall record the arrival date and removal date of the trailer. A copy of these record documents shall be with the trailer for duration of placement."
(cccccc) Amend subparagraph (1)(b) in subsection 2.13-1.1.2.1 to read: "A single-patient exam room for specialty clinical services as described in Section 2.1-3.2 (Clinical Service Rooms)."
(dddddd) Amend subsection 2.13-1.3.7.4 to read: “Applicable local and state requirements. All imaging facilities installations must comply with OAR chapter 333, divisions 100 through 123, and be licensed by the Oregon Health Authority, Radiation Protection Services program."
(eeeeee) Amend subsection 2.13-3.1.2 to read: "All mobile/transportable medical units shall be provided with a hand-washing station in accordance with Section 2.1-3.8.7 (Hand-Washing Station). For Class 1 imaging units that are not already provided with a hand-washing station, a hand-sanitation dispenser shall be provided instead."

STATUTORY/OTHER AUTHORITY: ORS 441.060, ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 441.060, ORS 441.201