Individually-Based Limitations (IBL) Guidance

The below direction applies to IBLs requested on/after April 1, 2024

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Purpose

This document is intended to provide guidance to providers, Medicaid Case Managers (CM), individuals receiving Home and Community-Based Services and Settings (HCBS), regulatory staff, and other readers. It is not meant to be a set of step-by-step instructions for providers to follow. There will be many actions a provider will continue to take that are not addressed here. The focus of this document is solely on HCBS and Individually-Based Limitations (IBL).

HCBS

Effective January 1, 2016, Oregon adopted the federal regulations around **H**ome and **C**ommunity-**B**ased **S**ervices and Settings (HCBS), along with **I**ndividually-**B**ased **L**imitations (IBL), into Oregon Administrative Rules (OAR). (OAR 411-004-0000 – 411-004-0040).

The HCBS standards created by the federal Centers for Medicare & Medicaid Services were designed to support and promote an individual's right to privacy, dignity, respect and freedom from coercion and restraint. HCBS rules ensure individuals retain their rights to experience their community and have genuine choice and self-direction. No matter where an individual lives, they should be able to control their lives and make their own decisions about their life, as long as it is safe to do so. When an individual's decision impacts the health or safety of themselves or others, a provider may request an IBL. This document is intended to provide clarification around IBLs and related issues.

WHAT IS AN IBL?

An **I**ndividually-**B**ased **L**imitation is a restriction to a person's HCBS rights, freedoms or protections, and is applied due to health and/or safety risks to the individual and/or others. (OAR 411-004-0010(10)) This basically means a provider may limit one or more of an individual's HCBS rights, freedoms or protections using the process outlined below, with the individual's consent (OAR 411-004-0010(11)), when the individual's health or safety is at risk, or if the individual puts the health or safety of others at risk. IBLs must be based on a specific, assessed need and only implemented with the informed consent of the individual or their representative. An IBL cannot be 'proactive' (put in place to prevent an activity, for example); it must be used in response to an active safety risk/need for support. For more information about IBLs, refer to OAR 411-004-0040.

To learn more about each of the HCBS rights and IBLs, refer to the IBL Visual Fact Sheet, read OAR 411-004 and the documents found on Oregon's HCBS website. When requesting an IBL, the provider must complete an Individual Consent to HCBS Limitation(s) form, APD 0556 (also referred to as the 556, or the IBL form).

Every individual is unique. As we work through situations where an IBL may be appropriate, we need to honor the individual's preferences and decisions, making sure we try less restrictive measures whenever possible. Below are various scenarios to help guide providers and CMs as they determine whether an IBL is appropriate. These scenarios are provided as guidance-only, not as requirements.

WHEN IS AN IBL APPROPRIATE?

Starting April 1, 2024, for a provider to request an IBL, there must be a *moderate* health or safety risk to the individual and/or others. *Moderate Risk* means an identified concern, that without mitigation, is likely to cause the individual to experience minor injury or loss (of functioning, of housing, and/or financial loss of $2,000 or less), within the next 90 days or has experience minor loss in the previous 30 days that will likely recur or worsen without mitigation. Refer to "Risk Assessment: Risk Level Definitions" for more information.

To implement the IBL, the individual (or their representative) must consent to it. Providers should remember that individuals may make decisions that are different from the ones the provider would make on their behalf. Consider the three scenarios provided below.

Scenario: Food choices

Mandy has well-managed diabetes. She enjoys chocolate and eats it every day. Her provider requests an IBL restricting access to food at any time because they are concerned about the impact on her health.

Guidance: An IBL is not appropriate, since: (a) There is no moderate health/safety risk to Mandy; and (b) Mandy can decide for herself whether to continue eating chocolate or set limits. Mandy gets to make her own decisions, even if the provider does not agree with them.

Scenario: Dementia and walks

Charles has dementia. He has always enjoyed walks to the local park. Lately, he has been getting lost, has fallen, and cannot find his way back

to the facility. The provider wants to ensure he remains safe, so they propose an IBL limiting his 'right to control his own schedule' by having him not go on walks alone.

Guidance: An IBL may be appropriate, to have someone accompany him on his walks.

Scenario: Rowdy visitors

Larry's friend, Mark, visits after midnight several times a week. They play loud music and become increasingly rowdy, waking the other residents and putting the health/safety of others at risk. Even though the provider has explained their concerns, the rowdy visits continue. The provider requests an IBL limiting this visitor to 8:00 AM – 10:00 PM, but Larry refuses to consent.

Guidance: Larry's refusal to consent to the IBL means it cannot be implemented. However, Larry may have other consequences (such as receiving a move-out notice due to the health risks to other residents). The RCF is private property and the provider has the right to ban individuals from entering and/or trespass the individuals if they do enter. Banning a visitor would be the last resort after having tried other options, interventions and strategies – all of which failed.

LESS RESTRICTIVE OPTIONS (TO IBLS)

Prior to requesting an IBL, providers need to work with the individual to try less restrictive options.

Scenario: Open flame candles

Fiona has a history of falling. She lives in an AFH and wants to light candles in her room in the evenings. The provider proposes an IBL to prevent her use of candles, as the open flame creates a safety risk if Fiona falls and knocks the candle over.

Guidance: Instead of an IBL to limit her choice of decorations, the provider might first try less restrictive options, such as flameless alternatives like battery-powered tea lights.

Scenario: Dietary restrictions

Aya has diabetes and requests food she has been advised to not eat, resulting in high blood sugars. The provider is unsure about whether to request an IBL.

Guidance: Instead of an IBL restricting certain foods as the first action, the provider should try offering other options.

STEPS TOWARD IMPLEMENTING AN IBL

The following steps must be taken when an IBL is needed. [*See also "Individually-Based Limitation Process Flowchart" on Oregon's HCBS website, under the APD Program, within the Tools section*]

1. Less restrictive options (to an IBL) have been tried and have failed;
2. There is a moderate health or safety risk to the individual or others;
3. The provider requests an IBL;
4. The individual decides whether to consent to or refuse the IBL.

Consent: The individual's HCBS rights will be limited according to the IBL, which is documented and made part of their person-centered service plan.

Refusal to Consent: The individual's HCBS rights cannot be limited; which means the IBL cannot be put in place. The refusal is documented. If the moderate health/safety risk to others still exists, the provider may need to take further actions to keep others safe.

Scenario: Unsafe visitor

Monica's boyfriend, Glen, has a history of physically abusing Monica and has threatened to hurt other residents. The provider tried numerous, less restrictive options for safer visits, including structured and/or supervised visits; all attempts failed. The provider requested an IBL to restrict visits from Glen, but Monica refused to consent to it. The provider 'trespassed' Glen from the facility.

Guidance: Even though the IBL cannot be implemented, the provider may impose reasonable restrictions to protect the security of all residents, which may include denying access to visitors who have been found to be abusive.

TEMPORARILY CHANGING ONE'S MIND WHEN AN IBL IS IN PLACE

An individual with an existing IBL in place may change their mind (for a limited time) without having to revoke their consent to that IBL.

Scenario: Changing one's mind about having restricted visitor

Viola has an IBL (visitors at any time) stating her son cannot visit between 8:00 PM – 8:00 AM, as he is verbally abusive when alone with Viola. Viola's daughter asks if she can bring him with her when she comes to visit when she gets off work around midnight. Viola is ok with having them visit together, since her son is not verbally abusive when others are present. Viola is not revoking her consent to the existing IBL; she is simply allowing this late-night visit that does not pose a moderate risk to her health/safety.

CONSENT TO IBL – LEGAL REPRESENTATIVE/OTHER DESIGNEE

When a provider determines an IBL is needed and appropriate, they will complete an IBL Request form (APD 0556), justifying the need for the IBL. [*See also Individually-Based Limitation (IBL) Process Flowchart, located on Oregon's HCBS website, under the APD program, within the Tools section. Within the document,* ***Chart 1*** *is for individuals who are able to consent to an IBL, or those who have someone who can consent on their behalf.* ***Chart 2*** *is for individuals who are unable to consent to an IBL, and have no one who can consent on their behalf.*]

Individuals who are able to consent to IBL (Chart 1)

For individuals receiving Medicaid: The provider will send the IBL request to the CM, who will review it to ensure it is appropriate and complete. If not, the IBL will not be implemented. If so, the CM will discuss it with the individual to determine if consent is given. The CM must obtain written consent (or refusal to consent) and signature on the APD 0556 form. If consented to, the CM will update the individual's person-centered service plan (via Service Plan Agreement), and distributes copies to the individual and provider – the IBL is implemented, and the provider updates the individual's care plan. If consent is refused, the IBL does not go into effect; the signed APD 0556 is kept on file.

For individuals privately paying: The provider will meet with the individual, representative and/or witness, to discuss the IBL and determine if consent is given. The provider must obtain written consent (or refusal to consent) and

signature on the APD 0556 form. If consented to, the provider must update the individual's care plan and provide a copy to the individual – the IBL is implemented. If consent is refused, the IBL does not go into effect; the signed APD 0556 is kept on file for review at next regulatory onsite visit.

Individuals who are unable to consent to IBL, but have a Legal Representative or Other Designee (Chart 1)

When a qualified healthcare professional (QHP)* (who knows the individual and who does not work for the individual's care home/facility) determines that an individual is no longer able to make the LTC decisions under consideration (the issues for which the provider is proposing an IBL), the Provider and/or CM may use any responsible adult that has a history of positively relating to the individual to support them and act as a representative for the IBL decision, unless objected to by the individual. If someone is already designated in writing (such as someone designated on the SDS 0737 or advanced health care directive), use that person first. [Medicaid: Refer to APD-AR-17-041 and APD-PT-20-090] The representative cannot be a paid employee of the individual, or work for the individual's residential care provider.

> *Qualified Healthcare Professional (QHP) means a Physician, Physician's Assistant, Nurse Practitioner, Qualified Mental Health Professional, or Psychiatrist, who knows the individual, who does not work for the individual's care home/facility, and who makes the determination on whether the individual can consent to the IBL -- whether the individual can make this long-term care decision of consenting to limiting an HCBS right. *(It is **not** a determination of the individual's cognitive ability.)*

For individuals receiving Medicaid: The CM may have documented the individual's choice on the SDS 0737 (Client representative) form and entered in the Oregon ACCESS Case Management system, under the Contacts tab, using the role "Client Representative".

If no one has been designated in writing or when choosing from multiple options, APD will use the following priority order to determine who is willing and available for use:

- Guardian or other Legal Representative
- Spouse

- Majority of adult children
- Parent
- Majority of adult siblings
- Any adult relative or friend

If there is no one to appoint, guardianship may need to be pursued. The CM will work with the representative/designee for consent.

For individuals who privately pay: The provider will work with the individual's representative for consent.

Best Practice: At intake/initial assessment and reassessments (for CMs), or at admission and quarterly care conferences (for providers), request information about whom the individual would want to make decisions for them in the future, if they should lose the ability to make decisions for themselves. This request for information is completely voluntary for the individual; they are not required to provide the information as a condition of eligibility.

Honouring the Individual's Wishes: When someone other than the individual is asked to consent to an IBL on the individual's behalf (due to the individual's inability to consent), the representative should not override a valid objection the individual may have to the proposed IBL. Also, the representative should consider how the individual *would have* responded to the proposed IBL he/she still had the capacity to make a decision. In many cases, if the individual would not have consented, the guardian or representative likely should not either.

> **Scenario**: **Access to food at any time**
> Joan loves peppermint and always carries some candy with her. Joan also has dementia and sometimes chokes on her food. She recently moved into an MCC. The provider is concerned about the potential health risk of the candy on her blood sugar and proposes an IBL to limit her access to the candy. Joan's son says his mother has *always* carried peppermints with her. In fact, when she lived in an AFH prior to this, his mother refused to consent to a similar IBL. Joan's son does not consent to this proposed IBL.

UNABLE TO CONSENT TO IBL – NO LEGAL REPRESENTATIVE/OTHER DESIGNEE

When the individual is unable to consent to an IBL and there is no Legal Representative or other designee to assist with consent, the provider must obtain a written statement from a QHP that the individual is unable to consent to the IBL. (See Chart 2)

For individuals receiving Medicaid: The provider will send the QHP statement and the IBL request to the CM, who will review it to ensure it is appropriate and complete. If not, the IBL will not be implemented. If so, the CM update the individual's person-centered service plan (via Service Plan Agreement) with the IBL, noting the individual is "Unable to Consent" to the IBL in the section where the individual would normally sign, and send a copy to the provider – the IBL is implemented, and the provider updates the individual's care plan. The APD 0556 and written QHP statement is kept on file for review at next regulatory onsite visit.

For individuals who privately pay: The provider will note that the individual is "Unable to Consent" on the IBL request (APD 0556), in the section where the individual would normally sign. The IBL is implemented, and the provider must update the individual's care plan. The APD 0556 and written QHP statement is kept on file for review at next regulatory onsite visit.

REVOKING CONSENT TO AN IBL

When an IBL is in place, the individual may revoke consent to it at any time. This may be done in writing or verbally. Either way, the CM and provider will still need to update the person-centered service plan and the resident's care plan, respectively. An IBL means limiting a person's HCBS Rights, Freedoms and/or Protections. Therefore, when an IBL is revoked, the individual's right, freedom, or protection is "reinstated." To qualify for an IBL in the first place, someone's health/safety was at risk. The IBL was put in place to mitigate that risk. Revocation of the IBL, which is removing the IBL, means the individual's (or another person's) health/safety may once again at risk.

OTHER IMPORTANT TOPICS

Door locks/keys:

- According to the federal Centers for Medicare & Medicaid Services, each individual must have a unique lock on the entrance door to their living unit/bedroom, and they must be given a key. Only appropriate staff may also have the key. Housekeeping staff would be appropriate; lawn maintenance staff would not.)
- Providers cannot remove the lock for an individual who continually locks themself out of their room, even though it may be inconvenient for staff who have to unlock the door each time.
- The default is that there is a lock on every entrance door to each individual's entrance door to their living unit/bedroom. Refer to program OARs for approved lock types. The individual does not have to use the lock, but it must still be there – except in rare circumstances.
- The individual must be given a key, regardless of whether they can use it. The individual may choose what they do with the key, which may be storing it in a drawer or giving it to family.
- The provider should update each individual's care plan noting any specific preferences regarding the key.

Propping doors open: Each facility needs to ensure they are in compliance with Oregon Fire Code around door types, closing mechanisms, fire alarms, fire doors, hold-open devices and closers, and smoke-activated doors. Providers cannot use a 'blanket practice' of propping open resident doors for their convenience.

Provider responsibility regarding food: HCBS residential providers licensed by APD are required to provide three nutritious meals a day and:

- **AFHs** are required to offer nutritious snacks and liquids to fulfill each resident's nutritional requirements;

ALFs/RCFs are required to make snacks available 7 days a week.

IBL SCENARIOS

ACCESS TO FOOD AT ANY TIME (FREEDOM/SUPPORT TO HAVE)

Scenario: Prader-Willi Syndrome

Steve has Prader-Willi Syndrome, a rare genetic disorder that results in a number of physical, mental and behavioral support needs. People with this syndrome want to eat constantly because they never feel full. Steve can't stop himself from

eating everyone's food (not just his own), which really impacts his health. The AFH provider has already tried numerous options to keep him from eating other resident's food (including putting Steve's personal food items in a plastic tub in his room), with no success. The provider requests an IBL to install locks on the food cabinets and refrigerator/freezer, and will give keys to all other residents to ensure Steve may still access his own food, but not the food of others.

> **Guidance:** An IBL would be appropriate. Steve will still have access to his own food at any time, with the exception of refrigerated and frozen items. An IBL is not necessary for the other residents (since they will continue to have access to their own food at any time, via the key), unless the solution doesn't work out for someone. If another resident is unable to use the key, an IBL would be necessary for that individual, too, since they would not have access to their food at any time. If Steve did not have Prader-Willi and stole everyone's food as a choice, the provider could issue a move out notice. In this case, an IBL may be appropriate to keep Steve safe.

Scenario: Food during the night

Veda lives in an ALF and has a kitchenette in her unit. She often has insomnia. While she eats the meals and snacks the provider offers, she gets bored and hungry during the night and often wants to eat more food. The ALF requests an IBL to limit her access to food at any time, so they don't have to cook for her.

> **Guidance:** An IBL would not be appropriate, as the HCBS right is that the individual have access to their own food at any time. Since Veda's living unit has a kitchenette with food storage bins, a microwave and a refrigerator, Veda may prepare her own food at any time. If the provider has additional portions of uneaten food prepared for breakfast, lunch or dinner, and they are willing to offer it to Veda, she may heat that in her microwave at night.

DECORATE AND FURNISH OWN UNIT/BEDROOM (FREEDOM TO)

Scenario: Diagnosed with a hoarding disorder

Carmen has mental health needs and has been diagnosed with a hoarding disorder. On his daily walks, he finds garbage or rotting food and brings them to his room. He refuses to let anyone in to clean the room, but the smell of garbage

and rotting food is overwhelming. When the provider raises the issue with him, he says he has a right to decorate his room as he sees fit. The provider is concerned about:

- Carmen's health (asthma triggered by mold, falling, getting trapped by shifting or falling items, difficulty for emergency personnel to enter the unit and access Carmen, if needed);
- The health and safety of others;
- An increased risk of fire, fire ignition and fire severity due to combustible materials near ignition sources like a mini-fridge or microwave;
- An increased risk of pest infestation, including cockroaches and mice, and contamination;
- Building safety issues (such as when technicians cannot perform general maintenance, annual inspections, maintenance of HVAC equipment and sprinkler systems) and blocking the escape path; and
- Violation of building and public safety codes (blocking access to exits, windows and hallways, or interfering with proper ventilation in the unit, which could result in injuries).

The provider proposes an IBL to restrict Carmen's right to decorate by suggesting: (1) Piles/stacks be knee-height or lower; (2) A clear walkway, at least three feet wide, must be maintained from the entrance door to the bed, and from the bed to the bathroom; (3) Housekeeping staff must be allowed into the room once each day to remove rotting food, food containers, and other health hazards.

> **Guidance:** If the provider has tried less restrictive options and those have failed, an IBL would be appropriate. While Carmen does have a right to decorate his unit, he does not have the right to put the health and safety of others at risk. His HCBS right to decorate is also limited to what is in the Residency Agreement, agreed to by Carmen. If Carmen refuses to consent to the IBL, it may result in a move out notice.

PRIVACY IN OWN UNIT (ENTRANCE/BEDROOM DOOR LOCK)

Scenario: Propping door open – generally

Staff at a CBC setting have been propping all resident's doors open "for safety" so they can quickly see each resident as staff walk down the hall.

> **Guidance:** The CBC setting cannot use a 'blanket practice' of propping open resident doors for the convenience of their staff. Residents have the right to privacy in their living units/bedrooms, and their preferences should be noted in their care plans. Additionally, special consideration must be given to complying with Oregon Fire Code for the door type in each facility or home.

Scenario: Propping door open – no safety risk

Sheila lives in a CBC setting. She is alert and oriented. She asked staff if she can keep her door propped open during the day. The provider requests an IBL to prop the door open.

> **Guidance:** Staff confirmed that propping her door open does not violate Oregon Fire Code. There is no health or safety risk, so an IBL is not appropriate. Sheila can decide to keep her door open or closed. The provider has added her preference to her care plan.

Scenario: Propping door open – safety risk

Lakshmi has numerous medical conditions which cause frequent falls. They mostly happen in her room after she wakes up. To help prevent falls, the provider put a floor mat next to the bed and implemented silent bed sensors to alert staff when Lakshmi attempts to get up. Despite these interventions, Lakshmi continues to fall frequently. The provider requests an IBL to prop her entrance door open so staff can visually monitor her, impacting Lakshmi's privacy. Her family believe the IBL is a good idea, and they hope it will prevent a serious injury from a future fall.

> **Guidance:** An IBL may be appropriate. There is a documented history outlining the steps the provider has taken to protect Lakshmi's health and safety that did have not worked. The provider will need to obtain consent to implement the IBL.

Scenario: Door lock/key

Ben and Gus live in an MCC. They both have advanced dementia and continually lock themselves out of their rooms. When they get to their doors and can't get in:

Ben stands nearby and waits until staff unlock the door for him. The provider requests an IBL to prop open his door or remove the door lock, since having to unlock his door is inconvenient for staff.

Guidance: An IBL is not appropriate. While inconvenient for staff, there is no health/safety risk involved.

Gus paces, then gets visibly agitated, lashes out and pushes anyone nearby. The provider requests an IBL to prop open his door or remove the door lock.

Guidance: An IBL may be appropriate in this scenario, as Gus is putting the safety of others at risk. The provider would need to verify whether propping the door meets Oregon Fire Code, and determine which option is in line with Gus' preferences. If that cannot be determined, the provider should look at Gus' history and/or talk to Gus' family/friends to see which option Gus would prefer. This is one of the ***rare*** situations where it may be appropriate to remove a lock from an individual's entrance door to their living unit/bedroom.

RESTRAINT/COERCION (FREEDOM FROM)

NOTE: A workgroup representing several ODHS program areas is being formed to discuss the need for possible amendments to OARs to ensure residents retain their HCBS rights while remaining safe when restraints and/or supportive devices with restraining qualities are used.

Scenario: Physical restraint - chair

Elise cannot get up/out of a low chair without either her walker or physical assistance. The provider wants to "keep her safe" while helping a different resident in another room – so they seat Elise in a low chair briefly and move her walker out of reach while they assist the other resident.

Guidance: Since Elise cannot get out of the chair on her own without the walker, this is a restraint. Specific OARs must be followed for any restraint, including having an IBL. There was no IBL. The Licensor cited this provider, who violating Elise's HCBS rights by restraining her for their own convenience.

Scenario: Physical restraint – bed rail [AFH]

Charlene lives in an AFH. She requests a partial bed rail to steady herself when shifting her weight from the bed to the floor. Her doctor agrees that bed rails would benefit her and provides a written order for the bed rail. While Charlene can get out of bed on her own without it, she still wants one. The provider does not request an IBL since Charlene's health/safety is not at risk. The provider documents the information in Charlene's person-centered service plan, and care plan; and the information is also reflected in weekly progress notes.

> **Guidance:** Since Charlene can get out of bed on her own, it is not a physical restraint, per say. However, under current OAR for AFHs, **an IBL is needed** in addition to the doctor's order when an individual has a bed rail (partial or full). The provider needs to request an IBL.

Scenario: Physical restraint – bed rail [AFH]

Dion lives in an AFH. He and his family want him to have a bed rail to ensure he does not fall out of bed at night (again), as he moves a lot in his sleep. His doctor agrees that a bed rail would benefit him and provides a written order for it. Even though Dion cannot get out of bed on his own with it in place, he still wants the bed rail. The provider requests an IBL and documents this information in Dion's person-centered service plan, care plan and the information is also reflected in weekly progress notes.

> **Guidance:** Since Dion cannot get out of bed on his own, this is a physical restraint. The IBL is appropriate. Under current OAR for AFHs, an IBL is needed in addition to the doctor's order whenever an individual has a bed rail (partial or full).

Scenario: Physical restraint – bed rail [CBC]

Tracy lives in a CBC setting. She requests a partial bed rail to help her reposition herself while in bed. Tracy can get out of bed on her own. The facility's Physical Therapist does a thorough assessment and finds that a partial bed rail would benefit Tracy. Tracy and facility direct care staff have been instructed on the correct use/precautions. The provider isn't sure whether to request an IBL since Tracy's health/safety are not at risk. The provider has documented alternatives they've tried that did not work; and they document this information in Tracy's person-centered service plan, care plan and the information is also reflected in weekly progress notes.

Guidance: Tracy can get out of bed on her own, and her health/safety are not at risk. Under current OAR for CBCs, this partial bed rail is considered a "supporting device with restraining qualities", not a restraint. Therefore, **no IBL is needed**.

Scenario: Physical restraint – bed rail [CBC]

Marcus lives in an ALF. He has some cognitive and mobility issues, including difficulty getting out of bed, due to a stroke. Marcus' family wants the ALF to use a bed rail to keep him from falling out of bed. The provider requests an IBL, documents the information in Marcus' person-centered service plan, care plan and the information is also reflected in weekly progress notes.

Guidance: First, an IBL would not be appropriate at this time. A request from Marcus' family is not sufficient reason to use a bed rail; there must be a medical need, a thorough assessment and comply with state regulations. Second, the provider should attempt less restrictive options with Marcus (documented in his care plan), such as lowering the bed close to the floor. If it is later determined that Marcus needs a bed rail, one may be requested. Third, under current OAR for CBCs, full bed rails meet the definition of a physical restraint. This means an IBL will be necessary if a full bed rail is used.

Scenario: Chemical restraint

Ed lives in an MCC. Staff noticed that Ed frequently becomes more active in the evening and displays wandering and exit-seeking behavior. This "sundowning" behavior occurs during the resident's dining and evening medication time, while most staff are assisting residents with meals or medication distribution. Ed requires frequent redirection and monitoring to bring him back to his meal and away from facility exits. He also tries to push past visitors as they come and go. Facility staffing levels have been difficult to maintain, so the provider requests an IBL to medicate Ed with melatonin in the early evening, so his behaviors are easier to manage. Ed's family is concerned, as this medication has led to falls in the past and has caused Ed to sleep through meals.

Guidance: An IBL would not be appropriate. This IBL request is for the convenience of staff rather than for the health or safety of Ed and others. Medications can be considered a chemical restraint and must never be used for staff convenience. In addition, the provider has not documented additional interventions short of restricting Ed's HCBS rights. Further, they

do not have a doctor's order for the medication. An APS referral might be appropriate if we have reason to suspect abuse, such as giving medication to residents without a doctor's order.

ROOMMATES (CHOICE OF; IN SHARED ROOM MODELS)

Scenario: Unable to communicate preferences in Memory Care

Hans lives in a shared room in an MCC. The provider has several prospective roommates, but due to Hans' cognitive impairment, he can no longer verbally indicate his preference. The provider asks for an IBL to choose the roommate without his input.

Guidance: The IBL may not be appropriate, depending on the level of Hans' impairment. Hans should be included in the process of selecting the roommate. The provider can arrange for them to meet, and can share information about their interests at that time. Hans may have ways to communicate his preference through body language, eye movements or other physical actions, including hugging or pushing the person away. In some cases, the choice may have to be determined through person-centered planning between the CM, provider, resident and their family/friends. If no other option exists, an IBL may be considered.

Scenario: Choosing friend as roommate

Diana and Susan move into an AFH at the same time. Until now, they've lived in separate rooms. A shared room opens up, and they decide they'd like to move into it together. The provider is not sure about HCBS and IBL requirements, so she has them sign a form stating this is their preference/agreement, and proposes an IBL around choice of roommates.

Guidance: In this scenario, an IBL would not be appropriate. The HCBS right is to have a choice in who one's roommate will be. In this scenario, Diana and Susan chose each other. (If an IBL was put in place, it would be to *remove* the ability for the individual(s) to choose their own roommate.) Additionally, there is no moderate health or safety risk that might necessitate an IBL.

SCHEDULE/ACTIVITIES (FREEDOM/SUPPORT TO CONTROL OWN)

Scenario: Alcohol

Tayn lives in an AFH, and likes to drink alcohol, which he does in moderation. When he goes to the bar, though, he always drinks to excess, resulting in dangerous behaviors that create health/safety risks for other residents. The provider requests an IBL to restrict Tayn's "control of his own activities" (going to the bar to drink alcohol), preferring to have Tayn drink at home. When considering whether to consent to the IBL, Tayn asks if the provider will be taking him to the liquor store to purchase the alcohol. The provider is unsure if they are allowed to do this.

> **Guidance:** Tayn's dangerous behaviors happen after getting intoxicated at the bar, so this IBL may be appropriate. If Tayn chooses to continue drinking at the bar – with behaviors that affect the health/safety of others – the provider could issue him a move out notice. If Tayn consents to an IBL, the provider may support Tayn's decision to buy alcohol for home consumption. If willing, the provider may stop at the liquor store while out grocery shopping with Tayn, so he may buy alcohol. Otherwise, Tayn may make his own arrangements to buy alcohol.

Scenario: Adult entertainment

Ethan regularly goes to a strip club. The provider disapproves his choices and requests an IBL to prevent Ethan from "controlling his own activities" of going to the club, and doesn't want to support it in any way.

> **Guidance**: Requesting an IBL simply to prevent him from doing an activity of which the provider disapproves is not appropriate. The provider does not have to agree with Ethan's choice of activities, but may still support Ethan's choices. For instance, the provider may arrange for transportation to/from the club, or help Ethan obtain information about public transportation. Or Ethan may make his own arrangements for transportation to/from the club.

Scenario: Scheduled meals

Several residents at an MCC have a weekly Book Club on Wednesday at 4:30 PM. The facility serves dinner in the dining room from 4:00–6:00 PM. The group asks to either have their meals held until 5:30 PM (when they are done with their meeting and can get to the dining room) or have their meals brought to the activity room between 4:00–6:00 PM. The provider requests an IBL for each of the residents to limit "control of their own schedule/activities", to have them join the

others in the dining room at 4:00 PM, or forgo having dinner at the facility on Wednesdays.

> **Guidance:** An IBL would not be appropriate in this instance. HCBS rights allow the residents to control their own schedules and activities, which includes when they eat dinner. If the residents miss a scheduled dinner, the provider may save that meal for them to be re-heated when the residents are ready to eat. Or the provider may grant one of the group's requests. Additionally, there is no moderate health/safety risk.

Scenario: Smoking with oxygen

Richard smokes while using oxygen. The provider requests an IBL to limit his control of this activity. Richard understands the risks but continues anyway, refusing to consent to the IBL.

> **Guidance:** In this case, Richard is making the conscious decision to continue putting the safety of others in danger. The provider needs to demonstrate interventions they have put in place, and may issue a move out notice.

Scenario: Smoking

Juan lives in a non-smoking AFH. He enjoys smoking pipe tobacco and propels his wheelchair across the street to a nearby park to smoke each day. The provider requests an IBL to limit his control of his own activities and wants to confiscate the pipe and tobacco, stating that Juan agreed to not smoke when he signed the Residency Agreement.

> **Guidance:** An IBL would not be appropriate. Juan has the right to smoke if he is not on the AFH property when he does so. The Residency Agreement pertains only to his smoking on the property.

VISITORS OF OWN CHOOSING AT ANY TIME

Scenario: Intoxicated while having visitors

Joe lives in a CBC setting and has a substance use disorder around alcohol. When intoxicated, Joe frequently invites visitors that are finically exploitative and destructive to the facility. When sober, Joe requests the facility staff to deny entry to those specific visitors any time he is intoxicated, even if he begs and pleads. Joe

signs a contract with the facility to ensure staff do not admit the visitors when he is intoxicated. The provider requests an IBL for Joe's "access to visitors at any time."

> **Guidance:** When drinking alcohol, Joe's judgment is impaired, and he puts his health and safety at risk. In this situation, an IBL would be appropriate.

Scenario: Late visits

Ivan lives in an AFH and enjoys daily visits from his granddaughter when she gets off work around 2:00 AM. While she only stays for a half-hour, they are quiet and stay in the living room. The provider requests an IBL to prevent visitors after 10:00 PM, as that is when they lock the doors for the night.

> **Guidance:** An IBL would not be appropriate. Ivan has a right to visitors at any time. The visits do not put anyone's health/safety at risk. Ivan could unlock/re-lock the door when his granddaughter enters/exists. The provider might set a personal alarm to wake up and open the door at 2:00 AM and/or lock the door at 2:30 AM, rather than waiting up the entire time. It is not appropriate to request an IBL to make things more convenient for the provider.

Scenario: Exploitive visitor

Betty has dementia. Her nephew visits her late at night. Each time, he has taken advantage of her financially. Sometimes her nephew visits with other family members, and no harm has come to Betty during these visits. The provider requests an IBL limiting all of Betty's visitors to come between 8:00 AM–5:00 PM, and requiring them to stay in the facility's common areas.

> **Guidance:** The proposed IBL is too restrictive. Betty's nephew takes advantage of her, so an IBL needs to be specific to his visits. The proposed solution is appropriate for when the nephew visits alone. However, it shouldn't apply when the nephew visits accompanied by other family members. The IBL should shield Betty from future financial exploitation, yet still allow her to visit with her nephew in the least restrictive way possible.

NOT AN HCBS FREEDOM, RIGHT OR PROTECTION

Scenario: Health hazard

Yuka has a brain injury and lives in an AFH. She refuses to wash her hands after toileting, then touches food or areas that are commonly used by others. The provider requests an IBL to keep her and others in the home safe, but doesn't know which "HCBS Right" to limit.

> **Guidance:** An IBL is not appropriate because this situation is tied to her ability to perform the activities of daily living (ADL) around personal hygiene, not to an HCBS right, freedom or protection. However, Yuka's behavior causes a safety risk for everyone. The provider should discuss the situation with Yuka's CM to ensure Yuka has the supports she needs. They may also try different ways to remedy the situation, like posting visual aids in bathroom, using soap with a scent Yuka really likes, using verbal reminders as she exits the bathroom, and using hand sanitizer.

Scenario: Vehicle modification

Quinn has a brain injury and becomes escalated during transport. He has unbuckled himself and attacked the driver on more than one occasion, and has attempted to exit the vehicle while it is still moving. The provider now uses the "child safety lock" feature on the rear doors, but needs a way to keep the driver safe. The provider requests an IBL to install a safety partition between the driver and the back seat of the vehicle.

> **Guidance**: An IBL is not appropriate because installing/having a safety partition in a vehicle is not an HCBS right, freedom or protection.

GLOSSARY OF ACRONYMS

AAA – Area Agency on Aging

AFH – Adult Foster Home

ALF – Assisted Living Facility

APD – Aging and People with Disabilities

AR – Action Request (Policy Transmittal requiring action from staff)

CBC – Community Based Care

CM – Medicaid Case Manager

HCBS – Home and Community-Based Services and Settings

IBL – Individually-Based Limitation

ICAA – Oregon’s Indoor Clean Air Act

LTC – Long Term Care

MCC – Memory Care Community

OAR – Oregon Administrative Rule

ODHS – Oregon Department of Human Services

OFC – Oregon Fire Code

PT – Policy Transmittal

RA – Residency Agreement

RCF – Residential Care Facility

SDS – Senior and Disabled Services (used as part of a form number)