81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

A-Engrossed
Senate Bill 266

Ordered by the Senate April 26
Including Senate Amendments dated April 26

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

[*Requires Department of Human Services to study and make recommendations to interim committees of Legislative Assembly, no later than September 15, 2022, for legislative changes needed to improve care of residents and training of staff in long term care facilities.*]

[*Sunsets January 2, 2023.*]

Requires Department of Human Services to consider specified factors in assessing whether residential care facility or facility with memory care endorsement has qualified awake direct care staff in sufficient numbers to meet scheduled and unscheduled needs of each resident 24 hours a day.

Requires entity that investigates abuse complaint at facility to provide initial status report to agency that licenses facility.

Adds requirements regarding investigation of complaints that facility does not have qualified awake direct care staff in sufficient numbers to meet scheduled and unscheduled needs of each resident 24 hours a day.

Requires department to prioritize health, welfare, safety and rights of residents in regulating residential care facilities and long term care facilities.

Requires department to impose condition on license of residential care facility or long term care facility in response to finding of immediate jeopardy.

Requires framework developed by department for assessing regulatory compliance of residential care facilities to include measures of whether facility has qualified awake direct care staff in sufficient numbers to consistently meet scheduled and unscheduled needs of each resident 24 hours a day and impact of any compliance deficiencies on rights, health, welfare and safety of residents.

Requires department to post on facility finder website notice that facility is in enhanced oversight and supervision program.

Requires department, no later than April 1, 2022, to publish and distribute framework to facilities, fully implement enhanced oversight and supervision programs and report to Legislative Assembly on publishing and distribution of framework and implementation of enhanced oversight and supervision program.

Takes effect on 91st day following adjournment sine die.

1 **A BILL FOR AN ACT**

2 Relating to licensure of long term care facilities; creating new provisions; amending ORS 441.650,
3 441.676, 441.677, 441.705, 441.726, 441.736 and 443.436; and prescribing an effective date.
4 **Be It Enacted by the People of the State of Oregon:**
5 **SECTION 1. (1) As used in this section:**
6 **(a) "Consistently" means regularly and typically.**
7 **(b) "Direct care staff" means staff who provide services for residents that include as-**
8 **sistance with daily living, medication administration, resident-focused activities, supervision**
9 **and support.**
10 **(c) "Facility" includes a:**
11 **(A) Residential care facility as defined in ORS 443.400; and**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(B) Facility with a memory care endorsement under ORS 443.886.

(2) In determining whether a facility has qualified awake direct care staff in sufficient numbers to meet the scheduled and unscheduled needs of each resident 24 hours a day as prescribed by rule, the Department of Human Services shall conduct an assessment, in accordance with rules for home and community-based settings adopted by the Centers for Medicare and Medicaid Services, and consider whether the facility consistently:

(a) Implements and maintains a current person-centered service plan for each resident as required by rule by the Centers for Medicare and Medicaid Services;

(b) Provides timely access, 24 hours a day, to all supports needed for activities of daily living including eating, hydration, toileting, hygiene, bathing, dressing, oral care and other supports included in the resident's person-centered service plan;

(c) Provides a timely response to issues impacting the dignity of the resident, including but not limited to wet or soiled briefs, clothing or linens; and

(d) Delivers care according to the schedule and procedures outlined in the resident's person-centered service plan, including but not limited to wound care, medication administration, pain control, behavior support, cueing and repositioning.

SECTION 2. ORS 441.650 is amended to read:

441.650. (1) Upon receipt of the oral or written report required under ORS 441.640, or of an abuse complaint, the area agency on aging, the Department of Human Services or the law enforcement agency shall cause an investigation to be commenced as follows:

(a) Within two hours, if the complaint alleges that a resident's health or safety is in imminent danger or that the resident has recently died, been hospitalized or been treated in an emergency room; or

(b) Prior to the end of the next working day, if the complaint alleges that circumstances exist that could result in abuse and that the circumstances could place a resident's health or safety in imminent danger.

(2) If the law enforcement agency conducting the investigation finds reasonable cause to believe that abuse has occurred, the law enforcement agency shall notify in writing the local office of the area agency or the department as appropriate. Except in cases where the investigation is part of nursing facility surveyor activity pursuant to federal law, the area agency or the department shall complete an initial status report within two working days of the start of the investigation that includes:

(a) A summary of the complaint that identifies each alleged incident or problem;

(b) The status of the investigation;

(c) Whether an abuse complaint was initially filed at the direction of the administration of the facility;

(d) A determination of whether protection of the resident is needed and whether the facility must take action;

(e) The name and telephone number of the investigator; and

(f) The projected date that the investigation report will be completed and a statement that the report will be available upon request after the department issues a letter of determination.

(3) The initial status report described in subsection (2) of this section shall be provided either in person or by mail to the following individuals as soon as practicable, but no later than two working days after its completion:

(a) The complainant, unless the complainant waives the requirement;

1 (b) If the complaint involves a specific resident, the resident or a person designated to receive
2 information concerning the resident;
3 (c) A representative of the Long Term Care Ombudsman, upon request; [*and*]
4 (d) The long term care facility**; and**
5 **(e) The agency that licenses the facility**.
6 (4) The initial status report described in subsection (2) of this section shall be available for
7 public inspection.
8 (5) When copies of the initial status report described in subsection (2) of this section are made
9 available to individuals listed in subsection (3) of this section, the names of the resident involved,
10 the complainant and any individuals interviewed by the investigator shall be deleted from the copies.
11 (6) In investigating an abuse complaint, the investigator shall:
12 (a) Make an unannounced visit to the facility, except as provided by ORS 441.690, to determine
13 the nature and cause of the abuse of the resident;
14 (b) Interview all available witnesses identified by any source as having personal knowledge rel-
15 evant to the abuse complaint, such interviews to be private unless the witness expressly requests
16 the interview not to be private;
17 (c) Make personal inspection of all physical circumstances that are relevant and material and
18 that are susceptible to objective observation; and
19 (d) Write an investigation report that includes:
20 (A) The investigator's personal observations;
21 (B) A review of documents and records;
22 (C) A summary of all witness statements; and
23 (D) A statement of the factual basis for the findings for each incident or problem alleged in the
24 complaint.
25 (7) Within five working days of completion of the investigation and not later than 60 days from
26 completion of the initial status report described in subsection (2) of this section, the investigator
27 shall provide the department with the written report required by subsection (6) of this section. The
28 department shall make the investigation report available upon request after the letter of determi-
29 nation is complete. When copies of the report are made available, the names of the resident in-
30 volved, the complainant and any individuals interviewed by the investigator shall be deleted from
31 the copies.
32 **SECTION 3.** ORS 441.676 is amended to read:
33 441.676. **(1) As used in this section:**
34 **(a) "Consistently" means regularly and typically.**
35 **(b) "Direct care staff" means staff who provide services for residents that include as-**
36 **sistance with daily living, medication administration, resident-focused activities, supervision**
37 **and support.**
38 [*(1)*] **(2)(a) Except as provided in paragraph (b) of this subsection,** for complaints of licensing
39 violations other than abuse, the Department of Human Services shall cause an investigation to be
40 completed within 90 days of the receipt of the complaint.
41 **(b) For complaints of licensing violations other than abuse that allege harm or potential**
42 **harm to a resident or for complaints that a facility does not have qualified awake direct care**
43 **staff in sufficient numbers to meet the scheduled and unscheduled needs of each resident 24**
44 **hours a day, the department shall cause an investigation to begin without undue delay.**
45 [*(2)*] **(3)** Except in cases where the investigation is part of nursing facility surveyor activity

1 pursuant to federal law, an investigator investigating a complaint other than a complaint of abuse
2 shall:
3 (a) Make an unannounced visit to the facility, while complying with ORS 441.690;
4 (b) Interview all available witnesses identified by any source as having personal knowledge rel-
5 evant to the complaint, such interviews to be private unless the witness expressly requests the
6 interview not to be private;
7 (c) Make personal inspection of all physical circumstances that are relevant and material and
8 that are susceptible to objective observation; [*and*]
9 **(d) Assess whether the facility has qualified awake direct care staff in sufficient numbers**
10 **to consistently meet the scheduled and unscheduled needs of each resident 24 hours a day,**
11 **if the complaint:**
12 **(A) Alleges harm or potential harm to a resident;**
13 **(B) Alleges injury to a resident; or**
14 **(C) Concerns staffing levels or the ability of the facility's direct care staff to consistently**
15 **meet the scheduled and unscheduled needs of each resident 24 hours a day; and**
16 [*(d)*] **(e)** Write an investigation report that includes:
17 (A) The investigator's personal observations;
18 (B) A review of documents and records;
19 (C) A summary of all witness statements; and
20 (D) A statement of the factual basis for the findings for each incident or problem alleged in the
21 complaint **including, if applicable, the investigator's assessment of staffing levels and whether**
22 **the facility has qualified awake direct care staff in sufficient numbers to consistently meet**
23 **the scheduled and unscheduled needs of each resident 24 hours a day**.
24 **SECTION 4.** ORS 441.726 is amended to read:
25 441.726. **(1)** In regulating residential care facilities and long term care facilities, the Department
26 of Human Services shall[*, whenever possible, use*] **prioritize the health, welfare, safety and rights**
27 **of residents.**
28 **(2) The department may, as appropriate, use** a progressive enforcement process that employs
29 a series of actions to encourage and compel compliance with licensing regulations through the ap-
30 plication of preventive, positive and progressively more restrictive strategies. Preventive and posi-
31 tive strategies are strategies that include but are not limited to technical assistance, corrective
32 action plans, training and consultation.
33 **(3) This section does not restrict the ability of the department to use more restrictive**
34 **strategies when necessary to achieve substantial compliance or to protect the health, wel-**
35 **fare, safety and rights of residents, including by imposing license conditions under ORS**
36 **441.736 or, for residential care facilities, taking additional steps dictated by the framework**
37 **established under ORS 443.436.**
38 **SECTION 5.** ORS 441.736 is amended to read:
39 441.736. (1) As used in this section:
40 (a) "Immediate jeopardy" means a situation in which the failure of a residential care facility or
41 a long term care facility to comply with a rule of the Department of Human Services has caused
42 or is likely to cause serious injury, serious harm, serious impairment or death to a resident.
43 (b) "License condition" includes but is not limited to:
44 (A) Restricting the total number of residents;
45 (B) Restricting the number and impairment level of residents based upon the capacity of the

1 licensee and staff to meet the health and safety needs of all residents;
2 (C) Requiring additional staff or staff qualifications;
3 (D) Requiring additional training for staff;
4 (E) Requiring additional documentation; or
5 (F) Restriction of admissions.
6 (c) "Substantial compliance" means a level of compliance with state law and with rules of the
7 department such that any identified deficiencies pose a risk of no more than negligible harm to the
8 health or safety of residents of a residential care facility or a long term care facility.
9 (2)(a) The department may impose a condition on the license of a residential care facility or long
10 term care facility in response to a substantiated finding of rule violation, including but not limited
11 to a substantiated finding of abuse, [*or*] **and shall impose a condition on the license** in response
12 to a finding of immediate jeopardy, whether or not the finding of immediate jeopardy is substantiated
13 at the time the license condition is imposed.
14 (b) The department shall impose a license condition in a scope and manner that is specifically
15 designed to remediate the finding that led to the license condition.
16 (c) If the department imposes a license condition in response to a finding of immediate jeopardy
17 to residents of the facility, and the finding of immediate jeopardy to residents of the facility is not
18 substantiated within 30 days after the imposition of the license condition, the department shall im-
19 mediately remove the license condition.
20 (d)(A) Except as provided in subparagraph (B) of this paragraph, the department shall provide
21 a facility with a notice of impending imposition of license condition at least 48 hours before issuing
22 an order imposing a license condition. The notice must:
23 (i) Describe the acts or omissions of the facility and the circumstances that led to the substan-
24 tiated finding of rule violation or finding of immediate jeopardy supporting the imposition of the li-
25 cense condition;
26 (ii) Describe why the acts or omissions and the circumstances create a situation for which the
27 imposition of a license condition is warranted;
28 (iii) Provide a brief statement identifying the nature of the license condition;
29 (iv) Provide a brief statement describing how the license condition is designed to remediate the
30 circumstances that led to the license condition; and
31 (v) Provide a brief statement of the requirements for withdrawal of the license condition.
32 (B) If the threat to residents of a facility is so imminent that the department determines it is
33 not safe or practical to give the facility advance notice, the department must provide the notice
34 required under this paragraph within 48 hours of issuing an order imposing the license condition.
35 (e) An order imposing a license condition must include:
36 (A) A specific description of how the scope and manner of the license condition is designed to
37 remediate the findings that led to the license condition; and
38 (B) A specific description of the requirements for withdrawal of the license condition.
39 (3) The department may impose a license condition that includes a restriction on admissions to
40 the facility only if the department makes a finding of immediate jeopardy that is likely to present
41 an immediate jeopardy to future residents upon admission.
42 (4)(a) Following the imposition of a license condition on a facility, the department shall:
43 (A) Within 15 business days of receipt of the facility's written assertion of substantial compli-
44 ance with the requirements set forth by the department for withdrawal of the license condition, re-
45 inspect or reevaluate the facility to determine whether the facility has achieved substantial

compliance with the requirements;

(B) Notify the facility by telephone or electronic means of the findings of the reinspection or reevaluation within five business days after completion of the reinspection or reevaluation; and

(C) Issue a written report to the facility within 30 days after the reinspection or reevaluation notifying the facility of the department's determinations regarding substantial compliance with the requirements necessary for withdrawal of the license condition.

(b) If the department finds that the facility has achieved substantial compliance regarding the violation for which the license condition was imposed, and finds that systems are in place to ensure similar deficiencies do not reoccur, the department shall withdraw the license condition.

(c) If after reinspection or reevaluation the department determines that the violation for which the license condition was imposed continues to exist, the department may not withdraw the license condition, and the department is not obligated to reinspect or reevaluate the facility again for 45 days after the first reinspection or reevaluation. The department shall provide the decision not to withdraw the license condition to the facility in writing and inform the facility of the right to a contested case hearing pursuant to ORS chapter 183. Nothing in this paragraph limits the department's authority to visit or inspect the facility at any time.

(d) If the department does not meet the requirements of this subsection, a license condition is automatically removed on the date the department failed to meet the requirements of this subsection, unless the Director of Human Services extends the applicable period for no more than 15 business days. The director may not delegate the power to make a determination regarding an extension under this paragraph.

SECTION 6. ORS 443.436 is amended to read:

443.436. (1) As used in this section[,]**:**

(a) "Consistently" means regularly and typically.

(b) "Substantial compliance" means a level of compliance with state law and with rules of the Department of Human Services such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents.

(2)(a) The department shall develop a framework for assessing the compliance of residential care facilities with regulatory requirements and for requiring corrective action that accurately and equitably measures compliance and the extent of noncompliance.

(b) The framework must include but is not limited to measures of the severity and scope of a residential care facility's noncompliance**, including but not limited to:**

(A) Whether the facility has qualified awake direct care staff in sufficient numbers to consistently meet the scheduled and unscheduled needs of each resident 24 hours a day; and

(B) The impact of any compliance deficiencies on the rights, health, welfare and safety of the residents.

(c) The department shall publish the framework on the department's website and shall distribute the framework to residential care facilities licensed in this state.

(3) The department shall administer a residential care facility enhanced oversight and supervision program that focuses department resources on residential care facilities that consistently demonstrate:

(a) A lack of substantial compliance with the requirements of ORS 443.400 to 443.455 **or rules adopted to implement ORS 443.400 to 443.455**; or

(b) Performance substantially below statewide averages on quality metrics reported under the Residential Care Quality Measurement Program established under ORS 443.446.

(4) The residential care facility enhanced oversight and supervision program shall take one or more of the following actions that the department deems necessary to improve the performance of a residential care facility:

(a) Increase the frequency of surveys of the residential care facility.

(b) Conduct surveys that focus on areas of consistent noncompliance identified by the department.

(c) Impose one or more conditions on the license of the facility under ORS 441.736.

(5) The department shall terminate the enhanced oversight and supervision of a residential care facility:

(a) After three years if the residential care facility has shown through at least two consecutive on-site surveys and reported quality metrics that the residential care facility no longer meets the criteria set forth in subsection (3) of this section; or

(b) After one year if the residential care facility submits a written assertion of substantial compliance and the department determines that the residential care facility no longer meets the criteria set forth in subsection (3) of this section.

(6) The department shall publish notice on the department's website, including any website where the public can access a database of long term care facilities, of any residential care facility that is in the enhanced oversight and supervision program.

[*(6)*] **(7)** Using moneys from the Quality Care Fund established under ORS 443.001, the department shall develop, maintain and periodically update compliance guidelines for residential care facilities serving seniors and persons with disabilities. The guidelines must be made available electronically.

[*(7)*] **(8)** This section does not preclude the department from taking any action authorized by ORS 443.400 to 443.455.

SECTION 7. ORS 441.705 is amended to read:

441.705. As used in ORS 441.705 to 441.745:

(1) "Direct patient care or feeding" means any care provided directly to or for any patient related to that patient's physical, medical and dietary well-being as defined by rules of:

(a) The Department of Human Services when the facility is a long term care facility, as defined in ORS 442.015, or a residential care facility, residential training facility or residential training home[*, as those terms are defined in ORS 443.400*]; and

(b) The Oregon Health Authority if the facility is a residential treatment facility or a residential treatment home[*, as defined in ORS 443.400*].

(2) "Person" means a licensee of a long term care facility, a residential care facility, a residential training facility, a residential treatment facility, a residential training home or a residential treatment home, or an unlicensed person who the Director of Human Services finds should be licensed to operate a long term care facility, a residential care facility, a residential training facility or a residential training home, or an unlicensed person who the Director of the Oregon Health Authority finds should be licensed to operate a residential treatment facility or residential treatment home. "Person" does not mean an employee of a licensee or unlicensed person who the Director of Human Services or the Director of the Oregon Health Authority finds should be licensed.

(3) "Residential care facility," "residential training facility," "residential training home," "residential treatment facility" and "residential treatment home" have the meanings given those terms in ORS 443.400.

[*(3)*] **(4)** "Staff to patient ratio" means the number and training of persons providing direct pa-

tient care as defined in rules of the:

(a) Department if the facility is a long term care facility, a residential care or residential training facility or a residential training home; or

(b) Authority if the facility is a residential treatment facility or a residential treatment home.

SECTION 8. ORS 441.677 is amended to read:

441.677. (1) Within 60 days of receipt of the investigation documents and the written report described in ORS 441.650 (6)(d) and 441.676 [*(2)(d)*] **(3)(e)**, but in no case longer than 120 days after an investigation has been commenced pursuant to ORS 441.650 or 441.676, the investigation shall be completed and the Department of Human Services shall prepare a written letter of determination that states the department's determinations concerning each incident or problem alleged in the complaint. The department shall determine whether the alleged incident or problem was substantiated or unsubstantiated or whether the department was unable to substantiate the alleged incident or problem. The department shall adopt by rule definitions for the terms "substantiated," "unsubstantiated" and "unable to substantiate." If the department determines that an incident or problem alleged in the complaint is substantiated, the letter of determination shall state whether the substantiated incident was abuse or violation of another rule. If abuse is substantiated, the letter of determination shall state whether the facility or an individual, or both, was responsible. The department shall adopt by rule criteria for determining responsibility for substantiated abuse.

(2) A copy of the letter of determination shall be placed in the facility's complaint file. Copies shall be sent to the facility, the complainant and the local office of the department. The facility and the complainant receiving the letter of determination shall be given 10 days to respond with additional information and shall be informed of the appeals process.

(3) If the department determines that an individual who holds a license or certificate for a health occupation is directly responsible for the abuse, the department shall send a copy of its letter of determination and investigation report to the state agency responsible for licensing or certifying the individual in the health occupation. In instances involving conduct of a nursing assistant, the department shall give the nursing assistant 10 days to respond with additional information. The department also shall notify by mail the nursing assistant implicated in the investigation of:

(a) The nature of the allegations;

(b) The date and time of occurrence;

(c) The right to a contested case hearing conducted in accordance with ORS chapter 183;

(d) The department's obligation to report the substantiated findings in the registry maintained under ORS 441.678 after the nursing assistant has had an opportunity for a contested case hearing; and

(e) The fact that the nursing assistant's failure to request a contested case hearing within 30 days from the date of the notice will result in the department's reporting the substantiated findings in the registry maintained under ORS 441.678.

(4) Notice sent to the nursing assistant's last-known address is sufficient to meet the requirements of subsection (3) of this section.

SECTION 9. No later than April 1, 2022, the Department of Human Services shall:

(1) Publish and distribute to residential care facilities the framework described in ORS 443.436 (2).

(2) Fully implement the enhanced oversight and supervision program described in ORS 443.436.

(3) Report to the appropriate interim committees of the Legislative Assembly, in the

1 **manner provided in ORS 192.245, on the publishing and distribution of the framework and the**
2 **implementation of the enhanced oversight and supervision program.**
3 **SECTION 10. This 2021 Act takes effect on the 91st day after the date on which the 2021**
4 **regular session of the Eighty-first Legislative Assembly adjourns sine die.**
5