DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 328

SUPPORTED LIVING PROGRAMS FOR ADULTS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

411-328-0550 Statement of Purpose
(Amended 06/29/2016)

(1) The rules in OAR chapter 411, division 328 prescribe standards for providers that support individuals with intellectual or developmental disabilities in a supported living setting and the procedures for the certification and endorsement of supported living settings under the rules in OAR chapter 411, division 323.

(2) These rules incorporate the provisions for home and community-based services and settings and person-centered service planning set forth in OAR chapter 411, division 004. These rules and the rules in OAR chapter 411, division 004 ensure individuals with intellectual or developmental disabilities receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving home and community-based services.

(3) Supported living provides the opportunity for an individual to live in the residence of his or her choice within the community with recognition that the needs and preferences of the individual may change over time. The levels of support for the individual are based upon individual needs and preferences as identified in a functional needs assessment and defined in an Individual Support Plan. Such services may include up to 24 hours per day of paid supports that are provided in a manner that protects the dignity of the individual.

(4) These rules ensure that providers meet basic management, programmatic, health and safety, and human rights regulations for individuals receiving services funded by the Department in supported living

settings. The provider is responsible for developing and implementing policies and procedures that ensure that the requirements of these rules are met and ensuring services comply with all applicable local, state, and federal laws and regulations.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0560 Definitions
(Temporary Effective 09/01/2016 to 02/27/2017)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 328:

(1) "Board of Directors" means the group of people formed by the provider agency to set policy and give directions to a provider delivering supports to individuals in a community-based service setting. A board of directors may include local advisory boards used by multi-state organizations.

(2) "CDDP" means "Community Developmental Disabilities Program".

(3) "Certificate" means the document issued by the Department to a provider that certifies the provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the provision of services in an endorsed supported living setting.

(4) "Endorsement" means the authorization to provide services in a supported living setting that is issued by the Department to a certified provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(5) "Executive Director" means the person designated by a board of directors or corporate owner that is responsible for the administration of services in a supported living setting.

(6) "Individual" means an adult applying for, or determined eligible for, Department-funded developmental disabilities services.

(7) "Individual Profile" means the written profile that describes an individual entering into a supported living setting. The profile may consist of materials or assessments generated by a provider or other related agencies, consultants, family members, or the legal or designated representative of the individual (as applicable).

(8) "ISP" means "Individual Support Plan".

(9) "OIS" means "Oregon Intervention System".

(10) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(11) "Provider" means a public or private community agency or organization that provides recognized developmental disabilities services and is certified and endorsed by the Department to provide these services under these rules and the rules in OAR chapter 411, division 323.

(12) "Supported Living" means the endorsed program that provides the opportunity for individuals to live in the residence of their own choice within the community. Supported living is not grounded in the concept of "readiness" or in a "continuum of services model" but rather provides the opportunity for individuals to live where they want, with whom they want, for as long as they desire, with a recognition that needs and desires may change over time.

(13) "These Rules" mean the rules in OAR chapter 411, division 328.

(14) "Unit" means the personal space and bedroom of an individual receiving home and community-based services in a provider owned, controlled, or operated residential setting, as agreed to in the Residency Agreement.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0570 Program Management
(Amended 12/28/2014)

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To provide services in a supported living setting, the provider must have:

(a) A certificate and an endorsement to provide services in a supported living setting as set forth in OAR chapter 411, division 323;

(b) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370; and

(c) For each specific geographic area where services shall be delivered in a supported living setting, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

(2) INSPECTIONS AND INVESTIGATIONS. The provider must allow inspections and investigations as described in OAR 411-323-0040.

(3) MANAGEMENT AND PERSONNEL PRACTICES. The provider must comply with the management and personnel practices as described in OAR 411-323-0050.

(4) PERSONNEL FILES AND QUALIFICATION RECORDS. The provider must maintain written documentation of six hours of pre-service training prior to supervising individuals that includes mandatory abuse reporting training and training on individual profiles, Transition Plans, and ISPs.

(5) CONFIDENTIALITY OF RECORDS. The provider must ensure the confidentiality of the records for individuals as described in OAR 411-323-0060.

(6) DOCUMENTATION REQUIREMENTS. Unless stated otherwise, all entries required by these rules must:

(a) Be prepared at the time or immediately following the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than five years.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0580 Application for Initial Certificate and Certificate Renewal
(Repealed 1/6/2012 – See OAR chapter 411, division 323)

411-328-0590 Certification Expiration, Termination of Operations, Certificate Return
(Repealed 1/6/2012 – See OAR chapter 411, division 323)

411-328-0600 Change of Ownership, Legal Entity, Legal Status, Management Corporation
(Repealed 1/6/2012 – See OAR chapter 411, division 323)

411-328-0610 Inspections and Investigations
(Repealed 1/6/2012 – See OAR 411-323-0040)

411-328-0620 Variances
(Amended 12/28/2014)

(1) The Department may grant a variance to these rules based upon a demonstration by the provider that an alternative method or different approach provides equal or greater program effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The provider requesting a variance must submit a written application to the CDDP that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept, or procedure proposed; and

(d) If the variance applies to the services of an individual, evidence that the variance is consistent with the currently authorized ISP for the individual.

(3) The CDDP must forward the signed variance request form to the Department within 30 days from the receipt of the request indicating the position of the CDDP on the proposed variance.

(4) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the provider, the CDDP, and to all relevant Department programs or offices within 30 days from the receipt of the variance request.

(5) The provider may request an administrative review of the denial of a variance request. The Department must receive a written request for an administrative review within 10 business days from the receipt of the denial. The provider must send a copy of the written request for an administrative review to the CDDP. The decision of the Director is the final response from the Department.

(6) The duration of the variance is determined by the Department.

(7) The provider may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0625 Provider Owned, Controlled, or Operated Residential Settings
(Adopted 06/29/2016)

(1) When an individual resides in a provider owned, controlled, or operated residential setting, the provider must assure that the setting complies with the qualities in OAR 411-004-0020 no later than September 1, 2018.

(2) Settings are considered provider owned, controlled, or operated when the provider authorized to deliver services to the individual --

> (a) Owns, rents, leases, or co-leases the setting where the services are delivered; or
>
> (b) Has a direct or indirect financial relationship with the owner of the property.

(3) RESIDENCY AGREEMENTS.

(a) The provider must enter into a written Residency Agreement with each individual specifying, at a minimum, the following:

(A) The rights and responsibilities of the individual and the provider; and

(B) The eviction process, notice requirements, and appeal rights available to each individual.

(b) The Residency Agreement may not violate the rights of an individual as stated in OAR 411-318-0010.

(c) The Residency Agreement may not be in conflict with any of these rules, the certification and endorsement rules in OAR chapter 411, division 323, or the home and community-based services and settings rules in OAR chapter 411, division 004.

(d) Prior to implementing changes to the Residency Agreement, the Residency Agreement may be subject to review and approval by the Department or the designee of the Department.

(e) The provider must review the Residency Agreement with and provide a copy to each individual and the legal representative of the individual, as applicable, at the time of entry and annually or as changes occur. The reviews must be documented by having the individual, or the legal representative of the individual, sign and date a copy of the Residency Agreement. A copy of the signed and dated Residency Agreement must be maintained in the record for the individual.

(4) INDIVIDUALLY-BASED LIMITATIONS.

(a) For an initial or annual ISP authorized to begin on or after March 1, 2017, the provider must identify any individually-based limitations to the following freedoms:

(A) Support and freedom to access the individual's personal food at any time;

(B) Visitors of the individual's choosing at any time;

(C) A lock on the individual's unit, lockable by the individual;

(D) Choice of a roommate, if sharing a bedroom;

(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with the Residency Agreement; and

(F) Freedom and support to control the individual's schedule and activities.

(b) All individually-based limitations must be included in the ISP no later than February 28, 2018.

(c) An individually-based limitation to any freedom in subsection (a) of this section must be supported by a specific assessed need due to threats to the health and safety of the individual or others. The provider must incorporate and document all applicable elements identified in OAR 411-004-0040, including:

(A) The specific and individualized assessed need justifying the individually-based limitation;

(B) The positive interventions and supports used prior to any individually-based limitation;

(C) Less intrusive methods that have been tried but did not work;

(D) A clear description of the condition that is directly proportionate to the specific assessed need;

(E) Regular reassessment and review to measure the ongoing effectiveness of the individually-based limitation;

(F) Established time limits for periodic review of the individually-based limitation to determine if the individually-based limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually;

(G) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(H) An assurance that the interventions and support do not cause harm to the individual.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0630 Medical Services
(Amended 12/28/2014)

(1) The medical records for individuals must be kept confidential as described in OAR 411-323-0060.

(2) The provider must provide sufficient oversight and guidance to ensure that the health and medical needs of the individuals are adequately addressed.

(3) Written health and medical supports must be developed as required for an individual and integrated into a Transition Plan or ISP. The plan must be based on a functional needs assessment of the health and medically related support needs and preferences of the individual and updated annually or as significant changes occur.

(4) The provider must have and implement written policies and procedures that maintain and protect the physical health of individuals. The policies and procedures must address the following:

(a) Early detection and prevention of infectious disease;

(b) Emergency medical intervention;

(c) Treatment and documentation of illness and health care concerns; and

(d) Obtaining, administering, storing, and disposing of prescription and non-prescription drugs, including self-administration of medication.

(5) The provider must ensure an individual has a primary physician or health care provider whom the individual has chosen from among qualified providers.

(6) Provisions must be made for a secondary physician, health care provider, or clinic in the event of an emergency.

(7) The provider must ensure that an individual receives a medical evaluation by a qualified health care provider no fewer than every two years or as recommended by a health care provider. Evidence of the medical evaluation must be placed in the record for the individual and must address:

(a) Current health status;

(b) Changes in health status;

(c) Recommendations, if any, for further medical intervention;

(d) Any remedial and corrective action required and the date of action;

(e) Restrictions on activities due to medical limitations; and

(f) Prescribed medications, treatments, special diets, and therapies.

(8) The provider must monitor the health status and physical conditions of the individual and take action in a timely manner in response to identified changes or conditions that may lead to deterioration or harm.

(9) Before the entry of an individual, the provider must obtain the most complete medical profile available for the individual, including:

(a) The results of most recent physical exam;

(b) Results of any dental evaluation;

(c) A record of immunizations;

(d) A record of known communicable diseases and allergies; and

(e) A summary of the medical history of the individual, including chronic health concerns.

(10) The provider must ensure that all medications, treatments, and therapies:

(a) Have a written order or a copy of a written order signed by a physician or qualified health care provider before any medication, prescription, or non-prescription is administered to, or self-administered by, an individual unless otherwise indicated by an ISP team in the written health and medical support section of the ISP or Transition Plan for the individual; and

(b) Be followed per written orders.

(11) PRN (as needed) orders are not allowed for psychotropic medication.

(12) The drug regimen of an individual on prescription medication must be reviewed and evaluated by a physician or physician designee no less often than every 180 days unless otherwise indicated by an ISP team in the written health and medical support section of the ISP or Transition Plan for the individual.

(13) All prescribed medications and treatments must be self-administered unless contraindicated by an ISP team or physician. For an individual who requires assistance in the administration of his or her own medication, the following must be met:

(a) The ISP team must recommend that the individual receive assistance with taking his or her own medication;

(b) There must be a written training program for the self-administration of medication unless contraindicated by the ISP team; and

(c) There must be a written record of medications and treatments that documents that the orders of a physician are being followed.

(14) The ISP for an individual who independently self-administers medication must include a plan for the periodic monitoring or review of the self-administration of medication.

(15) The provider must assist an individual with the use of a prosthetic device as ordered.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0640 Dietary
(Amended 06/29/2016)

(1) The provider is responsible for providing the support and guidance identified in the ISP to ensure individuals are provided access to a nutritionally adequate diet.

(2) Written dietary supports must be developed as required by an ISP team and integrated into a Transition Plan or ISP. The plan must be based on a review and identification of the dietary service needs and preferences of an individual and updated annually or as significant changes occur.

(3) The provider must have and implement policies and procedures related to maintaining adequate food supplies and meal planning, preparation, service, and storage.

(4) The provider must support the freedom of the individual to have access to the individual's personal food at any time.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0650 Physical Environment

(Amended 06/29/2016)

(1) All floors, walls, ceilings, windows, furniture, and fixtures must be maintained. The interior and exterior must be safely maintained and accessible according to the needs of the individuals.

(2) The water supply and sewage disposal must meet the requirements of the current rules of the Oregon Health Authority governing domestic water supply.

(3) Each residence must have:

(a) A kitchen area for the preparation of hot meals; and

(b) A bathroom containing a properly operating toilet, handwashing sink, and a bathtub or shower.

(4) Each residence must be adequately heated and ventilated.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0660 General Health and Safety
(Amended 12/28/2014)

(1) The provider must employ means for protecting the health and safety of the individuals which:

(a) Are not unduly restrictive;

(b) May include risks but do not inordinately affect the health, safety, and welfare of the individuals; and

(c) Are used by other people in the community.

(2) Written safety supports must be developed as required by an ISP team and integrated into a Transition Plan or ISP. The plan must:

(a) Be based on a review and identification of the safety needs and preferences of an individual;

(b) Be updated annually or as significant changes occur; and

(c) Identify how the individual evacuates his or her residence, specifying at a minimum the routes to be used and the level of assistance needed.

(3) The provider must have and implement policies and procedures that provide for the safety of individuals and for responses to emergencies and disasters.

(4) The need for emergency evacuation procedures and documentation thereof must be assessed and determined by an ISP team.

(5) An operable smoke alarm must be available in each bedroom and in a central location on each floor.

(6) An operable class 2A10BC fire extinguisher must be easily accessible in each residence.

(7) First aid supplies must be available in each residence.

(8) An operable flashlight must be available in each residence.

(9) The provider must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(10) Bedrooms must meet minimum space requirements (single 60 square feet, double 120 square feet with beds located three feet apart).

(11) Sleeping rooms must have at least one window that opens from the inside without special tools and provides a clear opening through which an individual is able to exit.

(12) Emergency telephone numbers must be available at the residence of each individual and include:

(a) The telephone numbers of the local fire, police department, and ambulance service, if not served by a 911 emergency service; and

(b) The telephone number of the Executive Director or the designee of the Executive Director, emergency physician, and other people to be contacted in case of an emergency.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0670 Safety: Personnel
(Repealed 1/6/2012 – See OAR 411-323-0050)

411-328-0680 Staffing Requirements
(Amended 12/28/2014)

(1) The provider must provide responsible people or an agency that is on-call and available to individuals by telephone at all times.

(2) The provider must provide staff appropriate to the number and needs of individuals receiving services as specified in their ISPs.

(3) Each provider must meet all requirements for staff ratios as specified by contract requirements.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0690 Individual Summary Sheets
(Amended 12/28/2014)

The provider must maintain a current one to two page summary sheet for each individual receiving services from the provider. The record must include:

(1) The name of the individual and his or her current address, home phone number, date of entry, date of birth, gender, marital status, social security number, social security beneficiary account number, religious preference, preferred hospital, and where applicable, the number of the Disability Services Office (DSO) or the Multi-Service Office (MSO) of the Department and guardianship status; and

(2) The name, address, and telephone number of:

(a) The legal or designated representative, family, and other significant person of the individual (as applicable);

(b) The primary care provider and clinic preferred by the individual;

(c) The dentist preferred by the individual;

(d) The identified pharmacy preferred by the individual;

(e) The day program or employer of the individual (if any);

(f) The services coordinator of the individual; and

(g) Other agencies and representatives providing services and supports to the individual.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0700 Incident Reports and Emergency Notifications
(Amended 06/29/2016)

(1) An incident report, as defined in OAR 411-328-0560, must be placed in the record for an individual upon injury, accident, act of physical aggression, or unusual incident. The incident report must include:

(a) Conditions prior to, or leading to, the incident;

(b) A description of the incident;

(c) Staff response at the time; and

(d) Follow-up to be taken to prevent a recurrence of the incident.

(2) A copy of all incident reports must be sent or made electronically available to the case manager within five business days of the incident.

(3) Upon request of the legal representative, a copy of the incident report must be sent or made electronically available to the legal representative

within five business days of the incident. If a copy of the incident report is sent or made electronically available to the legal representative of an individual, any confidential information about other individuals must be removed or redacted as required by federal and state privacy laws. A copy of an incident report may not be provided to the legal representative of an individual when the report is part of an abuse or neglect investigation.

(4) The provider must immediately notify the case management entity if an incident or allegation falls within the scope of abuse as defined in OAR 407-045-0260.

(5) In the case of a serious illness, injury, or death of an individual, the provider must immediately notify:

(a) The legal or designated representative, parent, next of kin, and other significant person of the individual (as applicable);

(b) The case management entity; and

(c) Any other agency responsible for the individual.

(6) In the case of an individual who is missing beyond the timeframes established by the ISP team, the provider must immediately notify:

(a) The designated representative of the individual;

(b) The legal representative of the individual, if any, or nearest responsible relative;

(c) The local police department; and

(d) The case management entity.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0710 Vehicles and Drivers
(Amended 12/28/2014)

(1) A provider that owns or operates a vehicle that transports individuals must:

(a) Maintain the vehicle in safe operating condition;

(b) Comply with the laws of the Department of Motor Vehicles;

(c) Maintain insurance coverage on the vehicle and all authorized drivers; and

(d) Carry a first aid kit in the vehicle.

(2) A driver operating a vehicle to transport individuals must meet all applicable requirements of the Department of Motor Vehicles.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0715 Financial Rights
(Amended 12/28/2014)

(1) Written individual financial supports must be developed as required by an ISP team and integrated into a Transition Plan or ISP. The plan must be based on a review and identification of the financial support needs and preferences of an individual and be updated annually or as significant changes occur.

(2) The provider must have and implement written policies and procedures related to the oversight of the financial resources for individuals.

(3) The provider must reimburse an individual for any funds that are missing due to the theft or mismanagement on the part of any staff of the provider, or of any funds within the custody of the provider that are missing. Reimbursement must be made to the individual within 10 business days from the verification that funds are missing.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0720 Individual Rights, Complaints, Notification of Planned Action, and Hearings
(Amended 06/29/2016)

(1) INDIVIDUAL RIGHTS.

(a) A provider must protect the rights of individuals described in OAR 411-318-0010 and encourage and assist individuals to understand and exercise these rights.

(b) Upon entry and request and annually thereafter, the individual rights described in OAR 411-318-0010 must be provided to an individual and the legal or designated representative of the individual.

(2) COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(3) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disability service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(4) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual or the legal or designated representative of the individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 for a denial, reduction, suspension, or termination of a developmental disability service or OAR 411-318-0030 for an involuntary reduction, transfer, or exit.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0730 Rights: Confidentiality of Records
(Repealed 1/6/2012 – See OAR 411-323-0060)

411-328-0740 Grievances
(Repealed 12/28/2014)

411-328-0750 Personalized Plans
(Amended 06/29/2016)

(1) The following information must be collected and summarized by the provider prior to any ISP meeting:

(a) One page profile reflecting, at a minimum, information gathered by the site where the individual receives services;

(b) Person-centered information reflecting, at a minimum, information gathered by the site where the individual receives services; and

(c) Information about known, identified serious risks.

(2) The following information must be developed by the provider and shared with the case manager and the individual, or if applicable the legal or designated representative of the individual, as directed by the ISP or Service Agreement.

(a) Implementation strategies, such as action plans, for desired outcomes or goals.

(b) Necessary protocols or plans that address health, behavioral, safety, and financial supports.

(c) A summary of the provider risk management strategies in place, including title of document, date, and where it is kept.

(d) A Nursing Service Plan, if applicable.

(e) Other documents required by the ISP team.

(3) The provider must maintain a copy of the ISP or Service Agreement provided the case management entity and signed by the provider.

(4) The provider must participate in ISP team meetings as requested by the individual or the legal or designated representative of the individual (if applicable).

(5) The provider must maintain documentation of implementation of each support and services specified in sections (2)(a) to (2)(e) of this rule in the ISP or Service Agreement for the individual. This documentation must be kept current and be available for review by the individual, the legal representative of the individual, the case management entity, and Department representatives.

(6) INDIVIDUAL PROFILE.

(a) The provider must develop a written profile within 90 days of entry. The profile is used to train new staff. The profile must include information related to the history or personal highlights, lifestyle and activity choices and preferences, social network and significant relationships, and other information that helps describe an individual.

(b) The profile must be composed of written information generated by the provider. The profile may include:

(A) Reports of assessments or consultations;

(B) Historical or current materials developed by the case management entity or nursing facility;

(C) Material and pictures from the family and friends of the individual;

(D) Newspaper articles; and

(E) Other relevant information.

(c) The profile must be maintained at the service site and updated as significant changes occur.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0760 Behavior Support
(Amended 06/29/2016)

(1) The provider must have and implement a written policy for behavior support that utilizes individualized positive behavioral theory and practice and prohibits abusive practices.

(2) The provider must inform an individual and, as applicable, the legal or designated representative of the individual, of the behavior support policy and procedures at the time of entry and as changes occur.

(3) A decision to develop a plan to alter a behavior must be made by the ISP team.

(4) The behavior consultant or a trained staff member must conduct a functional behavioral assessment of the behavior that is based upon information provided by one or more people who know the individual. The functional behavioral assessment must include:

(a) A clear, measurable description of the behavior, including frequency, duration, and intensity of the behavior (as applicable);

(b) A clear description and justification of the need to alter the behavior;

(c) An assessment of the meaning of the behavior, including the possibility that the behavior is one or more of the following:

(A) An effort to communicate;

(B) The result of a medical condition;

(C) The result of a psychiatric condition; or

(D) The result of environmental causes or other factors.

(d) A description of the context in which the behavior occurs; and

(e) A description of what currently maintains the behavior.

(5) The Behavior Support Plan must include:

(a) An individualized summary of the needs, preferences, and relationships of the individual;

(b) A summary of the function of the behavior as derived from the functional behavioral assessment;

(c) Strategies that are related to the function of the behavior and are expected to be effective in reducing problem behaviors;

(d) Prevention strategies, including environmental modifications and arrangements;

(e) Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response;

(f) A general crisis response plan that is consistent with OIS;

(g) A plan to address post crisis issues;

(h) A procedure for evaluating the effectiveness of the Behavior Support Plan, including a method of collecting and reviewing data on frequency, duration, and intensity of the behavior;

(i) Specific instructions for staff who provide support to follow regarding the implementation of the Behavior Support Plan; and

(j) Positive behavior supports that includes the least intrusive intervention possible.

(6) Providers must maintain the following additional documentation for implementation of a Behavior Support Plan:

(a) Written evidence that the individual, the legal or designated representative of the individual (if applicable), and the ISP team are aware of the development of the Behavior Support Plan and any objections or concerns have been documented;

(b) Written evidence of the ISP team decision for approval of the implementation of the Behavior Support Plan; and

(c) Written evidence of all informal and positive strategies used to develop an alternative behavior.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0770 Protective Physical Intervention
(Amended 06/29/2016)

(1) The provider must only employ protective physical intervention techniques that are included in the current approved OIS curriculum or as approved by the OIS Steering Committee. Protective physical intervention techniques must only be applied:

(a) When the health and safety of the individual or others is at risk, the ISP team has authorized the procedures as documented by the decision of the ISP team, the procedures are documented in the ISP or Service Agreement, and the procedures are intended to lead to less restrictive intervention strategies;

(b) As an emergency measure if absolutely necessary to protect the individual or others from immediate injury; or

(c) As a health-related protection ordered by a licensed health care provider if absolutely necessary during the conduct of a specific medical or surgical procedure or for the protection of the individual during the time that a medical condition exists.

(2) Staff supporting an individual must be trained by an instructor certified in OIS when the individual has a history of behavior requiring protective physical intervention and the ISP team has determined there is probable cause for future application of protective physical intervention. Documentation verifying OIS training must be maintained in the personnel file for the staff person.

(3) The provider must obtain the approval of the OIS Steering Committee for any modification of standard OIS protective physical intervention techniques. The request for modification of a protective physical intervention technique must be submitted to the OIS Steering Committee and must be approved in writing by the OIS Steering Committee prior to the implementation of the modification. Documentation of the approval must be maintained in the record for the individual.

(4) Use of protective physical intervention techniques that are not part of an approved Behavior Support Plan in emergency situations must:

> (a) Be reviewed by the Executive Director or the designee of the Executive Director within one hour of application;
>
> (b) Be only used until the individual is no longer an immediate threat to self or others;
>
> (c) Result in the submission of an incident report to the case manager or other Department designee (if applicable) and the legal or designated representative of the individual (if applicable), no later than one business day after the incident has occurred ; and
>
> (d) Prompt an ISP meeting if emergency protective physical intervention is used more than three times in a six month period.

(5) Any use of protective physical intervention must be documented in an incident report, excluding circumstances described in section (7) of this rule. The report must include:

> (a) The name of the individual to whom the protective physical intervention was applied;

(b) The date, type, and length of time the protective physical intervention was applied;

(c) A description of the incident precipitating the need for the use of protective physical intervention;

(d) Documentation of any injury;

(e) The name and the position of the staff member applying the protective physical intervention;

(f) The name and position of any staff member witnessing the protective physical intervention;

(g) The name and position of the person providing the initial review of the use of the protective physical intervention; and

(h) Documentation of a review by the Executive Director or the designee of the Executive Director who is knowledgeable in OIS, as evident by a job description that reflects this responsibility. The review must include the follow-up to be taken to prevent a recurrence of the incident.

(6) A copy of the incident report must be sent or made electronically available within five business days of the incident to the case manager and the legal or designated representative of the individual (when applicable).

(a) The case manager or the Department designee (when applicable) must receive complete copies of incident reports.

(b) Copies of incident reports may not be provided to a legal representative or other provider when the report is part of an abuse or neglect investigation.

(c) Copies sent or made electronically available to a legal representative or other provider must have confidential information about other individuals removed or redacted as required by federal and state privacy laws.

(d) All protective physical interventions resulting in injuries must be documented in an incident report and sent or made electronically available to the case manager or other Department designee (if applicable) within one business day of the incident.

(7) BEHAVIOR DATA SUMMARY.

(a) The provider may substitute a behavior data summary in lieu of individual incident reports when:

(A) There is no injury to the individual or others;

(B) There is a formal written functional behavioral assessment and a written Behavior Support Plan;

(C) The Behavior Support Plan defines and documents the parameters of the baseline level of behavior;

(D) The protective physical intervention techniques and the behavior for which the protective physical intervention techniques are applied remain within the parameters outlined in the Behavior Support Plan and OIS curriculum; and

(E) The behavior data collection system for recording observations, interventions, and other support information critical to the analysis of the efficacy of the Behavior Support Plan is also designed to record the items described in section (5)(a)-(c) and (e)-(h) of this rule.

(b) A copy of the behavior data summary must be forwarded or made electronically available every 30 days to the case manager or other Department designee (if applicable) and the legal or designated representative of the individual (if applicable).

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0780 Psychotropic Medications and Medications for Behavior
(Amended 06/29/2016)

(1) Psychotropic medications and medications for behavior must be prescribed by a physician through a written order.

(2) The use of psychotropic medications and medications for behavior must be based on the decision of a physician that the harmful effects without the medication clearly outweigh the potentially harmful effects of the medication. Providers must present the physician with a full and clear written description of the behavior and symptoms to be addressed, as well as any side effects observed, to enable the physician to make this decision.

(3) Psychotropic medications and medications for behavior must be:

(a) Monitored by the prescribing physician, ISP team, and provider for desired responses and adverse consequences; and

(b) Reviewed to determine the continued need and lowest effective dosage in a carefully monitored program.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0790 Entry, Exit, and Transfer
(Amended 06/29/2016)

(1) NON-DISCRIMINATION. An individual considered for Department-funded services may not be discriminated against because of race, color, creed, age, disability, national origin, gender, religion, duration of Oregon residence, method of payment, or other forms of discrimination under applicable state or federal law.

(2) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES. An individual who enters supported living is subject to eligibility as described in this section. To be eligible for supported living, an individual must:

(a) Be an Oregon resident;

(b) Be receiving a Medicaid Title XIX (OHP) benefit package through OSIPM or OCCS medical program. Individuals receiving Medicaid OHP under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to

the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(c) Be determined eligible for developmental disability services by the CDDP of the county of origin as described in OAR 411-320-0080;

(d) Meet the level of care as defined in OAR 411-320-0020;

(e) Be an individual who is not receiving other Department-funded in-home or community living support;

(f) Have access to the financial resources to afford living expenses, such as food, utilities, rent, and other housing expenses; and

(g) Be eligible for Community First Choice state plan services.

(3) ENTRY.

(a) A provider must participate in an entry meeting prior to the onset of services to an individual.

(b) Prior to or upon an entry ISP team meeting, a provider must demonstrate effort to acquire the following individual information from the referring case management entity:

(A) A copy of the eligibility determination document;

(B) A statement indicating safety skills, including the ability of the individual to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing;

(C) A brief written history of any behavioral challenges, including supervision and support needs;

(D) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The results of any dental evaluation;

(iii) A record of immunizations;

(iv) A record of known communicable diseases and allergies; and

(v) A record of major illnesses and hospitalizations.

(E) A written record of any current or recommended medications, treatments, diets, and aids to physical functioning;

(F) A copy of the most recent needs assessment. If the needs of the individual have changed over time, the previous needs assessments must also be provided;

(G) Copies of protocols, the risk tracking record, and any support documentation (if available);

(H) Copies of documents relating to the guardianship, conservatorship, health care representation, power of attorney, court orders, probation and parole information, or any other legal restriction on the rights of the individual (if applicable);

(I) Written documentation to explain why preferences or choices of the individual may not be honored at that time;

(J) A copy of the most recent ISP or Service Agreement, Behavior Support Plan, and assessment (if available);

(K) Information related to the lifestyle, activities, and other choices and preferences; and

(L) Documentation of financial resources.

(4) VOLUNTARY TRANSFERS AND EXITS.

(a) A provider must promptly notify the case manager if an individual or the legal or designated representative of the individual gives notice of the intent to exit or abruptly exits services.

(b) A provider must notify the case manager prior to the voluntary transfer or exit of an individual from services.

(c) Notification and authorization of the voluntary transfer or exit of the individual must be documented in the record for the individual.

(5) INVOLUNTARY REDUCTIONS, TRANSFERS, AND EXITS.

(a) A provider must only reduce, transfer, or exit an individual involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others;

(B) The individual experiences a medical emergency;

(C) The service needs of the individual exceed the ability of the provider;

(D) The individual fails to pay for services; or

(E) The certification or endorsement for the provider described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY REDUCTION, TRANSFER, OR EXIT. A provider must not reduce services, transfer, or exit an individual involuntarily without 30 days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the case manager, except in the case of a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others as described in subsection (c) of this section.

(A) The written notice must be provided on the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

(i) The reason for the reduction, transfer, or exit; and

(ii) The right of the individual to a hearing as described in subsection (d) of this section.

(B) A Notice of Involuntary Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(c) A provider may give less than 30 days advance written notice only in a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others. The notice must be provided to the individual, the legal or designated representative of the individual (as applicable), and the case manager immediately upon determination of the need for a reduction, transfer, or exit.

(d) HEARING RIGHTS. An individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction, transfer, or exit. If an individual or the legal or designated representative of the individual requests a hearing, the individual must receive the same services until the hearing is resolved. When an individual has been given less than 30 days advance written notice of a reduction, transfer, or exit as described in subsection (c) of this section and the individual has requested a hearing, the provider must reserve service availability for the individual until receipt of the Final Order.

(6) EXIT MEETING. A provider must participate in an exit meeting before any decision to exit an individual is made if required by the case management entity.

(7) TRANSFER MEETING.A provider must participate in a transfer meeting before any decision to transfer an individual is made if required by the case management entity.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670

411-328-0800 Entry, Exit, and Transfer: Appeal Process
(Repealed 12/28/2014)

411-328-0805 Individual/Family Involvement
(Repealed 1/6/2012 – See OAR 411-323-0060)

411-328-0810 Program Management
(Repealed 1/6/2012 – See OAR 411-323-0050)

411-328-0820 Certificate Denial, Suspension, Revocation, Refusal to Renew
(Repealed 1/6/2012 – See OAR chapter 411, division 323)

411-328-0830 Hearings
(Repealed 1/6/2012 – See OAR chapter 411, division 323)