PRESENTATION

CBC Facility Move-Outs

Involuntary Move-Out Rules (OAR 411-054-0080) for Residential Care & Assisted Living Facilities including Memory Care Communities

Community Based Care
Safety, Oversight and Quality
Aging and People with Disabilities
Oregon Department of Human Services

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OAR 411-054-0080

- Permanent rule in effect on February 8, 2021

  OAR 411-054-0080

- Guidance for Completing Move-Out Notices

- Revised Move Out Notices

  SDS 0567

  SDS 0568

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Objectives

- Review new definitions related to Move-Out Rule rules.
- Review the revised rules for Move-Out in residential care, assisted living facilities (including memory care communities)
  - Understand the process for issuing move-out notices
  - Review new forms for Move-Out Notices (0567 & 0568)
  - Review and discuss the Administrative Hearing Request process

New Definitions – OAR 411-054-0005

- (37) “Health Care Facility” means a facility, as defined in ORS 442.015(12)(a), that provides acute care or a higher level of care to a resident according to OAR 411-054-0080.

- (49) “Involuntary Move-Out” means a move out of a resident to which the resident or the resident’s legal representative does not agree.

Definitions Cont.

- (70) “Qualified facility staff,” for purposes of OAR 411-054-0080, means the facility nurse, administrator, or administrator’s designee.

- (93) “Voluntary Move-Out” means the facility and the resident, or resident’s legal representative, have mutually agreed the facility can no longer meet the resident’s health, behavior or care needs.

Disclosure Information

- OAR 411-054-0080 (1) references disclosure information (per OAR 411-054-0026) which includes
  - Uniform Disclosure Statement
  - Residency Agreement
  - Consumer Summary Statement
- These documents need to clearly state what types of health, nursing, behavior and care services the facility **is able and unable** to provide.
- Ensure there is consistency these documents

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Documentation Review by ODHS

- Documentation is up to date and accurately reflects the need for a different level of care or why the resident is being given a Move-Out Notice. This includes but not limited to:
  - Resident evaluations
  - Service Plans
  - Progress Notes
  - Medication Administration Records
- May interview witnesses or contacts that can provide information regarding the Notice.
- Disclosure Information per OAR 411-054-0026

Why Review Documentation?

- Understand the specific circumstances for the Notice.
- Understand what interventions were put into place to resolve the issue(s) that lead to the Notice and why they haven't worked.
- Ensure the resident and/or their responsible party had been informed regarding what services the facility does and does not provide.
- Ensure the resident's rights are protected.
- Ensure the Notice is completed accurately and is consistent with the documentation that is sent.

Additional Services if Needed

Depending on the circumstances for the move-out, the facility may need to provide additional services to meet a resident's needs on a short-term basis which may require additional staffing and/or providing intermittent needs.

30 Day Move-Out – OAR 411-054-0080 (2)

Criteria has not changed

- The resident's needs exceed the ADLs the facility can provide.
- Behavior that substantially interferes with the rights or health or safety of the resident or others.
- Complex or unstable medical or nursing condition
- Unable to accomplish fire evacuation.

30 Day Move-Out Cont.

Criteria has not changed cont.

- Behavior that poses a danger to self or others.
- Illegal drug use or criminal acts that poses a danger to self or others.
- Non-payment.

Revised 30 Day Involuntary Move-Out Notice Page 1

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SAFETY, OVERSIGHT AND QUALITY UNIT

Residential Care/Assisted Living Facility
Notice of 30 day Involuntary Move-Out
Oregon Administrative Rule 411-054-0080

Link to instructions

Notice issued to: Last name: _____ First name: _____
Date issued: __ / __ / ____ 30 days will be: __ / __ / ____
Name of facility: _____
☐ ALF ☐ MCC ☐ RCF ☐ SNC *(Special needs contract)*
Address: _____
City/state/ZIP: _____
Telephone: _____ Email: _____

You are being requested to move within ***30 days*** of receipt of this notice for the following reason(s) per OAR 411-054-0080(2):

- ☐ Your personal care needs (*activity of daily living*) exceed the level of services provided by the facility, as specified in the facility's disclosure information.
- ☐ You have engaged in behavior or actions that have repeatedly and substantially interfered with the rights, health or safety of residents or others.
- ☐ You have a medical condition that is complex, unstable or unpredictable and exceeds the level of health services as specified in writing in the facility's disclosure information.
- ☐ The facility is unable to accomplish resident evacuation in accordance with OAR 411-054-0090 *(Fire and Life Safety)*.
- ☐ You exhibit behavior that poses a danger to self or others.
- ☐ You have engaged in illegal drug use or have committed a criminal act that causes potential harm to yourself or others.
- ☐ Non payment of charges owed to the facility.

The specific reason(s) you are being asked to move:

SDS 0567 (03/2021) Page 1 of 5

Revised 30 Day Involuntary Move Out Notice Page 2

Print name | Title of Facility Representative

Signature and Title of Facility Representative | Date

This notice is required to be sent to the following people and agencies, the same day it is issued.

Name and relationship	Complete address and phone number or email address
☐ Resident ☐ Legal representative	
ODHS/SOQ/CBC	SOQ.Transfers@dhsoha.state.or.us
Office of Long-Term Care Ombudsman	ltco.info@oregon.gov or fax 503-373-0852
Case Manager or other interested party if applicable	

If you do not agree with this move-out notice:

You have ten (10) business days after receipt of this notice to request an administrative hearing. If you do not request the hearing on time, you may lose your right to a hearing.

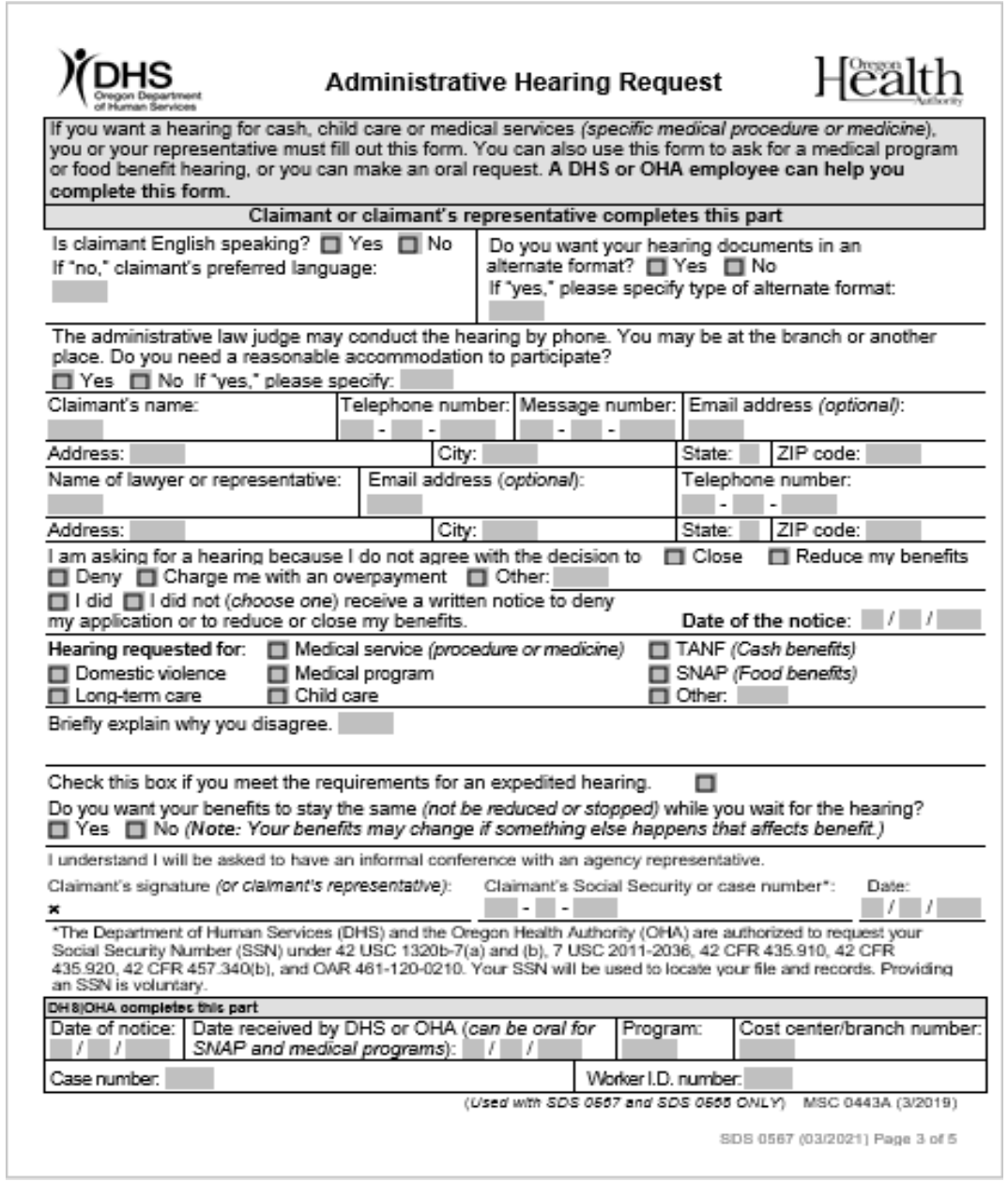
☐ Check here if you disagree with this notice and would like to return to or stay at the facility. You can inform the facility either verbally or in writing of your wish to request a hearing. The Administrative Hearing Request form attached to this notice must be completed and given to the facility. They are responsible for sending the request to ODHS.

- ODHS may hold an informal meeting to try to resolve this matter. If you are satisfied with the outcome of the informal meeting, no administrative hearing will be held.

If you need assistance understanding this notice, or your rights or if you need an advocate, the Long-Term Care Ombudsman Office can help you. You may contact the Ombudsman's office at:

Office of the Long-Term Care Ombudsman
3855 Wolverine NE, Suite 6
Salem, OR 97305-1251
Telephone: 1-800-522-2602 or ltco.info@oregon.gov

Administrative Hearing Request Attached to Move-Out Notice



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Administrative Hearing Request

Oregon Health Authority

If you want a hearing for cash, child care or medical services *(specific medical procedure or medicine)*, you or your representative must fill out this form. You can also use this form to ask for a medical program or food benefit hearing, or you can make an oral request. **A DHS or OHA employee can help you complete this form.**

Claimant or claimant's representative completes this part

Is claimant English speaking? ☐ Yes ☐ No
If "no," claimant's preferred language:

Do you want your hearing documents in an alternate format? ☐ Yes ☐ No
If "yes," please specify type of alternate format:

The administrative law judge may conduct the hearing by phone. You may be at the branch or another place. Do you need a reasonable accommodation to participate?
☐ Yes ☐ No If "yes," please specify:

Claimant's name:	Telephone number:	Message number:	Email address *(optional)*:
	- -	- -	

Address:	City:	State:	ZIP code:

Name of lawyer or representative:	Email address *(optional)*:	Telephone number:
		- -

Address:	City:	State:	ZIP code:

I am asking for a hearing because I do not agree with the decision to ☐ Close ☐ Reduce my benefits ☐ Deny ☐ Charge me with an overpayment ☐ Other:

☐ I did ☐ I did not *(choose one)* receive a written notice to deny my application or to reduce or close my benefits. **Date of the notice:** / /

Hearing requested for:
☐ Medical service *(procedure or medicine)* ☐ TANF *(Cash benefits)*
☐ Domestic violence ☐ Medical program ☐ SNAP *(Food benefits)*
☐ Long-term care ☐ Child care ☐ Other:

Briefly explain why you disagree.

Check this box if you meet the requirements for an expedited hearing. ☐

Do you want your benefits to stay the same *(not be reduced or stopped)* while you wait for the hearing?
☐ Yes ☐ No *(**Note:** Your benefits may change if something else happens that affects benefit.)*

I understand I will be asked to have an informal conference with an agency representative.

Claimant's signature *(or claimant's representative)*: ✖ Claimant's Social Security or case number*: - - Date: / /

*The Department of Human Services (DHS) and the Oregon Health Authority (OHA) are authorized to request your Social Security Number (SSN) under 42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b), and OAR 461-120-0210. Your SSN will be used to locate your file and records. Providing an SSN is voluntary.

DHS/OHA completes this part

Date of notice: / /	Date received by DHS or OHA *(can be oral for SNAP and medical programs)*: / /	Program:	Cost center/branch number:
Case number:		Worker I.D. number:	

(Used with SDS 0567 and SDS 0568 ONLY) MSC 0443A (3/2019)

SDS 0567 (03/2021) Page 3 of 5

Documentation to Review – OAR 411-054-0080 (3-6)

- Along with Move-Out Notice - send
  - ✓ Documentation of communication(s) with the resident or their legal representative to resolve issues prior to considering the Notice.
  - ✓ The two most recent service plans which demonstrate modifications attempting to resolve the reasons for the move-out notice.
  - ✓ Any relevant documentation that supports the facility's reason for the proposed move-out.
  - ✓ If move-out is for non-payment, send most recent invoices or demand letters, service plans do not need to be submitted.
- <u>If not sent with Notice, it will delay ODHS's decision</u> as to whether it meets criteria or not.

30 Day Move-Out –

- Facility must send to ODHS (SOQ):
  - ✓Move-out notice (SDS 0567) to SOQ.Transfers@dhsoha.state.or.us
  - ✓Documentation that supports the Notice.
  - ✓SOQ has two (2) business days to review the information.

30 Day Notice – If Criteria is Not Met – OAR 411-054-0080 (8)

- **If the Notice and documentation do not meet the criteria, the facility cannot issue the Notice.**
- A new Notice with additional information can be re-submitted.

30 Day Move-Out – If Criteria is met OAR 411-054-0080 (9)

- Move-Out Notice (SDS 0567) and Administrative Hearing Request (MSC 0443) must be given to the resident and/or their legal representative
- Must also be immediately sent to:
  - ✓ODHS at SOQ.Transfers@dhsoha.state.or.us
  - ✓Office of Long-Term Care Ombudsman – ltco.info@oregon.gov or fax: 503-373-0852
  - ✓Medicaid case manager, if applicable
  - ✓Other interested parties as appropriate

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OAR 411-054-0080 (9) (b)

- If the correct form, containing both the Notice and Administrative Hearing Request, is not delivered to all necessary parties, the 30-Day Move-Out and Hearing Notice form is insufficient, and the timeline does not start until both notices are jointly supplied.

Less Than 30 – Day Move-Out Notices

Given for the following reasons:

a. A resident has been admitted or treated at a health care facility for a significant medical or psychiatric event. At the time the resident is to return to the facility, qualified facility staff have evaluated the resident's health, medical, behavioral or care needs and have determined the facility is unable to meet the resident's needs pursuant to section (1) of this rule due to the resident's significant and ongoing change of condition related to a medical or psychiatric event, whether that event was the reason for leaving the facility for treatment, or arose while the resident was being treated at the health care facility.

b. The resident's behavior places the health or safety of the resident or others in jeopardy and undue delay in moving the resident increases the risk of harm.

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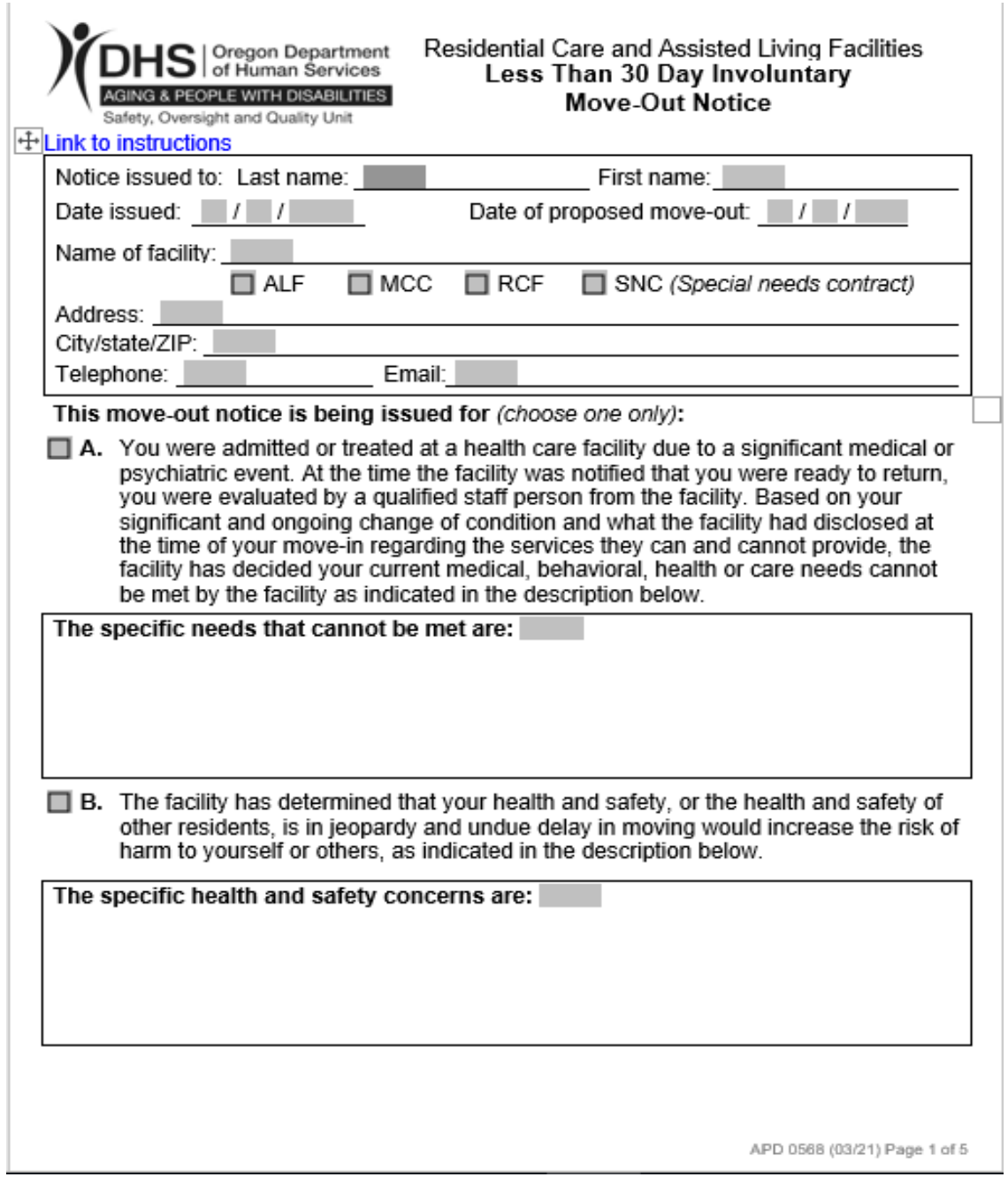
Revised Less Than 30 Day Involuntary Move-Out Notice Page 1



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Safety, Oversight and Quality Unit

Residential Care and Assisted Living Facilities
Less Than 30 Day Involuntary Move-Out Notice

Link to instructions

Notice issued to: Last name: _____ First name: _____
Date issued: __ / __ / ____ Date of proposed move-out: __ / __ / ____
Name of facility: _____
☐ ALF ☐ MCC ☐ RCF ☐ SNC *(Special needs contract)*
Address: _____
City/state/ZIP: _____
Telephone: _____ Email: _____

This move-out notice is being issued for *(choose one only)*:

☐ **A.** You were admitted or treated at a health care facility due to a significant medical or psychiatric event. At the time the facility was notified that you were ready to return, you were evaluated by a qualified staff person from the facility. Based on your significant and ongoing change of condition and what the facility had disclosed at the time of your move-in regarding the services they can and cannot provide, the facility has decided your current medical, behavioral, health or care needs cannot be met by the facility as indicated in the description below.

The specific needs that cannot be met are:

☐ **B.** The facility has determined that your health and safety, or the health and safety of other residents, is in jeopardy and undue delay in moving would increase the risk of harm to yourself or others, as indicated in the description below.

The specific health and safety concerns are:

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Revised Less Than 30 Day Involuntary Move-Out Notice Page 1

Print name

Title of Facility Representative

Signature and Title of Facility Representative

Date

This notice is required to be sent to the following people and agencies, the same day it is issued.	
Name and relationship	**Complete address and phone number or email address**
☐ Resident ☐ Legal representative	
ODHS/SOQ/CBC	SOQ.Transfers@dhsoha.state.or.us
Office of Long-Term Care Ombudsman	ltco.info@oregon.gov or fax 503-373-0852
Case Manager or other interested party if applicable	

If you do not agree with this move-out notice:

You have five (5) business days after receipt of this notice to request an administrative hearing. If you do not request the hearing on time, you may lose your right to a hearing.

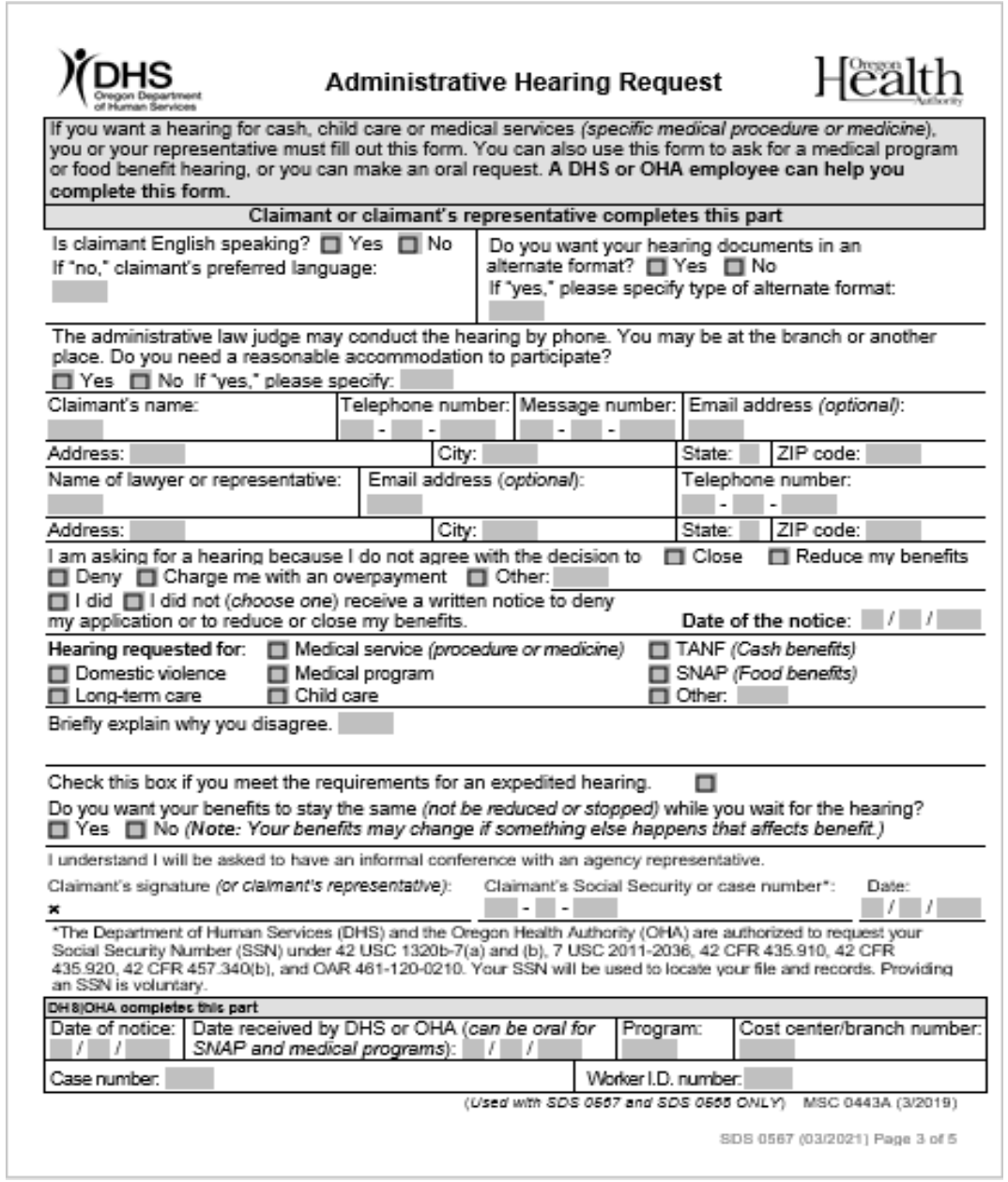
☐ Check here if you disagree with this notice and would like to return to or stay at the facility. You can inform the facility either verbally or in writing of your wish to request a hearing. The Administrative Hearing Request form attached to this notice must be completed and given to the facility. They are responsible for sending the request to ODHS.

- ODHS may hold an informal meeting to try to resolve this matter. If you are satisfied with the outcome of the informal meeting, no administrative hearing will be held.

If you need assistance understanding this notice, or your rights or if you need an advocate, the Long-Term Care Ombudsman Office can help you. You may contact the Ombudsman's office at:

Office of the Long-Term Care Ombudsman
3855 Wolverine NE, Suite 6
Salem, OR 97305-1251
Telephone: 1-800-522-2602 or ltco.info@oregon.gov

Administrative Hearing Request Attached to Move-Out Notice



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Administrative Hearing Request

Oregon Health Authority

If you want a hearing for cash, child care or medical services *(specific medical procedure or medicine)*, you or your representative must fill out this form. You can also use this form to ask for a medical program or food benefit hearing, or you can make an oral request. **A DHS or OHA employee can help you complete this form.**

Claimant or claimant's representative completes this part

Is claimant English speaking? ☐ Yes ☐ No
If "no," claimant's preferred language:

Do you want your hearing documents in an alternate format? ☐ Yes ☐ No
If "yes," please specify type of alternate format:

The administrative law judge may conduct the hearing by phone. You may be at the branch or another place. Do you need a reasonable accommodation to participate?
☐ Yes ☐ No If "yes," please specify:

Claimant's name:	Telephone number:	Message number:	Email address *(optional)*:
	- -	- -	

Address:	City:	State:	ZIP code:

Name of lawyer or representative:	Email address *(optional)*:	Telephone number:
		- -

Address:	City:	State:	ZIP code:

I am asking for a hearing because I do not agree with the decision to ☐ Close ☐ Reduce my benefits ☐ Deny ☐ Charge me with an overpayment ☐ Other:

☐ I did ☐ I did not *(choose one)* receive a written notice to deny my application or to reduce or close my benefits. **Date of the notice:** / /

Hearing requested for:
☐ Medical service *(procedure or medicine)* ☐ TANF *(Cash benefits)*
☐ Domestic violence ☐ Medical program ☐ SNAP *(Food benefits)*
☐ Long-term care ☐ Child care ☐ Other:

Briefly explain why you disagree.

Check this box if you meet the requirements for an expedited hearing. ☐

Do you want your benefits to stay the same *(not be reduced or stopped)* while you wait for the hearing?
☐ Yes ☐ No *(**Note:** Your benefits may change if something else happens that affects benefit.)*

I understand I will be asked to have an informal conference with an agency representative.

Claimant's signature *(or claimant's representative)*: ✖ Claimant's Social Security or case number*: - - Date: / /

*The Department of Human Services (DHS) and the Oregon Health Authority (OHA) are authorized to request your Social Security Number (SSN) under 42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b), and OAR 461-120-0210. Your SSN will be used to locate your file and records. Providing an SSN is voluntary.

DHS/OHA completes this part

Date of notice: / /	Date received by DHS or OHA *(can be oral for SNAP and medical programs)*: / /	Program:	Cost center/branch number:
Case number:		Worker I.D. number:	

(Used with SDS 0567 and SDS 0568 ONLY) MSC 0443A (3/2019)

SDS 0567 (03/2021) Page 3 of 5

Documentation for ODHS Review

- Evaluation completed by the qualified staff person if resident is in the hospital. *The facility must stay in communication with the health care facility for the duration of the resident's stay*.
- Two most recent service plans, that document modifications intended to resolve the issues prior to issuing the Notice, as applicable.
- Information that demonstrates the efforts taken to address all service needs of the resident, including obtaining third-party services, or providing intermittent direct nursing as applicable.

Documentation to Review Cont.

- Documentation demonstrating compliance with OAR 411-054-0070(1) (Staffing) and 411-070-0030(2)(b) (Resident Services/Ancillary Services).
- ODHS may contact the resident or other parties for additional information pertaining to the move-out.
- ODHS may request additional documentation if needed.

Less Than 30 Day Move-Out Notice - OAR 411-054-0080 (11)

- Facility must send to ODHS (SOQ)
  - ✓ Move-out notice (0568) to SOQ.Transfers@dhsoha.state.or.us
  - ✓ Documentation that supports the Notice
  - ✓ ODHS has two (2) business days to review the information.

Less Than 30 Day Move-Out – Criteria Not Met

- **If criteria has not been met, the facility cannot issue the notice.**
- However, a new notice with additional information can be submitted.

Less Than 30-Day Meets Criteria

- The Move-Out Notice with the Administrative Hearing Request may be issued to the resident and/or their legal representative.
- On that same day it is issued, the facility must send the Notice to:
  - ODHS (SOQ) at SOQ.Transfers@dhsoha.state.or.us
  - Office of the Long-Term Care Ombudsman at ltco.info@oregon.gov or Fax at 503-373-0852
  - Medicaid case manager, if applicable.

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Hearing Process

30 Day Move-Out Notice

- The resident, legal representative or LTCO can request a hearing either verbally or in writing by checking the box on page 2 of the Notice within 10 business days.
- Completed Administrative Hearing Request form must be immediately sent to SOQ at SOQ.Transfers@dhsoha.state.or.us
- An informal conference may be held. If issues are resolved, then there is no need for a hearing.

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Hearing Process

Less than 30 Day Notice

- If requested, ODHS/SOQ will ask for an expedited hearing.
- ODHS/SOQ may hold an informal conference at the request of the resident, their legal representative or the LTCO.
  - Less Than 30 Day Involuntary Notice, the informal conference to be held within four (4) business days of receiving the request.
- If there is a resolution, then no hearing will be held.
- If resident has been moved out of the facility, the facility cannot charge room and board.

Hearing Process Cont.

- Administrative Law Judge (ALJ) may hold a pre-hearing meeting to:
  - Determine if a resolution has been made
  - Request documentation
  - Set a hearing date
- If hearing takes place, the facility, resident/responsible party or advocate will present their facts.
- The ALJ will make the determination and provide it in writing.

Resources for Behavior Support

- Older Adult Behavioral Health Specialists
- Behavior Support Services
  - Medicaid program for RCFs and ALFs – Need referral from case manager may be available to private pay residents in some areas
- Private Resources - may need a referral for these services
  - Gero-psych specialists
  - Mental health agencies
  - Gero-psych hospitals
- For placement options - Aging & Disability Resource Connection (ADRC) – 1-855-673-2372

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Questions?

Thank you for attending

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