

Compliance Framework Guide

Community Based Care

(Residential Care and Assisted Living)



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Safety, Oversight and Quality Unit
Aging and People with Disabilities



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Preface: The Purpose of this Guide

In 2017 the Oregon State Legislature passed House Bill 3359 (HB 3359), a bill that made many reforms to Oregon's licensed long-term care system. The law requires that in regulating residential care and assisted living facilities, the Department of Human Services (DHS or the Department) shall, whenever possible, use a progressive enforcement process that employs a series of actions to encourage and compel substantial compliance with licensing regulations through the application of preventative, positive, and progressively more restrictive strategies. One section of HB 3359 called for DHS to develop a framework for assessing the substantial compliance of residential care facilities and assisted living facilities with regulatory requirements and for requiring corrective action that accurately and equitably measures substantial compliance and the extent of noncompliance. This framework will be published on the DHS website and be distributed to facilities licensed in the state.

To implement this requirement, the legislature determined that a comprehensive and detailed guide to the regulatory process was needed. To make this guide as clear and transparent as possible, we have included definitions both within the text and within a separate glossary, found in Chapter 10.

While the scope of this guide goes beyond the requirement within HB 3359, the Department intends for it to be a useful tool for both providers and the public in understanding the regulatory process used for assisted living and residential care facilities.

DHS is committed to a collaborative relationship with providers and is tasked with ensuring licensed long-term care settings meet their legal and regulatory requirements while providing each person with a high quality of care, dignity, independence and personal choice.

Please note: Any examples or scenarios included in this guide are intended to illustrate possible applications of the corrective action process. A variety of factors are considered when determining corrective action in any situation. Thus, specific incidents or violations may not result in the same outcomes detailed in these examples.

Chapter 1: Introduction to the Safety, Oversight and Quality (SOQ) Unit

Overall regulatory purpose

The Safety, Oversight and Quality Unit (SOQ) is the group of staff within the Aging and People with Disabilities (APD) Division of DHS responsible for licensing and regulatory oversight of long-term care facilities for older adults and people with physical disabilities.

SOQ licenses and regulates these types of facilities:

- **Community Based Care (CBC) facilities** (includes residential care facilities and assisted living facilities)
- **Adult Foster Homes (AFH)** (local DHS offices license and regulate, except for homes in Multnomah County, which are licensed and regulated by the county)
- **Nursing Facilities (NF)**
- **Endorsed Memory Care Communities (MCC)** (a residential care, assisted living, or nursing facility must complete additional requirements to earn an endorsement on top of the underlying license)
- **Continuing Care Retirement Communities (CCRCs)** (includes campuses with multiple levels of care; SOQ licenses the facility types above but does not license independent living facilities)

With the exception of adult foster homes, which are licensed through APD or Area Agency on Aging (AAA) offices, SOQ issues initial and renewal licenses and oversees surveys/inspections of all of the above facility types. SOQ determines corrective action based on surveys, licensing complaint reviews, inspections, and Adult Protective Service (APS) investigations. SOQ also registers Long Term Referral Agencies, which provide services to individuals looking for a suitable long-term facility.

SOQ staff have an unwavering commitment to the safety, health and well-being of individuals living in Oregon's licensed long-term care settings, and all of our decisions are guided by this commitment and the tenets of person-centered care.

Progressive enforcement process

SOQ's enforcement process is dependent upon the extent to which a facility is in substantial compliance with state regulation. "Substantial compliance" means a

level of compliance with state law and rules of the Department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents of a facility. (See OAR 411-054-0005(79)) SOQ employs a positive and progressive approach to corrective action whenever possible. To this end, our goal is always to protect older adults and people with disabilities who reside in licensed long-term care settings by accurately and equitably measuring facility substantial compliance and working collaboratively with providers to correct deficiencies as quickly as possible. Although we strive to impose the least restrictive actions, it is important to note there are times when noncompliance with rules places facility residents at a level of risk that requires SOQ to take immediate action to ensure residents' safety.

It is the goal of this guide to describe, in general, SOQ's regulatory response to varying levels of substantial compliance and noncompliance. This guide provides the overall approach used by SOQ, but it is impossible, of course, to address all potential scenarios within this guide.

Chapter 2: Overview of Safety, Oversight and Quality Programs

This framework addresses the regulatory oversight of both assisted living and residential care facilities. Both of these facility types fall under the definition of a “residential care facility” as defined in Oregon statute. (ORS 443.400(7)) To provide greater context, this section of the guide also overviews other types of facilities that DHS regulates, including adult foster homes and nursing facilities.

A. Residential Care Facilities and Assisted Living Facilities

These settings provide a wide range of individualized services in homelike settings to older adults and people with disabilities, including many individuals with dementia or Alzheimer’s disease. Residential care, assisted living facilities and memory care communities are collectively known as community-based care (CBC) settings, and they are governed by the same set of rules ([OAR chapter 411, divisions 054, 055, and 057](#)). The main difference between residential care and assisted living facilities is that assisted living facilities must provide individual apartments with private bathrooms and kitchenettes, while residential care facilities may have shared rooms and/or bathrooms and often do not have kitchenettes. Both facility types are required to receive a survey/inspection every 24 months (OAR 411-054-0105(2)).

B. Adult Foster Homes (AFH)

Adult foster homes are single-family residences that offer 24-hour care in a home-like setting to five or fewer individuals ([OAR chapter 411, division 049](#)). A wide variety of residents are served in adult foster homes, ranging from those needing only room, board and minimal personal assistance to those needing full personal care or skilled care with the help of community-based registered nurses. Adult foster homes are surveyed/inspected approximately every 12 months and are guided by OAR chapter 411, [division 049](#), [division 050](#), [division 051](#) and [division 052](#).

It is important to note that DHS local offices license all adult foster homes except for those in Multnomah County. Multnomah County has exercised its statutory authority to license and regulate all adult foster homes within its border; however, rules that guide these activities in Multnomah County must be at least as stringent as those adopted by DHS (ORS 443.705 to ORS 443.825; OAR chapter 411, divisions 049 to 052).

C. Nursing Facilities (NF)

Nursing facilities offer a higher level of skilled, clinical care than other facility types. They provide both short-term, rehabilitative care following hospitalization and long-term care for individuals who may have a chronic illness or disability. Unlike adult foster homes, residential care facilities and assisted living facilities, nursing facilities are required to have certified nursing assistant (CNA) caregivers on site at all times, as well as a licensed nurse on duty for each shift. Nursing facilities are inspected for compliance with federal regulations (42 CFR part 483, subpart B) and state regulations (ORS 441.087; OAR chapter 411, divisions 085 to 089) every 12 months.

D. Endorsed Memory Care Communities (MCC)

Endorsed memory care communities are either free-standing buildings or “neighborhoods” within a facility that provide specialized services for individuals with dementia in a secured environment (OAR chapter 411, division 057). In order to be endorsed as a memory care community, a facility must first be licensed as a nursing facility, residential care facility or assisted living facility. The memory care endorsement is in addition to a primary license.

In addition to following the rules related to their underlying licensure, endorsed memory care communities must also follow a set of rules specific to memory care communities (OAR chapter 411, division 057). Only facilities with a state endorsement, who comply with both sets of rules and have a valid memory care endorsement may market or advertise themselves as “memory care communities.”

Endorsed memory care communities must adhere to additional regulatory standards related to the specific care and services for persons living with dementia. Care and services are provided using a person-centered approach, which includes knowing and understanding the resident’s routine and preferences. Caregiving staff in endorsed memory care communities must also be specially trained to work with residents with Alzheimer's disease and other dementias.

Endorsed memory care communities must be located on the ground level of a building; have a secure outdoor area with certain required design features; maintain specific lighting inside the facility; provide locked exit doors with codes for guests; and meet other facility requirements. Endorsed memory care communities are surveyed/inspected according to their primary license type. Most endorsed memory care communities have a primary license as a residential care facility and are subject to the same survey intervals as residential care facilities.

Chapter 3: Staff Teams in Community-Based Care

A. Survey Teams

These staff conduct periodic surveys to inspect facilities and ensure substantial compliance with licensing rules and regulations (For CBC facilities, those rules are [OAR 411-054-0000 to 411-054-0320](#)). The survey teams that visit residential care, assisted living, and nursing facilities are centrally located with SOQ. (Licensors who inspect adult foster homes are located in local field offices throughout the state.) As described in Chapter 5 of this guide, surveyors determine the severity and scope of survey citations, while the corrective action coordinators determine severity and scope for abuse violations based on Adult Protective Services reports, as described in Chapter 10.

B. Licensing Complaint Unit (LCU)

This team investigates licensing complaints that DHS receives which allege that a particular facility is out of compliance. These are complaints that do not rise to the level of being screened in for an abuse investigation but do involve potential violations of the regulations governing residential care and assisted living facilities. The LCU team of compliance specialists investigates alleged licensing violations, and if a licensing violation has occurred, the team provides technical assistance to assist the facility to correct the problem. This team also has the authority to cite facilities for violations if those violations rise to a level requiring more than technical assistance. LCU investigates allegations of licensing violations in CBC settings only; LCU does not investigate alleged licensing violations in adult foster homes or nursing facilities.

C. CBC Policy and Corrective Action Team

There are two types of specialists that comprise this team – corrective action coordinators and policy analysts. These two groups coordinate closely with each and collaborative with facilities, as described below.

1. Policy Analysts

Policy Analysts (OPAs) provide technical assistance to facilities in a variety of different ways. Policy analysts answer questions, visit facilities, establish relationships with facility leadership and provide guidance related to interpretation of rules and regulations. They also work directly with the Long Term Care Ombudsman's (LTCO) office, local APD and AAA offices, families, and residents when

issues arise at a facility. When a facility needs to address a compliance issue, policy analysts can answer any questions concerning the regulation that was violated, and also provide technical assistance to help facilities correct the problem. Each facility is assigned a policy analyst and encouraged to contact their assigned policy analyst as a preventative resource and whenever questions arise.

2. Corrective Action Coordinators

Corrective action coordinators (CACs) promote substantial compliance with regulation by determining the appropriate sanction for the specific violation. These staff determine the *scope* (how many people were affected) and *severity* (how serious was the issue) of a violation and apply other mitigating and aggravating factors to determine appropriate action on behalf of the Department. Corrective action coordinators track and respond to both licensing violations and substantiated abuse allegations to ensure facilities regain substantial compliance as quickly as possible.

D. Other APD Partners

Adult Protective Services (APS)

The Adult Protective Services (APS) unit is an office separate from SOQ, but still within the APD program of DHS. APS investigators are located in field offices (DHS APD offices and Type B AAA offices) around the state; however, the Central APS Unit is located in Salem. APS investigates incidents of abuse or suspected abuse and then compiles information and reports outlining findings of the investigations. The facility abuse investigative reports are delivered to SOQ for processing and corrective action related to abuse and licensing violations.

Local Case Management

Each local office or Type B AAA office has a team of case managers who work with Medicaid consumers in that area. They frequently visit consumers living in long terms care settings, and SOQ works in conjunction with them to ensure consumers living in licensed settings are receiving quality care and services.

Central Delivery and Supports Unit

The APD Central Delivery Supports Unit is responsible for the administration of Specific Needs Contracts for Adult Foster Homes, Assisted Living Facilities, Residential Care Facilities, and Specialized Living Programs. The intent of the specific needs contract is to provide services to specific target group populations with a complex level of care that exceeds the care rendered in standard community-based

care settings. Specific Needs Contracts are developed in accordance with local communities in response to the specific needs of their populations. Contracts are awarded to established and experienced providers who have met a rigorous set of qualifications and have demonstrated the ability to soundly serve the specialized target group. Although SOQ is responsible for relicensure of these facilities with Specific Needs Contracts, SOQ and the APD Central Delivery Supports Unit work collaboratively to ensure facilities adhere to applicable licensing rules, as well as to the agreed-upon terms of their Specific Needs Contract.

E. Intergovernmental Partners

The Department of Human Services works with a variety of intergovernmental partners who provide the Department with information and resources needed to regulate facilities. Those agency partners include:

Long Term Care Ombudsman's Office (LTCO)

The Long-Term Care Ombudsman program is an independent state agency that serves long-term care facility residents through complaint investigation, resolution and advocacy for improvement in resident care. For older adults and people with physical disabilities, the LTCO program serves residents in nursing facilities, residential care facilities, assisted living facilities, continuing care retirement communities and adult foster care homes. LTCO program staff work with a statewide network of over 180 volunteers, and the services of the Long-Term Care Ombudsman program are free and available to residents, families, facility staff, and the public.

Oregon State Fire Marshal

The Oregon State Fire Marshal (OSFM) is the state agency responsible for interpreting the Oregon State Fire Code. Assisted living and residential care facilities are required by licensing rule (OAR 411-054-0090) to adhere to the fire code. This includes developing a safe evacuation plan and providing adequate staffing to ensure evacuation can be accomplished in a timely manner. The OSFM is responsible for reviewing facility's building plans and conducting health, fire and life safety surveys before a facility is initially licensed, and before a license is renewed.

Oregon Department of Veterans' Affairs

Oregon Department of Veterans' Affairs (ODVA) serves the increasingly diverse community of military veterans throughout Oregon. The Aging Veteran Services Division (AVS) is a major program within the ODVA, providing services to the state's

most vulnerable veteran populations. One of these services is to manage two Oregon Veteran Homes, which are long-term care nursing facilities in The Dalles and Lebanon, both licensed by SOQ.

The ODVA also assists veterans, their surviving spouses, minor children or helpless adult children of veterans, and dependent parents in managing their financial affairs and property. In addition, the Aging Veteran Outreach program provides education to those stakeholders who serve aging veterans, and the Volunteer Program focuses on mobilizing the power of volunteers to help Oregon veterans understand and use their earned benefits. For more information about ODVA, please see <https://www.oregon.gov/ODVA/Pages/default.aspx>

Governor's Advocacy Office (GAO)

The Governor's Advocacy Office at the Department of Human Services (DHS) is part of the Department Director's Office. Within the GAO, the DHS Ombudsman program works on issues related to the Department's cash, food, employment, family services, aging and disability medical programs, disability assistance and support services for families, adults and children. This includes adult protective services for vulnerable adults and long term care service issues that fall outside the scope of resident rights in community and nursing care settings.

Disability Rights Oregon (DRO)

Disability Rights Oregon (DRO) upholds the civil rights of people with disabilities to live, work, and engage in the community. This nonprofit works to transform systems, policies, and practices to give more people the opportunity to reach their full potential. While not a regulatory authority, DRO does have the right to visit facilities and offer suggestions related to how facilities can best protect the civil rights of residents with disabilities.

Chapter 4: Licensing Processes for CBC Facilities

A. Initial Licenses

All long-term care facilities must obtain a license from SOQ in order to operate in Oregon. Licenses are valid for one or two years, depending upon the license type. SOQ issues licenses for the operation of:

- Community-based care facilities (two-year license), which include:
 - Residential care facilities
 - Assisted living facilities
- Nursing facilities (one-year license)
- Adult foster homes (one-year license)

Before purchasing an existing building or beginning new construction, a CBC facility applicant must provide DHS with a Letter of Intent stating an interest in owning a new facility. No less than 60 days prior to the projected opening date, the applicant must submit:

- a licensing application;
- approved fire marshal documentation;
- proposed policies and procedures; and
- approved background checks for owner/operators.

Applicants must also provide proof of Secretary of State registration as a business entity, Medicaid paperwork (if serving individuals eligible for Medicaid), and a memory care community endorsement application, if applicable.

B. License Renewals

Facilities receive a renewal invoice approximately 60 days before their license expires. Facilities are requested to submit a license renewal application and fee at least 45 days prior to the expiration date of their license. If a facility does not submit the application and fee by the 45-day target, the assigned SOQ policy analyst will contact the facility within the final 30 days, as a courtesy, to remind the facility and offer assistance in completing the application renewal form. Due to this reminder process, it is extremely rare for a facility to fail to submit the application form and fee by the date the license is due to expire. **Facilities must submit the application form and fee by the expiration date in order to maintain an active license.**

There are additional documents that must also be submitted to renew the license:

- Completed background checks for owning entities and management company owners,
- EIN verification of owning entity and management company,
- Fire and life safety approval from the State Fire Marshal,
- Memory Care Community or Intensive Intervention endorsement application, if applicable,
- Record of satisfactory compliance with any outstanding licensing conditions or letters of agreement, and
- Any additional verification documents, as requested.

Although it is preferable for these items to be submitted by the renewal deadline, it is not necessary in order to maintain an active license. If these additional requirements are not completed by the deadline, the facility's existing license is extended until the facility submits this information and the facility addresses any outstanding substantial regulatory compliance issues. **Once all documentation has been submitted, the new license will be issued.**

C. Endorsements

Residential care facilities, assisted living facilities and nursing facilities can apply to receive a *memory care endorsement* and serve residents with dementia or Alzheimer's disease, if the licensee meets specific criteria to become endorsed as a memory care community.

There is also an endorsement for *Intensive Intervention Communities (IICs)*, governed by [OAR 411, division 055](#). These are small residential care facilities that allow residents with high behavioral, physical, and emotional needs to live in a setting with five or fewer individuals. At the time of this printing, the forms and application processes for this facility type were not yet available online. Once available, they will be found at <https://www.oregon.gov/DHS/PROVIDERS-PARTERS/LICENSING/Pages/index.aspx>.

D. Change of Owner or Manager

Change of Ownership (CHOW) - When the licensee (owner) of a facility changes, whether this is an overall change of the licensee or just a change in the ownership interest, this will result in the need for a change of ownership notification through SOQ. The current licensee must notify SOQ at least **60 days prior** to the proposed date of change and submit a required form.

Change of Management (CHAM) – When the management (operator) changes, the licensee must also notify SOQ **60 days** in advance and submit a required form. For both CHOWs and CHAMs, the residents of the facility (or their representatives, as applicable) must be notified via letter **at least 30 days** in advance of the proposed date of change. The notice to residents must include any changes to rates or policies. Questions about these processes should be directed to a facility's assigned policy analyst.

Chapter 5: CBC Survey Process

A. Overview

CBC survey staff conduct regular surveys to inspect facilities and ensure substantial compliance with regulations. The survey teams make unannounced visits to residential care and assisted living facilities, including endorsed memory care communities. A survey is conducted to determine if standards and regulations have been met. Including that the environment is safe and secure and that residents receive person-centered care that honors their dignity, independence, individuality and decision-making ability. The survey process includes pre-survey preparation, the onsite survey process (which includes entrance and tour, resident review, team decision making and an exit conference with facility staff), and post survey activities.

During each survey, the following areas and topics are evaluated:

- Overall physical environment of facility
- Resident living areas
- Kitchen and food service areas
- Medication and treatment administration
- Move-in process
- Review of residents' records
- Observation of residents' daily care
- Interviews with direct care staff to determine ability to meet resident' needs
- Evaluation of service plans for individual residents
- Review of training files of selected employees
- Fire and life safety

B. Pre-Survey Preparation

Prior to initiating a survey visit, the team collects information from a variety of internal DHS partners and the LTCO. The information includes complaints and concerns that have been investigated since the last licensure survey and helps inform the survey team about issues that may emerge.

C. On-Site Survey Process

Surveyors use a combination of methods, including interviews, observations, and record reviews to determine a facility's level of substantial compliance. After compiling and reviewing this information, surveyors determine if citations should be issued, and determine the level of those citations.

1. Entrance

When the survey team arrives for a survey, they first announce the survey and meet with facility staff to make introductions and provide an overview of the survey process. This meeting includes establishing a daily communication plan and providing the facility administrator with a copy of the entrance conference checklist. The survey team also requests additional materials, including a copy of menus, resident council minutes, employee names and hire dates, training records, schedules, disclosure statements, activity calendars, RN license documentation and a policy on medication administration. Finally, the team requests that signs are posted to alert residents and visitors a survey is in process.

2. Tour

An environmental tour is conducted to determine how resident rooms, dining, activity and common areas, bathing rooms and the outside environment may affect the residents' quality of life, health and safety. A kitchen review is completed with observations of food storage, food preparation, food service and sanitation. As needed, a review of the medication and treatment administration will be completed including observations, medication pass, and review of narcotic disposition logs.

An acuity interview is conducted to determine the level of care being provided. Care items include but are not limited to: heavy activities of daily living care; changes of condition; skin integrity issues; falls and fall risk; outside service providers; devices with restraining qualities; pain; behaviors; catheters/ostomies; and delegated tasks.

3. Resident Review

Interviews are conducted with residents (dependent on cognition), staff, families and sometimes outside providers. Survey staff conduct interviews to review care and services being provided, determine if the facility is responsive to changes of condition (per OAR 411-054-0040), and to determine quality of interactions between the resident and facility employees.

Observations are made of the resident, activities of daily living care, dining room experience, and environment and can include anything that impacts the resident's daily routine. Record reviews determine if identified and unidentified care needs (noted by observations and interviews) have been evaluated, monitored, assessed, and care planned. Additional record reviews address medication, treatment records, adherence to physician orders, and determine if the facility has systems in place to review the 24-hour care needs of residents.

4. Decision making

Surveyors meet daily as a team to discuss findings that indicate potential violations. The team reviews these findings to determine both the scope and severity of each violation.

- **“Scope”** refers to the number of residents or locations within a facility that are affected. Scope is categorized as:
 - **Isolated** - one or a very limited number of residents or employees are affected or a very limited area or number of locations within a facility are affected.
 - **Pattern** - more than a very limited number of residents or employees are affected, or the situation has occurred in more than a limited number of locations, but the locations are not dispersed throughout the facility.
 - **Widespread** - the problems causing the deficiency are pervasive and affect many locations throughout the facility or represent a systemic failure that affected, or has the potential to affect, a large portion or all of the residents or employees.
- **“Severity”** refers to the seriousness of the violation, or the harm (or potential for harm) the violation has caused. “Harm” is defined as a measurable negative impact to a resident’s physical, mental, financial or emotional well-being.
 - **Minor harm** means harm resulting in no more than temporary physical, mental or emotional discomfort or pain without loss of function, or in financial loss of less than \$1,000.
 - **Moderate harm** means harm resulting in temporary loss of physical, mental or emotional function, or in financial loss of \$1,000 or more, but less than \$5,000.
 - **Serious harm** means harm resulting in long-term or permanent loss of physical, mental or emotional function, or in financial loss of \$5,000 or more.

Violations are classified according to the assessed scope and severity, ranging from A to L, with A being no harm and L being widespread serious harm. These violations may be cross-reported to APS as needed. See the below chart.

SEVERITY	SCOPE		
	Isolated	Pattern	Widespread
Level 4	J	K	L
Serious harm or death			
Level 3	G	H	I
Moderate harm or potential for serious harm			
Level 2	D	E	F
Minor harm or potential for moderate harm			
Level 1	A	B	C
No actual harm or potential for only minor harm	Technical Assistance		

“Immediate Jeopardy” is a term uniquely used during the survey process.

Immediate Jeopardy occurs if the survey team encounters a situation in which the failure of the facility to comply with a rule of the Department has caused or is likely to cause serious injury, serious harm, serious impairment or death to a resident, the team will identify an immediate jeopardy. In these cases, the survey team will not exit the facility until the facility has submitted an approved a plan which ensures immediate safety for residents specifically addressing the situation(s) that led to an immediate jeopardy.

Survey staff generally speak with facility administration at the end of each survey day to provide updates regarding the violations being determined and the level of harm of those violations. The survey team will also provide the facility with the specific status of the survey, including findings with the environment, kitchen, medication administration and individual record reviews.

5. Exit Conference

Once the onsite survey is complete, surveyors hold an exit conference with facility staff to discuss findings of the survey. During the exit conference, the following will be discussed: an explanation of the findings and what they mean in terms of substantial compliance with required rules; the timeline for completion of the

written survey report; any requirement(s) for the facility to prepare a plan of correction (if required by the findings); and what to expect concerning any survey revisits. When the exit conference has been completed, the surveyors leave the facility.

D. Post-Survey Activities

1. Survey Report

Within 10 business days of leaving the facility, the survey team completes a detailed report, called a 2567, outlining the citations and specific examples that pertain to the regulations. The facility then has 10 business days from receipt of the report to respond and submit a Plan of Correction (POC; 411-054-0105(2)(a)) to SOQ. The POC describes the action that will be taken by the facility to correct any violations and any systemic issues to ensure violations will not happen again.

When a facility submits a Plan of Correction, the survey team coordinator reviews the POC to determine if the following questions have been sufficiently addressed:

- What actions will be taken to correct the rule violation for each example/resident?
- How will the system be corrected to prevent recurrence and ensure compliance is maintained?
- How often will the area needing correction be evaluated?
- Who will be responsible to see that the corrections are completed/monitored?

The survey team coordinator reviews the POC and either approves it or not, based on whether the POC successfully addresses these questions. If the POC is not approved, the survey team coordinator will contact the facility administrator and request changes be made to improve the POC in order to ensure compliance issues are sufficiently addressed.

2. Informal Dispute Resolution (IDR) related to Survey

If the facility believes the survey report is factually inaccurate or reflects an inaccurate application of licensing standards and wants to dispute the findings of the survey, the facility must request an Informal Dispute Resolution (IDR) within the same 10 business day time period during which the facility provides the plan of correction.

The Community-Based Care Manager manages the overall IDR process. An IDR may be held by telephone, in writing, or at a face-to-face meeting, with the facility informing the manager of the facility's preferred option. If the facility does not have a preference concerning format, the manager will most likely hold the IDR by telephone. The manager and the facility shall mutually agree upon the time and location for the IDR. The manager is responsible for ensuring an objective, third-party staff member from the Department is present at the IDR to serve as the decision-maker. An individual who performed the survey at issue shall not serve as an IDR decision-maker.

If the facility or SOQ plans to have an attorney attend the IDR, that party must notify the other of the intent prior to the IDR meeting. A facility may challenge the survey by demonstrating that a deficiency should not have been cited. In order to successfully demonstrate that a specific deficiency should not have been cited, the facility will need to present new information that was not considered during the survey and is directly relevant to the citation(s) being disputed or demonstrate that the licensing standard was inaccurately applied to the circumstances.

The facility will be sent the final decision within 10 business days from the date of the IDR. If the facility is successful at demonstrating a deficiency should not have been cited, SOQ will send the facility a revised copy of the survey report.

- Example 1: The facility requested an IDR regarding a citation concerning the call system. During the IDR process, the facility failed to provide evidence sufficient to indicate the relicensure survey citation was in error. With no new evidence presented, the survey team determined the citation should not be removed, and no changes were made.
- Example 2: The facility requested an IDR regarding a citation concerning the call system. On the day the survey team asked for call system records, the call system report software had not been functioning correctly. The facility brought reports from the call system to the IDR meeting that showed call times were within appropriate boundaries. This information indicated the facility was in substantial compliance, which caused the survey team to remove the call system citation.

3. Corrective Action Process related to Survey

The corrective action coordinators receive the results of every survey from the survey team. The coordinators review every survey that has tag citations and

consider all suggestions from the survey team (i.e., require training be conducted, require consultants be hired, etc.). The corrective action coordinators consult with policy analysts if it appears that progressive interventions are the best approach, given the circumstances. The coordinators will also determine if sanctions are appropriate. This involves the coordinator considering the scope and severity of each violation as indicated by the survey report, applying mitigating and aggravating factors, and then issuing sanctions, as outlined in Chapter 11 of this guide. If SOQ issues a sanction such as a license condition based on survey results, facilities will have due process rights, including hearing rights.

Chapter 6: Licensing Complaint Unit (LCU) Process

During recent years, the number of licensed residential care facilities and assisted living facilities has increased greatly, which means the number of complaints DHS receives has also increased. In response, the Department examined ways of assisting facilities to resolve issues before they rose to the level of abuse or survey citations. To that end, the Department created the Licensing Complaint Unit (LCU).

When SOQ receives a complaint related to a potential licensing violation within a facility, LCU deploys a trained compliance specialist to the facility to review the complaint. Compliance specialists review both the circumstances surrounding an individual occurrence and possible systems issues. If a complaint is confirmed, the compliance specialist will generally provide technical assistance; however, if the issue of non-compliance reaches a level beyond technical assistance, compliance specialists have the authority to issue violations at this early stage, so that facilities can come into substantial compliance without the need for a complaint investigation or survey review.

A. Receipt of complaints (APS referral, public, internal)

LCU is often deployed if DHS is notified there may be potential licensing violations at residential care facilities or assisted living facilities. These notifications may come in the form of complaints from public citizens; referrals from agency partners, such as APS or LTCO; or based on information or concerns from within SOQ.

B. Review/Investigation

Through observation, record review, and interviews, LCU staff investigate complaint allegations of licensing rule violations. LCU's compliance specialists visit facilities unannounced in response to allegations, as well as conduct revisits to ensure facilities have followed through on correction plans to remedy areas of non-compliance. An LCU investigation is narrower in scope than a survey inspection and is usually focused on specific alleged incidents or practices. LCU does not review allegations of abuse; however, if a compliance specialist witnesses or suspects abuse, that specialist will immediately refer the situation to APS for an abuse investigation. Likewise, LCU may also refer complaints to the LTCO if there are issues of resident preference unrelated to any licensing rules.

C. Determination and Follow Up

If the LCU compliance specialist finds there is not enough information to confirm a complaint, they will close the complaint, and the facility will receive a report stating that the allegation was not confirmed and that there will be no action taken.

If the compliance specialist finds evidence to confirm the complaint, the compliance specialist may take either of the actions below:

- Provide technical assistance to the facility to assist the facility in correcting the problem; or
- Send his/her report to the corrective action coordinator and recommend additional response.
 - The corrective action coordinator will review the report and determine if it is appropriate to sanction the facility for a licensing violation pursuant to the process described in Chapter 13. If a civil penalty is warranted, the corrective action coordinator will use the severity grid described in this framework and apply aggravating and mitigating factors described in Chapter 11.

(Please see later chapters for specific information concerning range of possible sanctions.)

Once an investigation is complete, LCU will issue a report of the findings to the facility and any complainant who indicates the desire to receive a copy.

D. Due Process

Findings resulting in technical assistance do not have the same due process rights as higher level violations. Technical assistance findings are not posted on the website, nor do they result in sanctions. Facilities may, however, be asked to provide a plan of correction that details how the facility will address the issue. Higher level violations always require a plan of correction and are posted to the [Licensed Long Term Care Complaints Search website](#).

Chapter 7: CBC Adult Protective Services (APS) Process

Local Adult Protective Services (APS) offices (DHS or Type B AAA) receive, screen and respond to reports of abuse, suspected abuse, or injuries of unknown cause where abuse cannot be ruled out for residents of APD-licensed facilities, including CBC settings. The process for receiving, screening and investigating reports of abuse of CBC residents is outlined in OAR Chapter 411, Division 20.

A. Screening

All reports of abuse of residents of CBC facilities are screened by APS staff according to OAR 411-020-0060. APS screeners gather information to determine if the individual meets eligibility for adult protective services and whether the reported concern, *if true*, meets a definition of abuse in OAR 411-020-0002(1).

Any resident of an DHS APD-licensed residential care or assisted living facility is considered eligible for adult protective services. APS receives reports of suspected abuse of residential care or assisted living facility residents from various sources, including residents, families of residents, professionals involved in residents' care, facility care staff or facility management. Every incident self-reported to APS by a facility is considered a report of potential abuse and screened accordingly.

If the reported concern does not meet the APS definition of abuse (i.e. even if the incident is found to have occurred, it would not have met the APS definition of abuse), APS staff will close the intake and then make any needed referrals for information or follow-up by case managers, licensors, the long term care ombudsman or other entities. If the reported concern does meet a definition of abuse, it will be assigned for APS investigation.

B. Investigation by APS

APS is required to conduct a complete, thorough and objective facility investigation when a resident is reported to have been abused by a facility licensee, facility staff, contractor or volunteer of the facility and the reported concern, *if true*, meets the APS definition of abuse. OAR 411-020-0002(1) defines the following types of abuse:

- Physical Abuse
- Neglect
- Abandonment
- Verbal or Emotional Abuse

- Financial Exploitation
- Sexual Abuse
- Involuntary Seclusion
- Wrongful Use of a Physical or Chemical Restraint

APS or AAA staff screen and investigate reported incidents on a single-victim basis. This means that every resident who is an Alleged Victim (AV) of abuse will have a separate case, separate investigation and separate determination of whether abuse occurred or not. In addition, APS names every individual staff member alleged to have abused an Alleged Victim as a separate Alleged Perpetrator (AP) in a separate allegation. A report is written on behalf of each AV. A report may contain multiple allegations of abuse against one AV; however, no single report would ever have multiple AVs.

In addition to individual staff named as Alleged Perpetrators, APS names the facility licensee as an Alleged Perpetrator to determine whether the facility's actions or inactions contributed to the reported abuse. The APS investigator conducts interviews and gathers evidence to determine whether the facility actively or passively failed to provide the basic care or services necessary to maintain the health and safety of an adult, *when that failure results in abuse as defined above*.

For example, neglect may be substantiated even if there is no actual harm (physical or emotional) to a resident, if the resident was placed at "risk of serious harm" by the facility's actions or inactions.

C. Determination and Processing by APS

When the investigation of each allegation is complete, the APS investigator evaluates all the evidence and reaches a determination for each allegation. Possible determinations include Substantiated Abuse, Unsubstantiated Abuse, Inconclusive, or Administrative Closure, if the investigation is not able to be completed (see OAR 411-020-0121). The standard of proof for an APS determination is "preponderance of the evidence," which means that a majority of the evidence supports a particular conclusion.

To substantiate abuse by the facility, a preponderance of the evidence gathered by the investigator needs to indicate that the facility's actions or inactions led to (1) physical harm, significant emotional harm, unreasonable discomfort or serious loss of personal dignity, or (2) risk of serious harm to the resident, defined in OAR 411-

020-0002(41) to mean that, “without intervention, the individual is likely to incur substantial injury or loss.”

To close the investigation, the APS investigator must enter a determination for every allegation against every Alleged Perpetrator named in the case. Depending on the facts of the case, the findings against the facility and individual staff will vary.

Possible variations include:

- Facility substantiated, individual staff substantiated:
 - E.g. staff abused a resident, and evidence indicates facility could have foreseen or prevented the abuse but did not.
- Facility substantiated, individual staff unsubstantiated:
 - E.g. no individual staff abused the resident, but evidence indicates facility’s actions/inactions caused harm or potential for harm.
- Facility unsubstantiated, individual staff substantiated
 - E.g. staff abused a resident, and evidence indicates facility could not have foreseen or prevented the abuse.
- Facility unsubstantiated, individual staff unsubstantiated
 - Evidence indicates no abuse occurred by facility or any facility staff.

D. Report processing by APS and SOQ

APS and SOQ jointly have 120 days to complete an investigation. Once the APS investigator completes a preliminary draft report, a supervisory review in APS occurs. By internal policy, APS generally uses 60 days to complete this draft report and supervisory review. Following the supervisory review and approval, the draft report is forwarded to SOQ, and up to 60 additional days may be used process the report.

If any allegations of abuse have been substantiated in the investigation, local APS sends the preliminary draft report to the facility for safety planning at the same time the report is sent to SOQ for processing. The preliminary report is provided to the facility as a courtesy, so facility staff may begin any planning processes needed to ensure all residents are safe and to prevent recurrence of abuse. The facility’s opportunity to dispute the findings of the report comes later in the process, after SOQ has approved and finalized the report.

Once the APS report is sent to SOQ, SOQ assigns a corrective action coordinator to review and process the report. SOQ's corrective action coordinators review substantiated abuse violations, determine scope and severity of the abuse violations, consider any aggravating and mitigating factors and issue sanctions. Corrective action coordinators also review APS reports to determine whether any licensing violations have occurred, determine the scope and severity of those violations, and issue sanctions if appropriate as outlined later in this guide.

Following these processes, the facility and the Registered Agent receive the final report and any associated sanctions via written notice from SOQ. The notification also explains the facility's opportunity to dispute the findings of the report and/or the sanction. If a sanction is imposed, a facility has the option to request a hearing and engage in an informal conference with SOQ prior to the hearing, if they choose to do so. Substantiated APS reports are publicly posted when all due process opportunities have been exercised or timelines have expired.

- If a sanction is issued, facilities are entitled to request a contested case hearing as provided by ORS 183.415, and they may choose to be represented by an attorney at the hearing. The timeline for requesting a hearing will be detailed in the notice of sanction.
- Requests for hearing may be sent by US Mail or by email. A request sent by U.S. mail is "received" on the date it is postmarked.

Chapter 8: Corrective Action – STEP 1

Reports Sent to Corrective Action Coordinators

A progressive, positive approach is used by the CBC team to address regulatory non-compliance whenever possible. SOQ's goal is to work collaboratively with facilities to achieve substantial compliance with regulations as quickly as possible and to maintain that substantial compliance on a permanent basis. CBC staff apply corrective action that is designed to encourage facilities to analyze and remedy issues of non-compliance as quickly as possible with the least amount of oversight.

SOQ prefers to work closely with facilities to address problems as early as possible and with open communication, as this achieves the best possible result for the Oregonians living in licensed settings. The CBC policy and corrective action team works with internal and inter-agency partners to apply the most appropriate and least restrictive corrective action possible to keep residents safe and support person-centered care.

This chapter outlines the process that is followed from the time the Department learns of a potential violation, through the final issuance of a sanction.

A. Allegation Occurs

An allegation occurs when a facility, resident, family member, or another party notifies DHS about a potential issue of noncompliance at a licensed facility. This notification might be a phone call to the DHS SAFE line (1-855-503-SAFE (7233)), a facility self-report, a complaint to the CBC Licensing Complaint Unit, a referral from the Governor's Advocacy Office (GAO), a phone call to a staff person, or any number of other sources. Whatever the source of the allegation, once SOQ learns of a potential violation, this alleged incident will receive follow up from the Department.

B. APS, Survey and LCU Investigate and Submit Reports to CACs

APS investigators, the CBC survey team, and LCU have been discussed earlier in this guidebook. APS investigates alleged abuse, LCU investigates alleged licensing violations, and the survey team conducts licensing and re-licensing surveys of each facility. Each of these three programs sends completed reports to the CBC corrective action coordinators for processing:

- APS office – send reports of substantiated abuse
- CBC Survey team – send all survey reports that contain citations
- LCU team – send complaint reports from site visits

Following are examples of how DHS might learn of an alleged incident and describes what might happen:

Example 1: A family member calls the DHS SAFE line and reports that her mother fell, bumped her head, and received a painful bruise because facility staff left her walker across the room after helping her into bed. APS would screen this incident to determine if actions or inactions of facility staff may have resulted in the resident experiencing harm.

Example 2: A resident's family member contacts APS and complains about slow assistance during meal time. Since this involves a potential licensing violation and does not rise to the level of abuse, the LCU team would follow up to determine whether the facility violated a licensing rule. If so, LCU would likely provide technical assistance.

Example 3: The Ombudsman forwards a concern to a CBC policy analyst that a resident is not receiving enough assistance with bathing, but that there is no evidence that any harm has yet occurred. This concern would either be referred to the APS or the LCU for screening, depending on the facts of the situation and the level of risk to the resident.

Example 4: While conducting a survey, a member of the survey team learns of a resident to resident altercation in which one resident received a large skin tear on the arm. The surveyor would ensure the facility reported the incident to APS immediately and walk them through the steps if needed. If the facility failed to self-report the incident immediately, they would be subject to a civil penalty for failure to self-report abuse or suspected abuse.

Chapter 9: Corrective Action – STEP 2

Determine Type of Violations

As described in the previous chapter, LCU, Survey, and APS each send reports to the CBC team for final action. The CBC corrective action coordinators use this information to issue sanctions for three basic types of violations:

- **Abuse violations** for substantiated harm or risk of serious harm to a resident, as determined by APS;
- **Licensing violations** for failures to substantially comply with licensing rules, as determined by SOQ; and/or
- **Failure to self-report** abuse or suspected abuse.

Role of the Corrective Action Coordinator

When a corrective action coordinator receives a report from an APS investigator, the coordinator will first determine which finding the APS investigator has made (Substantiated Abuse, Unsubstantiated Abuse, Inconclusive, or Administrative Closure). If the finding is unsubstantiated abuse, the coordinator will determine if a licensing violation can be substantiated for the same conduct. The coordinator will also identify who is responsible for the violations. The corrective action coordinators will first begin by categorizing the violation(s) as follows:

1. Does the violation deal with abuse?

Has abuse been substantiated? APS determines if a facility has failed to substantially comply with an Oregon Administrative Rule (OAR) related to abuse (OAR chapter 411, division 020). If APS investigates an allegation of abuse and “substantiates” the abuse, the decision is forwarded to CBC’s corrective action to determine the appropriate response. The Department has the authority to issue sanctions that include civil penalties for incidents of substantiated abuse. If a report is “unsubstantiated” for abuse, the corrective action coordinator may still determine a non-abuse licensing violation has occurred.

2. Does the violation deal with licensing?

If abuse is not substantiated, has a licensing violation occurred? Licensing violations occur when a facility has failed to substantially comply with an Oregon Administrative Rule (OAR chapter 411, division 054 for facility and 057 for memory care communities). “Substantial compliance” means a level of compliance with state law and with rules of the Department such that any identified deficiencies pose a

risk of no more than negligible harm to the health or safety of residents of a facility. Licensing violations occur when a state regulation is violated but there is no substantiated abuse. These violations may be issued as a result of:

- Deficiencies found during the survey process
- Deficiencies found during the LCU complaint review process
- Deficiencies found during an abuse investigation in which a facility failure did not rise to the level of abuse but *did* represent a violation of a licensing rule (OAR chapter 411, divisions 54 or 57).

3. Did the facility self-report abuse or potential abuse?

Facilities are required to report abuse or suspected abuse of a resident, or injuries of unknown cause where abuse cannot be ruled out, to the Department immediately, which means within 24 hours. This deadline includes weekends and holidays. If a facility fails to report within 24 hours, the Director may impose a civil penalty of not more than \$1,000. The facility must not retaliate in any way against anyone who participates in making an abuse complaint. For more information on abuse investigation and reporting, please see the [Abuse Investigation and Reporting Guide for Providers](#).

Once the CBC corrective action coordinator determines what type of violation occurred, the next steps involve determining severity and scope, and then applying sanctions.

Chapter 10: Corrective Action – STEP 3

Name the Responsible Party and Determine Severity and Scope

CBC corrective action coordinators and policy analysts use specific processes to make decisions related to corrective action. The processes for determining sanctions for substantiated abuse allegations and licensing violations are very similar, as described in this guide.

Sanctions for both substantiated abuse and licensing violations are issued according to who is deemed responsible, as well as the severity, or level of harm or potential for harm, that a resident or residents have experienced or to which they are exposed. (*See Appendix A for a flowchart of the corrective action process for sanctioning substantiated abuse violations, and see Appendix B flowchart illustrating the licensing violation sanction process.*) It is current Department policy that civil penalties are always issued when a facility is substantiated for abuse.

3.1. Which parties are responsible for the violation(s)?

As described in Chapter 7, APS investigators investigate allegations of abuse in facilities to determine whether the facility itself, an individual staff member, or both should be substantiated for abuse. Each allegation is substantiated separately based on the facts of the case, with the following variations possible:

- *Facility substantiated for abuse, staff not substantiated* - this occurs when APS finds the facility was solely responsible for the occurrence of abuse.

Example: A resident at risk for falling must be checked every two hours to assist with toileting, but due to lack of adequate staff, the resident goes four hours without toileting assistance. In that time, the resident attempts to walk to the toilet independently, and in the process, the resident falls and breaks a hip. In this case, the facility would receive a letter of determination indicating the results, as well as a notice of civil penalty.

Example: The facility failed to train a caregiver on the use of a Hoyer lift. A supervisor told the caregiver to use the Hoyer lift to transfer a resident who was care planned for one-person transfer assistance for all transfers. The caregiver had not received any training on Hoyer transfers and while assisting the resident with a Hoyer transfer, the resident was injured.

- *Both the facility and individual staff substantiated for abuse* – this occurs when APS finds a staff person acted independently when abusing a resident, but the facility was also responsible (culpable) for allowing the abuse to occur or could have done something to intervene and prevent the abuse to the resident.

Example: A resident experiences sexual abuse by a caregiver. The investigation reveals the facility was aware of repeated incidents of inappropriate sexual contact with residents by the staff but did not respond appropriately. The facility would be substantiated for neglect and receive a letter of determination indicating the results, as well as a notice of civil penalty. The alleged abusive staff would be substantiated for sexual abuse and receive separate notification and due process.

- *Individual staff substantiated for abuse, facility not substantiated for abuse, but licensing violation issued* – this occurs when APS finds an individual staff acted independently to commit abuse, but there is insufficient evidence for APS to substantiate neglect on the part of the facility. In such cases, SOQ may still determine that the facility violated a licensing rule, based on the evidence in the investigation, and issue a licensing violation to the facility.

Example: Staff person steals a resident's medications from the medication cart. Abuse is substantiated for the staff person because they committed financial exploitation (theft of resident property), but there is insufficient evidence to substantiate neglect by the facility. The investigation does reveal, however, that several staff have expired background checks, so the facility is issued a licensing violation for failing to ensure current background checks.

- *Individual staff substantiated for abuse, facility not substantiated for abuse or issued a licensing violation* – this occurs when APS finds that an individual acted independently to commit abuse, but there was no responsibility on the part of the facility for the abuse or grounds for issuing any licensing violation.

Example: A staff person, who was up-to-date on all training, had worked in the facility for 10 months, and had no prior history or incidents, stole jewelry from a resident's room. When advised of the incident, the facility put the employee on administrative leave pending investigation and contacted APS and law enforcement right away. APS substantiated financial exploitation by the individual

staff but determines that the incident was not foreseeable or preventable by the facility.

- *Neither facility or staff substantiated for abuse; licensing violation issued* – this occurs when no abuse is found by APS, but the CBC corrective action coordinator determines a licensing rule was violated. The corrective action coordinator would determine scope and severity of the potential for harm and issue a licensing violation, according to the corrective action process described below.

Example: Facility fails to order a resident’s prescription skin cream in a timely manner, resulting in the resident missing two scheduled applications. The resident does not experience harm but is placed at risk of moderate harm by missing two applications of the cream.

- *Neither facility or staff substantiated for abuse; no licensing violation* – this occurs when no abuse is found by APS and the CBC corrective action coordinator has determined that no licensing rules have been violated. In this case, no action is taken, and the facility receives a letter of determination indicating that the case is closed.

Example: Facility self-reports that a resident in memory care scheduled for toileting checks every two hours fell on the way to the toilet, fracturing a hip in the process. Documentation shows that the facility was following the care plan as written and that the resident had received the appropriate toileting check just over an hour before the fall. As a result of the incident, the facility immediately sends the resident to the ER, documents the fall, evaluates the situation, and updates the resident’s care plan to hourly toileting checks.

3.2 Determining Severity

The next step is to determine the severity or “seriousness” of harm or potential for harm for purposes of any corrective action. (One exception: Survey teams will determine level of severity and include that determination in survey reports.) Corrective action for both substantiated abuse and licensing violations are issued according to the level of harm or potential for harm, that a resident or residents have experienced or to which they are exposed. Generally, penalties will not be imposed for a licensing violation until other lesser sanctions have been imposed without resolving the issue.

Harm is defined in Oregon administrative rule for residential care and assisted living facilities as “a measurable negative impact to a resident’s physical, mental, financial, or emotional well-being.” (See OAR 411-054-0120(2)(d)) Oregon law defines several different levels of harm. (See ORS 441.731) These harm definitions apply to both abuse and licensing violations.

In each case, the corrective action coordinator determines which of the following severity of harm levels apply to the substantiated abuse or licensing violation for purposed of any corrective action:

- **Level 1 harm** - no actual harm, but potential for minor harm. (No violations or civil penalties are issued for Level 1 violations.)
- **Level 2 harm** - minor harm or potential for moderate harm
- **Level 3 harm** - moderate harm or potential for serious harm
- **Level 4 harm** - has caused or is likely to cause serious harm, serious impairment, or death
- **Elevated harm** is a term that applies when the Department investigates and makes a finding of abuse in a residential care facility arising from deliberate or other than accidental action or inaction that is likely to cause a negative outcome by a person with a duty of care toward a resident of a residential care facility. If the abuse resulted in the death, serious injury, rape or sexual abuse of a resident, the Director shall impose a civil penalty on the facility of not less than \$2,500 and not more than \$15,000 for each occurrence of substantiated abuse, not to exceed \$40,000 for all violations occurring in a facility within any 90-day period.

Examples of different levels of harm, and different potential sanctions based on those harm levels, are presented in the chart below.

<i>Level</i>	<i>Definitions</i>	<i>Abuse</i>	<i>Licensing Violation</i>
Level 1	<i>No actual harm or potential for minor harm:</i> <i>This means no actual harm occurs, or there is potential for no more than temporary physical, mental or emotional discomfort or pain without loss of function or potential for financial loss of under \$1000.</i>	 <i>No actual harm or potential for minor harm</i>	<i>Potential for minor harm</i>

- **Level 1** no penalty issued for either abuse or a licensing violation.
- Example of **Level 1 licensing violation**: Resident missed one dose of daily vitamin. No harm occurred. LCU will provide technical assistance.

Level 2	Minor harm or potential for moderate harm: <i>This means there is no more than temporary physical, mental or emotional discomfort or pain without loss of function, there is potential for temporary loss of physical, mental or emotional function or there is financial loss of less than \$1,000, or potential financial loss of \$1,000 or more, but less than \$5,000.</i>	➡	Minor harm	Potential for moderate harm
	• Example of Level 2 abuse: Resident falls due to poor lighting in her room. She suffers minor soreness for a couple of hours. • Example of Level 2 licensing violation: Resident misses a dose of scheduled medication for arthritis pain but experiences no pain. Despite the fact the resident experiences no actual harm, there was <i>potential</i> for moderate harm.			

Level 3	Moderate harm or potential for serious harm: <i>This means there is temporary loss of physical, mental or emotional function, or potential for long-term or permanent loss of physical, mental or emotional function, or financial loss of \$1,000 or more, but less than \$5,000, or potential financial loss of \$5,000 or more.</i>	➡	Moderate harm or potential for serious harm	Potential for serious harm
	• Example of Level 3 abuse: A resident attempts to walk to the toilet independently after four hours without the facility staff performing the two-hour toileting checks required in the care plan. The resident falls and fractures a hip. Facility evaluated injury and immediately sent resident to ER for evaluation, where it was determined resident sustained a fractured hip. Facility staff did not follow the care plan, which resulted in substantiation of neglect by both the individual staff and the facility, based on the evidence gathered during the investigation. • Example of Level 3 licensing violation: A level 3 facility licensing violation is frequently issued in conjunction with substantiated abuse attributed to the individual. In these cases, an individual is found to be responsible for abuse, but often evidence indicates the facility could not have prevented the abuse. However, facilities are responsible for the conduct of their employees while at work, so the facility will generally be issued a licensing violation. Example: Individual staff did not give scheduled medication to a resident as ordered, causing a risk of serious harm, despite the facility having provided all necessary training and other support related to medications. Individual staff is substantiated for abuse, and the facility receives a licensing violation for failure to administer medication as ordered.			

Level 4	Serious harm: <i>This means there is long-term or permanent loss of physical, mental or emotional function or financial loss of \$5,000 or more.</i> • Example of Level 4 abuse: Resident falls after tripping on loose rug and complains of pain. Facility fails to adequately evaluate and monitor the resident after the fall and facility fails to seek medical attention until the resident complained of pain for several days. When the resident arrives at the hospital, she is found to have fractured a hip after sustaining the fall. Both individual staff involved and the facility as a whole are substantiated for neglect, based on the evidence gathered during the investigation. (This example differs from the Level 3 abuse example in the following ways – here, the facility failed to immediately assess and evaluate the resident, failed to adequately address the resident’s pain, and the problem persisted for a longer period of time.) • Example of Level 4 licensing violation: This does not generally apply to licensing violations as this level of potential harm would constitute abuse.	 Serious harm or death	<i>Generally defined as abuse, and not a licensing violation</i>
Elevated	Serious injury, sexual abuse, rape, or death that arose from deliberate or by other than accidental action or inaction that is likely to cause a negative outcome by a person with duty of care toward resident, and if the abuse resulted in the death, serious injury, rape, or sexual abuse of a resident, the action was likely to cause a negative outcome. • Example of Elevated abuse: A facility staff member contacts APS to report a co-worker who is believed to be touching residents’ genitals during care. The staff member making the allegation claims she and other co-workers have shared their concerns with the facility administrator on several occasions. Evidence from the APS investigation shows a preponderance of evidence that the employee in question was touching residents inappropriately and the administrator failed to report the incidents or remove the threat, despite several staff communicating concerns. • Example of Elevated licensing violation: This does not apply. This category involves harm to a resident, which would constitute abuse rather than a licensing violation.	 Serious injury, sexual abuse, rape, or death	<i>Does not apply to licensing violations; this would be considered abuse</i>

Please note: Final sanction(s) will depend upon the specific circumstances of each individual case.

3.3. Determining Scope

The corrective action coordinator is responsible for determining the scope of the violation, except that survey teams determine scope during the survey process. The

survey teams and corrective action coordinators use the same definition of scope. Scope involves determining how many residents or staff are affected.

The corrective action coordinator reviews the existing violation to determine the level of the scope of the violation:

- If an **isolated** violation has occurred affecting one or a very limited number of residents or employees, or affecting a very limited number of locations within the facility;
- If the facility has a **pattern** of similar violations affecting more than a limited number of residents or employees, or the situation has occurred in more than a limited number of locations throughout the facility; or
- If there are **widespread** violations that are pervasive or result in systemic violations, and affect, or had the potential to affect, a large portion or all of the residents or employees.

Chapter 11: Corrective Action – STEP 4

Determine Civil Penalty Amount

All instances of substantiated abuse violations will receive a civil penalty. Licensing violations will only result in civil penalties if the licensing violation(s) has not been remedied, as required by prior correction action, and is determined to be a severity level 2 or higher.

Once the severity of the level of harm and the scope of the violation have been determined, the next step before finalizing the civil penalty amount involves applying aggravating and mitigating factors. The corrective action coordinator goes through the following process to apply the factors listed below, to determine if the amount of civil penalty should be increased or reduced.

4.1 Does the facility have a history of similar violations?

The corrective action coordinator will pull the corrective action history of the facility to determine if the facility has had similar violations in the past. This history will be used to answer the questions below concerning aggravating and mitigating factors.

Based on the following, should the penalty be increased or decreased?

Aggravating factors (increase civil penalty amount):

- *Facility's history* – the facility had prior similar violations.
- *Failure to remedy* – the facility failed to satisfactorily correct prior similar violations or failed to prevent a recurrence of similar violations.
- *Financial benefit* – the facility or facility employees gained financially as a result of the violation.

Mitigating factors (decrease civil penalty amount):

- *Facility's history of correcting past violations* – the facility corrected previous violations and prevented the recurrence of violations.
- *Facility's ownership/management history* – the previous violations happened under prior ownership/management.
- *Self-report* – the facility self-reported immediately.

4.2 Apply Civil Penalty Matrix

Once the corrective action coordinator has reviewed all relevant information, identified responsible parties, determined severity and scope of the violation, and applied both mitigating and aggravating factors, the final step is to determine the appropriate corrective action. It is current Department policy that, if substantiated abuse is involved, a civil penalty will always be imposed.

Using the chart below, the corrective action coordinator begins at the “None or Both Factors Apply” point on the appropriate severity row (Level 1, Level 2, etc.).

Then, the corrective action coordinator considers whether any aggravating or mitigating factors apply. If the answer to any of the aggravating factors questions is “yes,” the civil penalty is increased to the top of the penalty range. If the answer to any of the mitigating factors questions is “yes,” the civil penalty is decreased to the bottom of the penalty range.

If both types of factors exist, or no factors at all, the civil penalty amount stays in the middle of the range, at the “None or Both Factors Apply” point.

Civil Penalty Chart

Severity Level	Mitigating Factors Apply	None or Both Factors Apply	Aggravating Factors Apply	Penalty Range
Level 1	0	0	0	0
Level 2	\$250	\$375	\$500	\$250 - \$500
Level 3	\$500	\$1,000	\$1,500	\$500 - \$1,500
Level 4	\$1,500	\$2,000	\$2,500	\$1,500 - \$2,500
Elevated Abuse	\$2,500	\$8,500	\$15,000	\$2,500 - \$15,000

(The Department does not issue civil penalties for Level 1 violations, as these represent no actual harm or potential for only minor harm. For example: a facility failed to give a resident their daily multi-vitamin in the morning, as preferred, but realized the error and gave it several hours later. The resident experienced no harm as a result.)

After determining scope and severity of harm and reviewing both mitigating and aggravating factors, the corrective action coordinator will make a determination as to the appropriate civil penalty amount.

4.3 Civil penalty for failure to self-report abuse

As of January 1, 2018, DHS may issue a fine of up to \$1,000 for each instance in which a facility fails to report abuse of a resident to DHS as required by state law. In these instances, DHS generally issues a violation and a \$750 penalty for the first instance of failure to self-report. Each subsequent instance generally results in a violation and a penalty of \$1,000.

If a facility self-reports, the penalty amounts for substantiated abuse may be reduced as follows:

- In the case of substantiated allegations of level 2 abuse (minor harm or potential for moderate harm) or level 3 abuse (moderate harm or potential for serious harm), facilities that self-report incidents will receive a 25% reduction in the civil penalty amount.
- Facilities may also submit documentation that they have acted to remediate the issue leading to the level 2 or level 3 abuse violation in order to receive an additional reduction of 10% reduction in the civil penalty amount.

These reductions will not be applied to level 4 (serious harm or death) violations.

It is crucial that facilities understand when and how to report abuse and suspected abuse. Detailed information related to these issues may be found in the [Abuse Reporting and Investigation Guide](#) for Providers.

Applying Other Sanctions

As discussed above, all substantiated abuse violations will receive a civil penalty. However, in addition to a financial penalty, there are other sanctions that may be imposed for substantiated abuse violation(s). These sanctions are described in Chapter 12, in order of increasing progressive discipline.

Chapter 12: Corrective Action – STEP 4

Determining Other Tools and Sanctions

Once the corrective action coordinator determines responsibility and severity of the harm, the next step is to determine what corrective action tool would best apply to bring the facility back into substantial compliance with the least restrictive sanction needed to achieve compliance.

Issuance of Violations

A violation is simply a formal acknowledgement by the Department that a facility is not in substantial compliance with licensing rules. Some violations, such as abuse violations, automatically result in a civil penalty. Other violations may not be accompanied by a civil penalty or other sanction.

When either a licensing violation or substantiated abuse violation is above a Level 1, that violation is published on the [Licensed Long Term Care Settings Search website](#). Also, a Letter of Determination (LOD) is issued directly to the facility alerting them to the violation and encouraging the facility to contact their policy analyst to discuss the issues that led to the violation(s), as well as possible remedies. Anytime a violation is issued, the facility is expected to fix the problem, and will be encouraged to contact CBC staff to discuss possible responses.

Again, the goal is to use progressive interventions or discipline to motivate the facility to correct the licensing violation or address the substantiated abuse. Following are the different levels of corrective action, in progressive order, from most collaborative to most directive, or in order of least amount of agency intervention to most involved oversight:

1. Technical Assistance and Support

SOQ staff, including policy analysts, corrective action coordinators, and other staff are always available to engage with facility staff to discuss questions and concerns, help identify problems and brainstorm solutions. Staff may also recommend that a facility engage in internal or external quality assurance/improvement activities, participate in external quality projects and programs, and ensure staff attend specific trainings.

Occasionally, a facility might have a minor licensing issue that can be quickly addressed. In such an instance, the assigned SOQ policy analyst might speak with a

facility administrator and collaborate on an action for what needs to occur to handle the minor issue. In these cases, the policy analyst sends a follow-up email confirming the action that will be taken by the facility to address the situation. If the issue is quickly and satisfactorily addressed, no further action is taken. If the facility fails to address the issue, then the policy analyst will recommend additional corrective action.

- Example: A staff member needs a food handler's card before continuing to assist with serving meals in the dining room. The policy analyst and administrator agree through email that the facility will provide documentation that the staff member has earned the food handler's card before handling any more food products.

2. Email Agreement

This involves the corrective action coordinator or policy analyst sending an email to the facility describing what needs to be addressed to remedy a violation. The facility then responds and indicates if that remedy can be accomplished. The email agreement should contain specific steps to take and should also contain a timeframe for addressing the necessary steps. This email agreement is only used for less serious problems that can (hopefully) be remedied fairly quickly and easily.

3. Voluntary Letters of Agreement (LOA)

Voluntary Letters of Agreement involve SOQ and the facility working collaboratively to determine what the facility needs to do to correct a given situation. Unlike licensing conditions which are imposed on a facility, LOAs are a joint effort between SOQ and the facility. LOAs are not posted on the facility search website and do not require public signage if a voluntary restriction of admission is agreed upon by both parties.

SOQ initiates the LOA process and proposes initial terms, allowing a reasonable opportunity for the facility to present potential alternatives. Ultimately, this document should reflect a joint agreement outlining the actions the facility will take to address issues that do not meet substantial compliance. SOQ seeks to develop each LOA collaboratively with each facility, recognizing the unique facility characteristics and the circumstances supporting the LOA, and considers the facility's input and suggestions throughout the process.

LOAs may be simple or more complex, depending on the situation and remediation needed to fix areas that are not in substantial compliance. In cases where there appears to be a more systemic problem, SOQ may recommend the facility perform a

“root cause analysis” to determine the contributing factors and the scope of the problem, along with requesting an action plan for how the facility will address the problem. In more limited situations, a more focused approach may be sufficient. Like all terms within an LOA, restrictions on admissions in an LOA must be mutually agreed upon between SOQ and the facility.

The length of time an LOA remains in place is dependent on the facility’s progress in achieving substantial compliance and meeting the terms agreed upon in the LOA. Timelines for LOAs are dependent on facility progress; however, LOAs may include agreed upon timelines for Department review and/or reinspection upon an assertion of substantial compliance. Providers are also encouraged to contact their assigned corrective action coordinator when they believe that progress warrants amendments to the LOA, or to discuss what is necessary to remove the LOA entirely. If a Department review/reinspection finds a new potential violation not related to the original LOA, a new corrective action may be administered; the original LOA will not be modified to address a new, unrelated violation.

If an LOA proposed by SOQ includes mandated staffing and the facility does not agree with the need for additional staffing, SOQ and the facility may use the acuity tool to resolve the staffing agreement. If the facility decides to forgo an LOA, SOQ may opt to place a condition.

4. Safety Plans

Safety Plans are developed in cooperation with facilities and the Department to support independence, promote safety, well-being, honor choice and mitigate risk of harm to all residents. Safety Plans may be put in place at any time the Department identifies a concern or risk to residents, such as when an allegation of abuse occurs, or while a plan of correction is being implemented after survey. Safety Plans can be developed for an individual resident or residents or for an entire facility systematic concern depending on the unique set of circumstances.

Elements of a Safety Plan may include, but are not limited to:

- Ways the facility will prevent recurrence of events that have posed a risk to resident safety
- Ways the facility will address problems that may contribute to unsafe circumstances
- Additional training or education for staff that will address safety issues

5. Licensing Conditions

CBC will **place a condition** on a license if there have been serious licensing violations or substantiated abuses and the Department determines a more restrictive option than a letter of agreement is warranted. A condition will often be used in instances such as:

- When a facility has failed to comply with previous notices from the Department, thereby subjecting residents to actual harm or risk of harm.
- When the Department is made aware of serious incidents of substantiated non-compliance through survey (such as immediate jeopardy situations) or APS that have already resulted in harm or that threaten the safety of residents.
- When a facility has continued to have issues with substantiated non-compliance, despite other actions, such as a letter of agreement, and the Department must take more restrictive measures to protect resident safety.
- A condition involving restriction on admission may only be imposed if the Department makes a finding of immediate jeopardy that is likely to present an immediate jeopardy to future residents. This finding must be substantiated within 30 days after imposition of the condition.

The Department shall **provide a facility with a notice of impending imposition** of license condition at least 48 hours before issuing an order imposing a license condition. The notice must:

- Describe the acts or omissions of the facility and the circumstances that led to the substantiated finding of rule violation or finding of immediate jeopardy supporting the imposition of the license condition;
- Describe why the acts or omissions and the circumstances create a situation for which the imposition of a license condition is warranted;
- Provide a brief statement identifying the nature of the license condition;
- Provide a brief statement describing how the license condition is designed to remediate the circumstances that led to the license condition;

If the threat to residents of a facility is so imminent that the Department determines it is not safe or practical to give the facility advance notice, the Department must provide the notice required under this paragraph within 48 hours of issuing an order imposing the license condition.

Conditions may include requiring the facility to ensure staff complete training courses, hire a consultant to assist with compliance activities, adopt mandatory staffing patterns, temporarily restrict admission of new residents, or other requirements specific to the issue(s) of non-compliance.

Once the Department has **received the facility's written assertion of substantial compliance** with the requirements of the conditions, the Department must reinspect the facility within 15 business days to determine if substantial compliance has been achieved. The Department then must:

- Notify the facility of the findings of the reinspection or reevaluation within five business days after completion of the reinspection or reevaluation.
- Issue a written report to the facility within 30 business days after the reinspection or reevaluation notifying the facility of the Department's determinations.
- If the Department finds the facility has achieved substantial compliance regarding the violations, and finds systems are in place to ensure similar deficiencies do not reoccur, the Department shall withdraw the license condition.
- If after reinspection or reevaluation the Department determines the violation that led to the condition continues to exist, the Department may choose not to withdraw the license condition.
- The Department is not obligated to reinspect or reevaluate the facility again for 45 days after the first reinspection or reevaluation. The Department shall inform the facility of the decision in writing, and include information concerning contested case hearing rights.

A license condition is automatically removed if the Department does not meet the requirements listed above. However, the Department Director may extend the reinspection or reevaluation period for up to 15 business days. The Director may not delegate the power to make an extension determination.

6. Civil Penalties

The process for issuing civil penalties is discussed in detail in Chapter 11. Civil penalties are being mentioned here to acknowledge that financial penalties can be considered part of the progressive discipline hierarchy.

As described earlier in this document, the corrective action coordinator will determine an appropriate civil penalty after determining severity and scope of harm and reviewing both mitigating and aggravating factors.

In addition to issuing civil penalties for abuse or for continued licensing violations, civil penalties will also be issued for **failure to self-report abuse**. DHS may issue a fine of up to \$1,000 for each instance in which a facility fails to report abuse of a resident to DHS as required by state law. In these instances, DHS generally issues a violation and a \$750 penalty for the first instance of failure to self-report. Each subsequent instance generally results in a violation and a penalty of \$1,000.

7. Enhanced Oversight Program

The Enhanced Oversight Program is designed specifically for facilities that repeatedly demonstrate a lack of substantial compliance with licensing or abuse rules and/or report performance that is substantially below the statewide average on Quality Metrics prescribed by the Quality Metrics Council.

The primary purpose of the Enhanced Oversight Program is to provide additional support and monitoring through more frequent and/or focused surveys in order to ensure enrolled facilities make the changes needed to regain and maintain substantial compliance.

A facility may be considered for the Enhanced Oversight Program by the Department based on any of the following:

- Repeated licensing conditions imposed within a survey cycle
- Repeated need for increasing progressive discipline related to licensing violations during a survey cycle
- High number of survey tags or multiple tags with high levels of severity
- Multiple APS substantiations with high levels of severity
- Performance substantially below statewide averages on Quality Metrics

Facilities enrolled in the Enhanced Oversight Program may receive any or all of the following:

- Increased frequency and monitoring by the CBC survey unit
- Surveys focused on specific areas of consistent noncompliance
- Increased monitoring to ensure substantial compliance

- Routine meetings or conference calls between facility staff and the assigned corrective action coordinator, policy analyst, and consultant(s) (when applicable).

Facilities will be removed from the Enhanced Oversight program if:

- After two survey cycles, if the facility no longer meets the criteria for being in the program.
- After one year, if the facility asserts substantial compliance and the Department reviews and agrees that the facility is in substantial compliance and no longer meets criteria to be in the Enhanced Oversight Program.

Facilities will be notified in writing of the Department's decision to enroll them into the Enhanced Oversight Program.

During the time a facility is enrolled in the Enhanced Oversight Program, notification will show on the Licensed Long Term Care Complaints Search website (<https://ltclicensing.oregon.gov/>).

8. Notice of intent to non-renew, suspend, or revoke a license

If a facility has significant compliance issues placing residents at serious risk of harm, and/or has repeatedly failed to respond to corrective actions directed toward substantial compliance, the Department may issue a notice of intent to revoke the license. The requirements for issuance of these notices are described in OAR 411-054-0130.

9. Actual revocation or non-renewal of license

If a facility has been issued a notice of intent to revoke a license, and the facility continues to fail to address regulatory concerns and fails to come back into substantial compliance, CBC may revoke the license or refuse to renew the facility's license. See OAR 411-054-0130.

Chapter 13: Corrective Action for Licensing Violations

As discussed earlier in this guide, a **licensing violation** occurs when a facility has failed to substantially comply with an Oregon Administrative Rule. “Substantial compliance” means a level of compliance with state law and with rules of the Department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents of a facility.

Assuming the facility works with the Department to make progress toward substantial compliance, the Department will implement a positive and progressive enforcement process and will not issue a civil penalty. If the facility repeatedly does not follow through with agreed upon remediation and compliance efforts, however, the Department may still issue a civil penalty upon a finding of potential for harm at level 2 severity or above.

STEP 1 – Receive report

Licensing violations occur when a state regulation is violated but there is no substantiated abuse. These violations may be issued as a result of deficiencies found during:

- A licensing or re-licensing survey (citation at scope/severity level "D" or above),
- An LCU complaint investigation (citation at scope/severity level "D" or above), or
- An abuse investigation in which a facility failure did not rise to the level of abuse but *did* represent a violation of a licensing rule (OAR chapter 411, divisions 54 or 57).

STEP 2 – Review report

The corrective action coordinator will determine the scope and severity of the violation using the same process described earlier in Chapter 10. After making these determinations, the corrective action coordinator will follow the process outlined below and work closely with the assigned policy analyst to implement the appropriate corrective action.

STEP 3 – Determine Appropriate Corrective Action

Upon receipt of evidence demonstrating a violation of an OAR, the corrective action coordinator and/or policy analyst must review the evidence provided along with the facility's compliance history and determine one of the following:

1. ***First licensing violation*** of its kind in the last six months:
 - a. Issue Letter of Determination; and
 - b. Consider referring to policy analyst to contact the facility based on severity of violation to offer technical assistance in determining solutions.
2. ***Second licensing violation*** similar in nature in the last six months:
 - a. Issue Letter of Determination referencing prior related violation and current violation with associated complaint report investigation numbers. Use more stringent language in the narrative warning the facility that failure to achieve substantial compliance may result in issuance of sanctions.
 - b. Consider referring to policy analyst to contact the facility based on severity of violation to offer technical assistance in determining solutions.
3. ***Third licensing violation*** similar in nature in the last six months:
 - a. Issue Letter of Determination referencing all related violations and associated complaint report investigation numbers.
 - b. Conduct consultation between assigned corrective action coordinator, assigned policy analyst and facility administrator to discuss:
 - i. What went wrong?
 - ii. How many residents were or could have been affected?
 - iii. What actions will be taken to prevent violations from re-occurring?
 - iv. Provision of technical assistance related to the violations;
 - v. Request that facility submit written plan to correct violations to the policy analyst and corrective action coordinator no later than seven calendar days after consultation.
 - c. Consider issuing Civil Penalty upon a finding of severity of level 2 or higher, compliance, cooperation and reasons violations occurred.
 - d. The assigned policy analyst or corrective action coordinator must document the above communication.

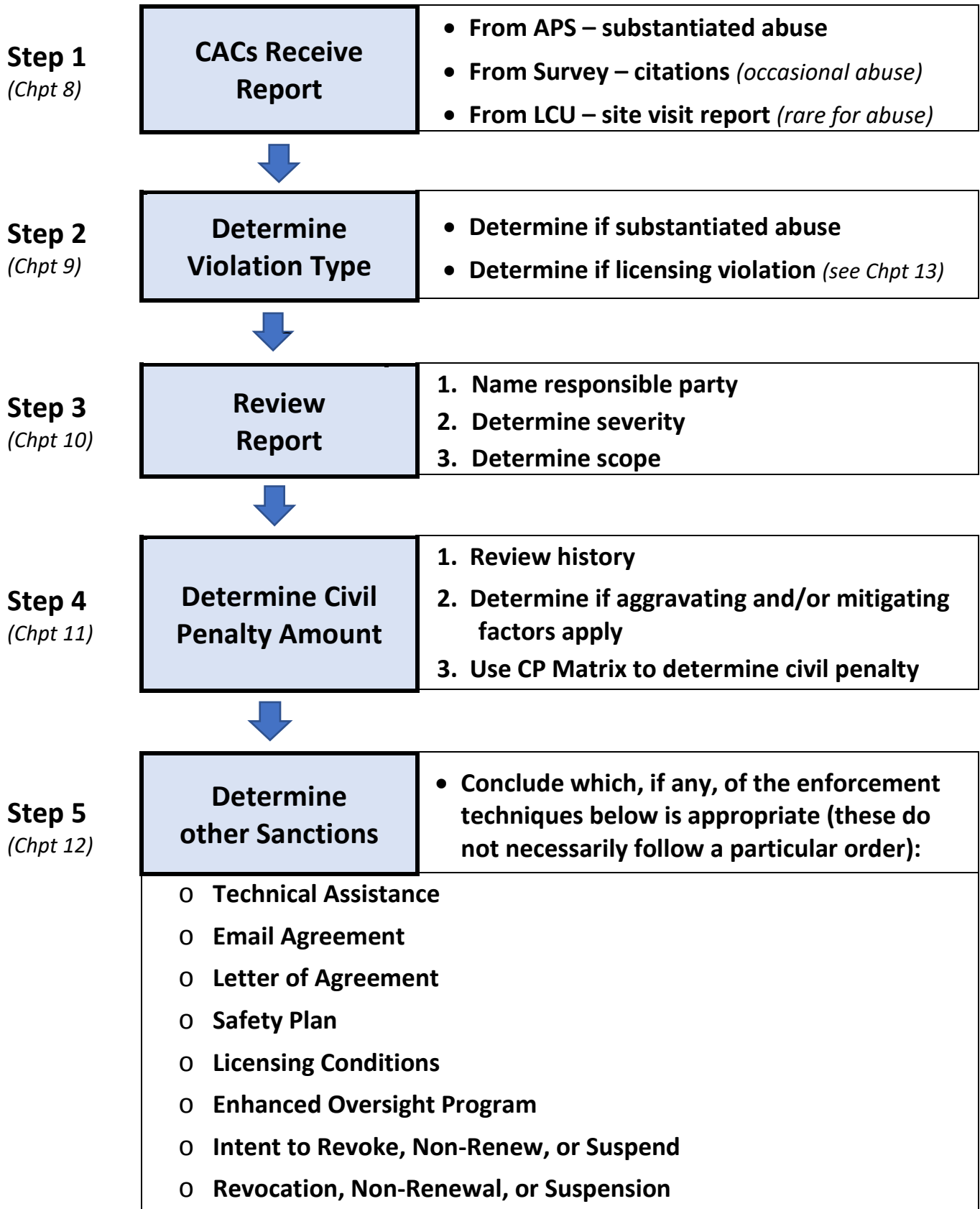
4. ***Fourth licensing violation*** similar in nature in the last six months:
- a. Issue Letter of Determination referencing all related violations and associated report numbers.
 - b. Conduct consultation between assigned corrective action coordinator, assigned policy analyst and facility administrator to discuss:
 - i. What went wrong?
 - ii. How many residents were or could have been affected?
 - iii. What actions will be taken to prevent violations from re-occurring?
 - iv. Provision of technical assistance related to the violations; and
 - v. Request facility submit written plan to correct violations to the policy analyst and corrective action coordinator no later than five calendar days after consultation.
 - vi. The Department may suggest the facility consider:
 - Contracting with an Administrative or RN Consultant;
 - Conduct a pharmacy audit; and/or
 - Provide staff training.
 - c. Consider issuing an aggravated Civil Penalty upon a finding of severity of level 2 or higher, compliance, cooperation and reasons why incidents occurred.
 - d. Consider issuing a Letter of Agreement.
 - i. Reference all related violations and associated complaint report investigation numbers;
 - ii. Request the facility provide a root cause analysis of why prior remediation failed;
 - iii. Additional requirements could include an Administrator or RN consultant, pharmacy audit, and/or staff training; and
 - iv. Request facility submit written plan to correct violations to the policy analyst and corrective action coordinator no later than five calendar days after consultation.
 - e. Consider issuing additional sanctions.
 - f. The assigned policy analyst and corrective action coordinator will maintain direct contact with the facility regularly to provide continued technical assistance to achieve facility compliance or document continued deficiencies which could lead to additional sanctions.
 - g. The assigned policy analyst or corrective action coordinator must document the above communication.

STEP 4 – Notify Facility of Corrective Action

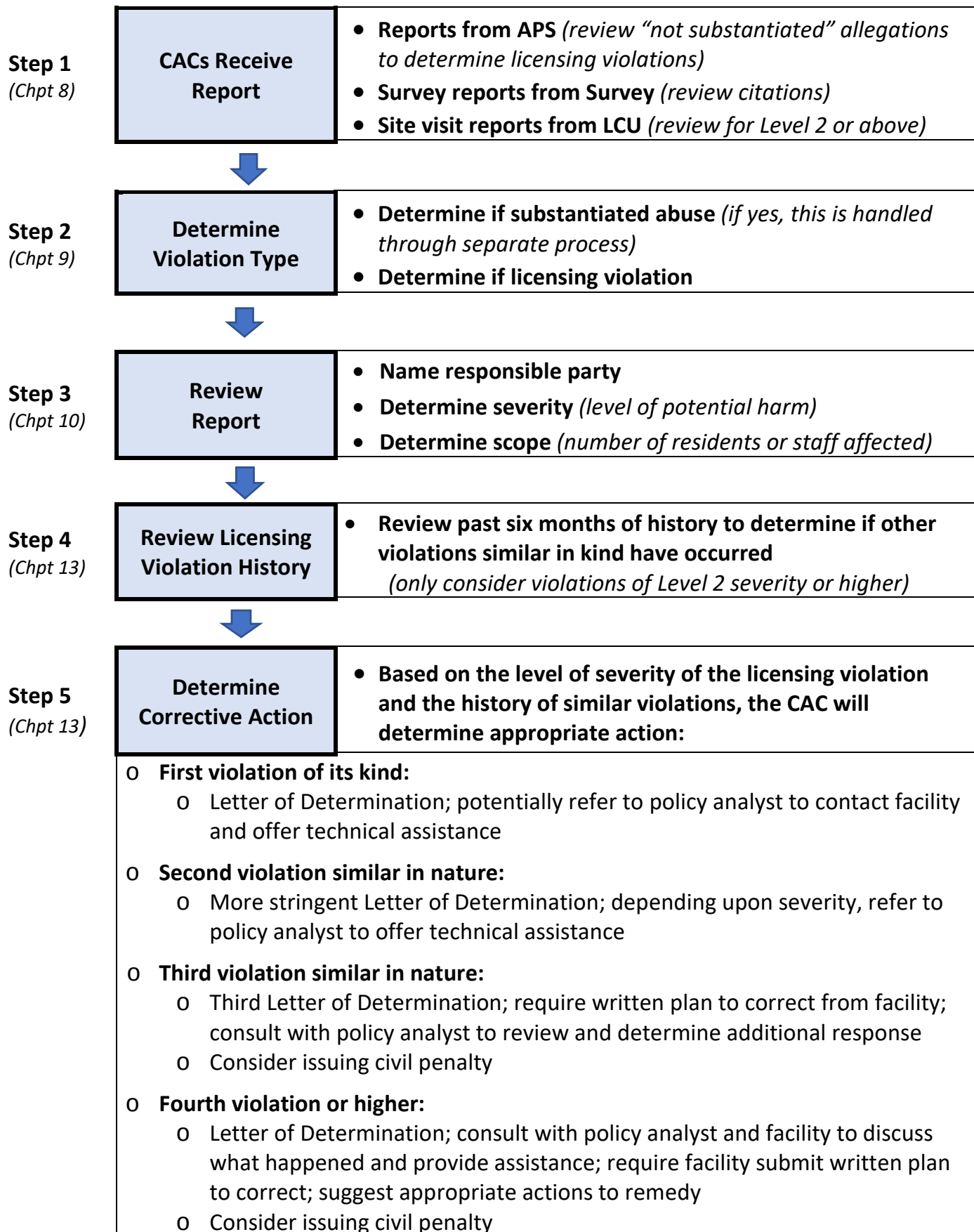
After taking all steps to determine the appropriate corrective action, the corrective action coordinator will inform the facility of the action to be taken by issuing a Letter of Determination (LOD) describing the violation. An LOD will be issued for every licensing and abuse violation at a Level 2 (minor harm or potential for moderate harm) or above. In addition, these violations will be posted to the [Licensed Long Term Care Settings Search website](#).

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Appendix A: Corrective Action Processes for Substantiated Abuse



Appendix B: Corrective Action Process for Licensing Violations



Appendix C: Glossary of Corrective Action Terms

1. **Abuse violation.** This occurs when a resident has suffered harm or potential for serious harm, which has been substantiated by APS.
2. **Civil penalty:** If abuse is substantiated, the corrective action coordinator will issue a monetary fine against the facility. The amount of the fine corresponds to the level of severity of the harm, the scope of the harm, and the mitigating and aggravating factors that are present.
3. **Condition:** CBC issues a written document to the facility when serious or pervasive licensing violations must be addressed.
4. **Licensing violation:** This occurs when a facility has failed to follow a regulation included in applicable Oregon Administrative Rules which results in a potential for harm.
5. **Scope:** This refers to the number of residents or locations within a facility that are affected. Scope is categorized as:
 - **Isolated** - one or a very limited number of residents or employees are affected or a very limited area or number of locations within a facility are affected
 - **Pattern** - more than a very limited number of residents or employees are affected, or the situation has occurred in more than a limited number of locations, but the locations are not dispersed throughout the facility
 - **Widespread** - the problems causing the deficiency are pervasive and affect many locations throughout the facility or represent a systemic failure that affected, or has the potential to affect, a large portion or all of the residents or employees.
 - **Severity:** This refers to the seriousness of the violation, or the harm (or potential for harm) the violation has caused. “Harm” is defined as a measurable negative impact to a resident’s physical, mental, financial or emotional well-being.
6. **Substantial compliance:** This means a level of compliance with state law and with rules of the Department such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents.

Appendix D: Resources

- A. *RCF/ALF Rules*: https://www.dhs.state.or.us/policy/spd/rules/411_054.pdf
- B. *Memory Care Rules*:
http://www.dhs.state.or.us/policy/spd/rules/411_057.pdf
- C. *Regulatory Guidelines on Specific Topics*: (Not yet completed)
- D. *Abuse Rules*: http://www.dhs.state.or.us/policy/spd/rules/411_020.pdf
- E. *Abuse Reporting and Investigation Guide* (Form APD 0472);
<https://apps.state.or.us/Forms/Served/se0472.pdf>
- F. *CBC Licensing Web Page*: <https://www.oregon.gov/DHS/providers-partners/licensing/CBC/pages/index.aspx>
- G. *Oregon Care Partners Website*: <https://oregoncarepartners.com/>
- H. *Alzheimer's Network of Oregon*: <https://alznet.org/>
- I. *Consumer Guide (ADRC)*: <https://www.adrcforegon.org/consite/index.php>
https://www.adrcforegon.org/forms/AssistedLiving_ResidentialCareFacilityGuide.pdf
- J. *Comparison Tool (ADRC)*:
<https://www.adrcforegon.org/consite/downloads/ADRC-toolkit-August2017.pdf>
- K. *Disability Rights Oregon (DRO)*: <https://droregon.org>