Oregon
Kate Brown, Governor

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May 6, 2015

The Honorable Alan Bates, Co-Chair
The Honorable Nancy Nathanson, Co-Chair
Joint Ways and Means Subcommittee on Human Services
900 Court St. NE, S-205
Salem, OR 97301

Dear Co-Chairs:

I am pleased to respond to the questions you and other members of the Subcommittee on Human Services raised during the February 12th budget hearing for the Office of the Long-Term Care Ombudsman. Thank you for your support of our agency and desire to assist us in our mission to help as many of Oregon's long-term care facility residents as possible.

What financial resources would be needed to visit 100% of the adult foster homes in Oregon twice per year?

- $400,000 per biennium will fund two additional deputy positions to support the additional 30 volunteers necessary to achieve this benchmark. A volunteer to deputy ratio of 15:1 is necessary to achieve this objective. The 15:1 ratio allows the deputy to adequately recruit, train, and supervise volunteers performing these visits. It also anticipates the deputy needing to cover a significant portion of the care homes in support of the new volunteers. In LTCO's experience, residents respond most candidly and openly when we have a Certified Ombudsman volunteer who has had several meetings with residents to establish the trust necessary for residents to feel confident enough to bring concerns forward. Our volunteers who regularly visit adult foster homes believe that this takes about four to six visits per year. Based on their experiences, we believe that one *visit per quarter is the threshold number of visits that would accomplish meaningful contact in Oregon's adult foster homes.*

- In order to meet the benchmark of meaningful contact with residents achieved by four visits per year to every adult foster home, $800,000 per biennium would fund the 4 additional deputy positions to support the additional 60 volunteers needed.

What are the top 10 complaints LTCO receives? What really drives these concerns? *These complaints are presented in order of most frequent to least frequent concerns. These complaints have been fairly consistent for many years, despite our work with individual residents and our efforts to change public policy on these issues through work with long-term care providers and DHS.*

1. **Discharge and eviction concerns:** Residents cite fear of being given an involuntary move-out notice as their number one reason for being reluctant to ask for service improvements.

   Sometimes, since facilities do not follow the rules on move–out notices, without ombudsman assistance residents would never know the move-out notice was invalid. When residents are given an involuntary move-out notice, but the resident feels they should be able to stay and receive additional care, it's a scary time for the resident and a vulnerable time to lose housing. Objecting to an involuntary move-out notice is a technical process and residents often need ombudsman assistance to object.

   The most common reason facilities cite is the resident exceeds the level of care they can provide, especially in assisted living facilities and residential care facilities The second most common reason is a payment dispute between the resident and the facility.

   Resident behavioral needs and transfer assistance (e.g. from bed to wheel chair or wheel chair to toilet) are usually the tasks that exceed the facility's level of care. Many facilities struggle to manage the increasing behavioral health needs of younger residents who present with addiction and mental health needs that tax the abilities of many facilities. Most assisted living facilities do not provide two staff members for transfer assistance or assistance to residents who develop dementia. This results in residents being discharged to more expensive and institutional nursing facilities or memory care communities.

   The reasons underlying a resident's failure to pay vary. Residents who receive Medicaid assistance for long-term care still must pay most of their monthly social security for room and board and are only afforded a small monthly allowance. Sometimes they fail to pay and get in arrears. In this case the resident must start making remedial payments and may be required to find a representative payee (often the facility administrator) for their social security in order to preserve their facility placement. Residents may also have a failure to pay while waiting for a change in payment source from either private payment or Medicare to Medicaid.

2. **Food and menu dissatisfaction:** There are two consistent themes in resident complaints regarding food. The first is residents do not like the food served because it is poor quality, the wrong temperature and planned without their input. While facilities are required by administrative rule to actively seek input from residents on menu planning and incorporate fresh and seasonal fruits and vegetables, we observe that this requirement is frequently disregarded and replaced by the use of a menu provided by the food vendor. These foods are largely heat and serve and not prepared on-site. Commercial food vendors offer menu-planning services that many facilities use in lieu of consultation with residents.

   Second, residents report feeling confused regarding what therapeutic diets are available. Many diabetic residents tell us that the diabetic diet they receive is a reduced portion of the regular meal, which leaves them feeling hungry. Regular enforcement of existing rules, with an emphasis on feedback from residents and response by providers, would create a high-quality dining experience for residents. There are many excellent providers in Oregon who have great models for quality dining programs.

3. **Conflicts with Other Residents:** There are two main causes of conflict between residents. The *first* is driven by the prevalence of shared rooms in most nursing facility beds and the inevitable conflicts that arise when two adults share a room while they're recovering from an illness or disease. New nursing facility construction is trending toward private rooms, but the majority of older buildings still have mostly shared beds. Private rooms are generally reserved for private pay and Medicare residents with higher reimbursement rates. Long-term residents receiving Medicaid support are the most likely to have shared rooms.

   The *second* cause is altercations between residents in memory care communities. Facilities are obligated to keep their residents safe while being careful not to rely on excessive use of anti-psychotic drugs to moderate behavior. Insufficient numbers of staff or staff inadequately trained to work with residents who have dementia make altercations between residents more likely. And like nursing facilities, most memory care communities have shared rooms for residents and this also contributes to altercations between residents.

4. **Failure to respond to requests for assistance:** Residents continue to complain of slow or no response to their call lights. Residents in care facilities are dependent upon caregivers to meet their personal needs, including using the restroom, accessing food, control of their environment (temperature, noise, etc.) and many experience delays over 15 minutes to receive assistance. Many residents report that help was never delivered—either no one answered the call light or the caregiver answered the call light and then was distracted by the needs of other residents and forgot to get back.

5. **Care plan – inadequate or failure to follow:** Oregon has a good regulatory environment to create resident-centered care plans that describe in sufficient detail the needs of the individuals who live in licensed care facilities, *when these rules are followed*. Despite this, residents continue to miss care they need, or receive the wrong care, because the care plans are insufficient in detail and busy staff are not allowed time to become familiarized with a complete plan.

6. **Personal Property – lost, stolen, etc.:** There are two consistent themes in these complaints. *First,* living in a congregate setting, staffed by a workforce that turns over regularly and with a resident population where memory loss and cognitive impairment are frequent creates an environment easily exploited by opportunists. While the vast majority of facility staff and caregivers are honest and hard working, the problem of theft is still in the top 10 resident complaints.

   The *second* concern for all license types, but particularly acute in memory care communities, is lost property. The complaints show a trend in memory care communities where a resident's dentures (or glasses or hearing aides, etc.), that can cost thousands of dollars and are critical to maintaining health, are lost. And yet, some facilities take no accountability and refuse to reimburse residents and replace lost dentures. The most engaged providers make specific care plans to safeguard residents' properties, maintain inventories, check shift-to-shift for assistive devices like hearing aides, dentures and glasses and replace the devices of memory care residents under their care when they are lost, but there aren't regulations to require this. The rules could be made more specific to require plans to safeguard resident property like dentures and hearing aides.

7. **Medication administration, organization:** Complaints regarding medication administration are that medications are delivered late, delivered incorrectly, and not available because of ordering problems. Good medication management in licensed care facilities requires a Medication Aide who has been evaluated by a qualified professional as competent and performs the task frequently enough to become good at reading medication orders and delivering medications correctly and on time. Medication Aides need to be able to answer resident questions regarding their medications and have sufficient time to perform the task correctly. Residents report regular difficulty adhering to their physician-ordered pain management plans and not receiving the directed medications on a schedule that sufficiently manages pain. The most well-organized and accurate medication administration systems have consistent training programs and internal controls that ensure accuracy in delivery and staff competence.

8. **Exercise preference, choice and/or civil, religious rights:** Residents express a variety of concerns about not having the choice to access the community, receive services in a time or manner appropriate to the individual and accommodations for special dietary needs. There is an inherent power differential between the organization providing care and the recipients of that care. Economies of scale and efficiency concerns sometime override personal preference and rights in a resource-scarce environment. Access to an ombudsman often supports resolution of these issues for residents.

9. **Cleanliness, pests, and general housekeeping:** Residents report a variety of complaints about general cleanliness. These reports are often easy to substantiate and, therefore, resolve, but they still recur often enough to remain in the top 10.

10. **Equipment and Buildings -- disrepair, hazard, poor lighting, and fire safety:** The care facility is the residents' home and the provider controls their environment. Some complaints in this category include such things as broken elevators, dirty carpets and doors/windows in poor repair. *Deferred maintenance*, the practice of postponing maintenance activities in order to save costs, meet budget funding levels, or realign available budget monies, is an issue experienced by some providers, and it seems to be more common with providers that serve large Medicaid populations.

    The ability of scarce overnight staff to evacuate residents in a fire event is questionable in some community-based care facilities, where there is no required minimum staff to resident ratio and residents have expressed their concerns to us.

What are the rates of staffing turnover in community-based care (assisted living and residential care facilities)?

- According to a recently published DHS report, annual turnover among direct care workers, that is, the caregivers at the resident's bedside, was 64% a year in 2014, with wide variation across provider types. Residential care facilities for adults with developmental disabilities had the highest turnover rates at 90% per year, while adult foster care homes for people with developmental disabilities had the lowest turnover rate at 30%. Nursing facilities had turnover rates of 54%. The mean (average) wage per hour for direct care workers was $12.38 and the median was $11.15. Source: *Nathan M. Singer, Deputy Chief Operating Officer APD, Oregon Department of Human Services: Wages, Fringe Benefits, and Turnover for Direct Care Workers Working for Long-Term Care Providers in Oregon Final Report, Section 6.1, January 2015.*

- There is significant turnover in administrative, nursing, activities, and other staff that has a negative impact on resident care. Despite this, no one is tracking this turnover. We have some licensed facilities that have had 6 or

more administrators in the space of 18 months. Administrators set the overall tone in the building and are responsible for the health and safety of the residents and oversight of all systems including medication administration.

What is the fine schedule for abuse and rule violation in licensed care facilities?

- The maximum penalty for death, serious injury, rape, or sexual abuse is only $15,000. A full schedule of the fines is attached. It is our opinion that *the way fines are currently administered and the current schedule of fines is insufficient to motivate changes in behavior.* We have observed that the corrective action function of the Office of Licensing and Regulatory Oversight (OLRO) is often not exercised to the full extent allowed under current law. Specifically, OLRO often does not use its power to aggregate fines in situations where the abuse or neglect occurred on multiple occasions. Sometimes, cases where actual harm occurred are treated as rule violations. Enhanced penalties for repeat violations are not issued in many cases. Facilities could be monitored more rigorously for failures to self-report incidents of abuse or injuries of unknown origin, as required by current rule.

How does the Ombudsman's office interface with OLRO?

- An ombudsman attempts to resolve problems before they become large ones and works informally with facility leadership to resolve resident questions and concerns. Our volunteers and deputies resolve about 85% of all resident and family complaints using this approach. Sometimes, a resident's concern is based on a rule violation, *but the LTCO does not enforce rule or law.*

- The Office of Licensing and Regulatory Oversight (OLRO) are charged with enforcing rules. There are over 490 assisted living and residential care facilities in the state. The licensure division for assisted living of OLRO has three policy analysts assigned to respond to complaints of rule violations across the entire state. They are all based in Salem. This has resulted in a regulatory system limited to biannual inspections. If there is a rule violation that occurs in between inspection intervals, we have observed that there will rarely be regulatory action unless it rises to the level of abuse.

- We have worked to develop an effective relationship with OLRO. We established quarterly meetings beginning in April 2014 to exchange complaint information, discuss trends and formulate responses. These exchanges are still developing. Accountability by each agency to engage in the exchange of information and participation in quality improvement design is critical. Our mutual goal is to work together to protect and improve the lives of the thousands of vulnerable Oregonians living in licensed long-term care facilities.

If you were offered additional resources to best advocate for and protect resident rights, what projects would you propose and what budget is needed?

- Almost half of our complaints come to us over our 1-800 help line. $200,000 would fund a second deputy to answer the increasing number of calls for assistance that come into our 800-number help line and expand our service to seven days a week. Both residents and volunteers use the 800-number for assistance. Residents often face difficult and urgent discharge problems because it's the weekend and have enhanced need for access to the ombudsman. The second deputy would speed up the response time to consumers and support speedy resolutions.

- $200,000 per biennium would fund one additional deputy ombudsman position dedicated to serving the needs of Oregon's Veterans living in licensed care facilities. Almost 55% of Oregon's Veteran's are 65 years or older. They need assistance accessing federal benefits and other Veteran's benefits that will assist with care costs and management - - and reduce the cost of their care for the Oregon Medicaid program

- $200,000 per biennium would fund one additional deputy ombudsman position dedicated to training volunteers, long-term care providers, the public and other agencies and organizations. We believe that offering trainings for the provider community on resident rights and quality care is a proactive and cost effective way to promote system improvement and reduce consumer concerns.

- $100,000 per biennium for recruitment and retention of volunteers. This would support additional and more effective volunteer recruitment and retention.

- $30,000 to improve our website and make it a tool that residents, their families and providers can use to solve their own problems and increase transparency of the publicly available documents such as facility survey reports that are difficult for the general public to access.

- $50,000 to create a computer-based remote training and continuing education program for our certified ombudsman volunteers. Engaging training presentations on our website could also be used by residents and their families to help them address some of our most commonly heard concerns such as involuntary move-out notices, accurate medication administration and violations of other resident rights.

Thank you very much for this opportunity to respond to your questions. We are committed to hearing, addressing and resolving the questions, concerns, and complaints of our fellow Oregonians - - and their friends and families - - living in licensed long-term care facilities. Much progress has been made in the past few years and there is more to go. We are excited about our role in this important mission.

Sincerely,

David Berger

David Berger, JD
Interim State Long-Term Care Ombudsman

Appendices Page

RATE SCHEDULE

(Effective January 1, 2015)

Rates apply to Home and Community-Based Care and Nursing Facility Services provided by Aging and People with Disabilities.

Room & Board	In-Home Maintenance Allowance	Personal Incidental Funds
AB $570.00	$1,233	NF $60
AD/OAA $570.00	$1,233	CBC $163

Community-Based Care (CBC) Rates

	Residential Care Facilities	Adult Foster Homes
Base	$1,338 / Month	$1,338 / Mo.
Base plus 1 add-on	$1,597	$1,597
Base plus 2 add-ons	$1,856	$1,856
Base plus 3 add-ons	$2,115	$2,115
Hourly Exception Rate	$12.00 / Hr.	$12.00 / Hr.

Assisted Living Facilities	
Level 1	$1,073 / Month
Level 2	$1,330
Level 3	$1,669
Level 4	$2,096
Level 5	$2,522

Memory Care (Endorsed Units Only)	$3,508/month

Nursing Facility (NF) Daily Rate	
Basic Rate	$257.56
Complex Medical Rate	$360.38
Pediatric Rate	$417.49

Comparable Monthly NF Rate	
Basic Rate	$7,273.20 / Month
Complex Rate	$10,400.68 / Mo.

Homecare Workers (HCW)	Hourly	Live-in
Activities of Daily Living Assistance Tasks	$13.75	$13.75
Instrumental ADLs	$13.75	$6.88
24-Hour Availability	N/A	$6.88
Enhanced HCW	Add $1 per Hr.	
Mileage, Non-Medical	$.485 per Mile	
24-Hour Relief Wage for Live-in Homecare Workers w/ Leave	$175 per Day	

Providence ElderPlace (PACE) Capitated Rate: $3,711.61 / Month

Home Delivered Meals: $ 9.54 / meal

Long Term Care Community Nursing Services: $15.00 / 15 minute unit of service

In-Home Agencies: $21.24 / Hr.

HK Shelter: $59.09/ month $1.94 / Day

Adult Day Services: Refer to Contracted Rates

In-Home Service Plan Max. Hour Local Office Tier 2 Hours Approval

ADL: 145
IADL (Self-Mgmt): 85
24-Hour Avail: 159 (Live-in only)

Tier 2=SPD/AAA local office over-ride

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January 2015

Wages, Fringe Benefits, and Turnover for Direct Care Workers Working for Long-Term Care Providers in Oregon

Final Report

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6. TURNOVER

6.1 Introduction

Chapter 6 provides data on turnover among direct care workers employed by long-term care providers participating in the Medicaid program in Oregon. ***Highlight Box 4*** summarizes the findings of this chapter. Annual turnover rate was calculated as the estimated total number of direct care workers in 2014 (Q18) divided by the number of current direct care workers (Q12) and then was adjusted by the proportion of year for which the data were collected. ***Figure 6-1*** describes the average annual turnover rate of OR direct care workers in 2014 by provider type. ***Table 6-2*** analyzes how turnover varies by provider, client, and direct care worker characteristics.

Highlights Box 4: Turnover Among Direct Care Workers Employed by Long-Term Care Providers Participating in the Medicaid Program in Oregon

- Average annual turnover among direct care workers was 64% a year, with wide variation across provider types. Residential care facilities for adults with developmental disabilities had the highest turnover rates at 90% per year, while adult foster care homes for people with developmental disabilities had the lowest turnover rate at 30%. Nursing facilities had turnover rates of 54%.
- Provider, service user, and direct care worker characteristics were associated with different turnover rates. Nonprofit ownership, chain ownership, micropolitan and rural location, providers focusing on people with developmental disabilities and severe mental illness, a low proportion of minority workers, and a high proportion of minority service users were associated with high turnover rates. Turnover rates did not differ by whether the provider served a high or low proportion of Medicaid beneficiaries.
- A multivariate analysis of turnover rates found that, controlling for other factors, the following variables were statistically significantly associated with higher turnover rates: residential care facilities for adults with developmental disabilities, for-profit and chain ownership, requiring direct care workers to have 75 or more hours of training, and lower wages paid to direct care workers. Variables statistically significantly associated with lower turnover rates include: proportion of long-term care workers who are nonwhite location in a metropolitan areas and proportion of service users who use Medicaid as their primary method of payment for services.

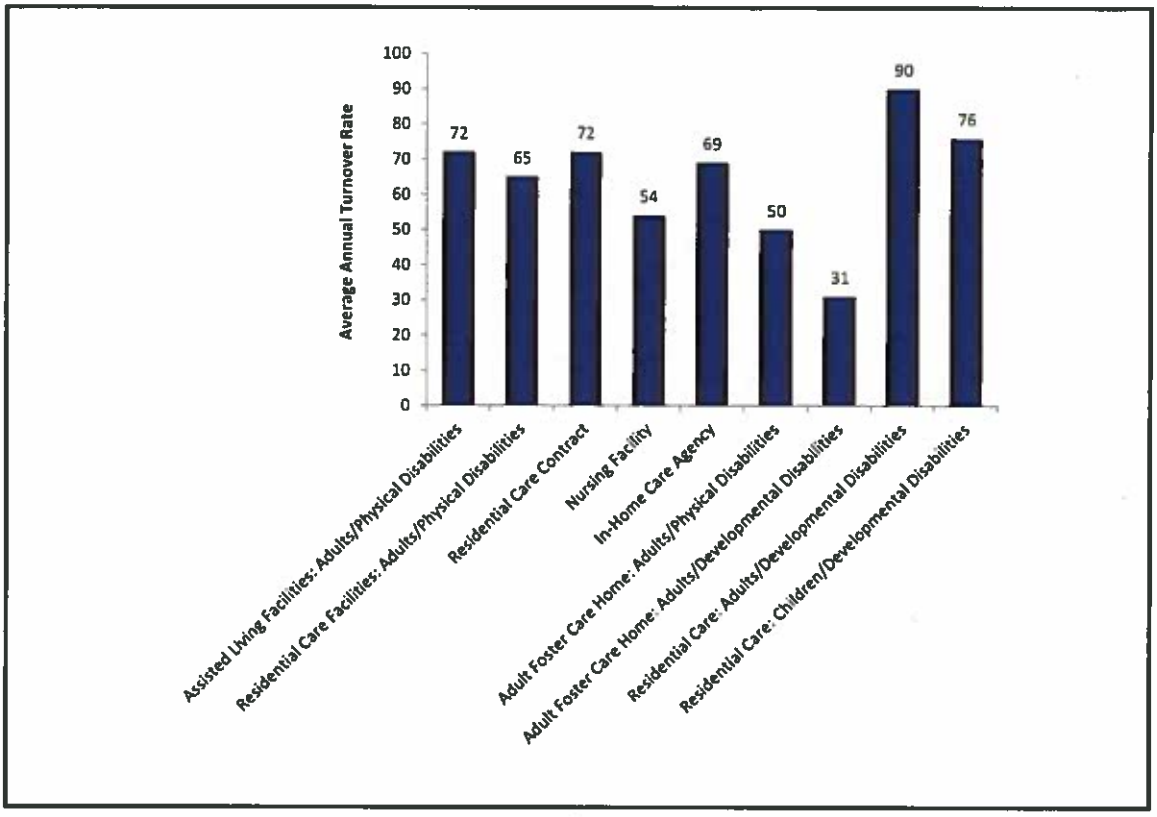
Oregon long-term care providers had high turnover rates of direct care workers in 2014. RCFs-APD had the highest turnover rates while AFCs-APD had the lowest. Certain, provider characteristics that are related to higher turnover rates in OR. The characteristics of those providers include those that are part of a corporate chain, micropolitan and non-metropolitan/non-micropolitan, and those with a higher proportion of direct care workers with more than 75 hours of training. There are slight differences in the proportion of

provider turnover rates when looking at beneficiary characteristics including race and ethnicity. Providers with a larger proportion of low minority direct care workers, however, had a higher turnover rate compared to those providers with a larger proportion of high minority direct care workers.

6.1.1 Overall Turnover Rates (Figure 6-1) (Table 6-1)

Figure 6-1 and ***Table 6-1*** show overall turnover in 2014 was 64% a year. AFCs-DD had the lowest turnover rate and are the only provider to have less than a 70% turnover of their direct care workers (67%). RCFs-DD had the highest turnover over rate of direct care workers, over 100% (106%). In-home Care Agencies and ALFs-APD had the second highest direct care worker turnover rates at 89% and 91% respectively. AFCs-DD, Nursing Facilities, and RCFs-APD had lower, but still high, rates of direct care worker turnover from 76% to 86% (77%, 82%, and 86% respectively).

Figure 6-1. Average Turnover Rate of Direct Care Workers, by Provider Type, 2014



Note: Turnover calculated as estimated total number of direct care workers in 2014 divided by the number of current direct care workers. Unit of analysis is providers. No columns for Adult Day Services and Specialized Living Facilities because there were <30 responses. Data on Residential Care Facilities with Contract Rates Residential Care Facilities for Children with Developmental Disabilities, and Supportive Living Services for Individuals with Developmental Disabilities are included in ***Appendix D.***

Source: RTI International analysis of the 2014 Oregon Wage and Fringe Benefit Survey of Long-Term Care (LTC) Providers.

Table 6-1. Average Turnover Rate of Direct Care Workers, by LTC Provider Type, 2014

LTC Provider Type	Average Annual Turnover
Total Number of Providers	2,867
Total LTC Providers	0.64
Assisted Living Facilities: Aged/Physical Disabilities	0.72
Residential Care Facilities: Aged/Physical Disabilities	0.65
Residential Care Contract	0.72
Nursing Facility	0.54
In-Home Care Agency	0.69
Adult Foster Care Home: Aged/Physical Disabilities	0.50
Adult Foster Care Home: Adults/Developmental Disabilities	0.31
Residential Care: Adults/Developmental Disabilities	0.90
Residential Care: Children/Developmental Disabilities	0.76

Note: Turnover calculated as estimated total number of direct care workers in 2014 divided by the number of current direct care workers. Unit of analysis is providers.

Source: RTI International analysis of the 2014 Oregon Wage and Fringe Benefit Survey of Long-Term Care (LTC) Providers.

6.1.1 Provider Characteristics

Table 6-2 shows that almost all types of providers, regardless of their characteristics or the characteristics of their beneficiaries had high turnover rates of direct care workers in 2014. Private, non-profit facilities had over a 68% turnover of their direct care workers in 2014 compared to a 61% turnover of these workers in private, for-profit providers. In contrast, government providers experienced a lower turnover rate of their direct care workers (28%). Providers owned by a corporate chain had a 50% higher direct care worker turnover rate compared to those providers that were individually owned providers (75% compared to 50%). Providers located in non-metropolitan/micropolitan areas had a 100% turnover of their direct care workers compared to those providers located in metropolitan and micropolitan areas (54% and 84%, respectively). Turnover rates in large or small providers are equally high (63% and 61%, respectively).

Providers that had a higher proportion of direct care workers with a higher education (more than an Associate's Degree) compared to those that did not had a seven percentage point lower turnover rate of their direct care workers in 2014 (57% and 63% respectively). In contrast to education levels, training requirements of direct care workers appears to be associated with turnover rates, although not in the expected direction. Providers that required 75 or more hours of training had a higher turnover of these staff compared to providers that required less training (less than 75 hours) (68% and 59% respectively). Turnover rate of direct care workers and the wages appear to be somewhat inversely related. Providers that paid less than $12.00 per hour had a 66% turnover rate compared

with 54% for providers that paid $12.00 to $16.00 per hour and 75% for providers that paid more than $16.00 per hour.

Table 6-2. Average Turnover Rate of Direct Care Workers, by Provider Characteristics, 2014

Provider Characteristics	Average Annual Turnover
Total Number of Providers	**2,867**
Type of Ownership	
Private, non-profit	0.68
Private, for profit	0.61
Government: federal, state, county or local	0.28
Chain Ownership	
Part of corporate chain (yes)	0.75
Individual entity (no)	0.50
MSA	
Metropolitan	0.54
Micropolitan	0.84
Non-Metropolitan/Non-Micropolitan	2.00
Dependence on Medicaid	
> median beneficiaries with Medicaid as primary payer	0.63
< =median beneficiaries with Medicaid as primary payer	0.64
Most Common Disability Among Individuals Served	
Frailty, dementia, and physical disabilities	0.56
Intellectual/ developmental disabilities	0.68
Severe mental illness	0.74
Traumatic brain injury	0.32
HIV	0.31
Ethnicity of Direct Care Workers	
High Hispanic/Latino workers (> median)	0.63
Low Hispanic/Latino workers (< =median)	0.60
Race of Direct Care Workers	
High minority workers (> median of all non-white race categories)	0.49
Low minority workers (< =median of all non-white race categories)	0.75

(continued)

Table 6-2. Average Turnover Rate of Direct Care Workers, by Provider Characteristics, 2014 (continued)

Provider Characteristics	Average Annual Turnover
Ethnicity of Beneficiaries	
High Hispanic/Latino beneficiaries (> median)	0.53
Low Hispanic/Latino beneficiaries (< =median)	0.64
Race of Beneficiaries	
High minority beneficiaries (> median of all non-white race categories)	0.63
Low minority beneficiaries (< =median of all non-white race categories)	0.59
Age of Target Population	
Elderly (65 years or more)	0.58
Younger individuals with disabilities (Less than 65 years)	0.65
Employer Size	
Large provider (more than 75 beneficiaries)	0.63
Small provider (75 beneficiaries or less)	0.61
Education of Direct Care Workers	
Higher than median education	0.57
Lower than median education	0.64
Training of Direct Care Workers	
Less than 75 hours	0.59
75 hours or more	0.68
Fringe Benefits Offered in 2014	
Health insurance with family coverage	0.52
Health insurance for employee only	0.79
Paid personal time off, vacation time, or sick leave	0.50
Paid holidays	0.76
Pension or 401(k) or 403(b) accounts	0.42
Employer-sponsored life insurance	0.73
Wage Rates	0.57
Less than $12.00 per hour	0.66
$12.00 to $16.00 per hour	0.54
More than $16.00 per hour	0.75

Note: Turnover calculated as estimated total number of direct care workers in 2014 divided by the number of current direct care workers. Unit of analysis is providers.

Source: RTI International analysis of the 2014 Oregon Wage and Fringe Benefit Survey of Long-Term Care (LTC) Providers.

The ethnicity and race of direct care workers appears to have some influence over turnover rates of direct care workers. Providers with a higher proportion of Hispanic/Latino direct care workers had a slightly higher turnover rate (88%) of these staff compared to providers with a lower proportion of Hispanic/Latino direct care workers (84%). The race of direct care workers had a bigger impact on turnover rates compared to ethnicity. Providers with a lower proportion of minority workers had a much larger turnover rate compared to those providers with a higher proportion of minority workers (94% and 78%, respectively).

6.2 Predictors of the Annual Turnover Rate for Long-Term Care Direct Care Workers

Table 6-3 presents the results of a multivariate analysis of annual turnover rates for direct care workers. The analysis was conducted pooling all long-term care providers. The table provides information on which factors affect the turnover rate for direct care workers in Oregon holding other factors constant. The analysis focuses on certain characteristics of long-term care providers that may influence the turnover rates of direct care workers, including the types of providers as well as their ownership, size, location, and requirements around training for direct care workers. Other factors that were accounted for in the regression include the ethnicity, race, and education levels of the direct care workers, as well as the service users' age and primary payer source for services received.

Table 6-3. OLS Regression of Direct Care Worker Turnover Rate, 2014

Variables	Coefficient	P-Value
Type of Provider		
Nursing Facility	0.0553	0.8080
Residential Care APD	0.0457	0.8422
Residential Care DD Adult	0.4484	0.0144
Adult APD	0.1438	0.4658
Adult DD	-0.0148	0.9398
Assisted Living Facility APD	0.0994	0.6554
In Home Care Agency	0.1837	0.4983
Adult Day Services APD	0.0883	0.8184
IC Specialized Living	0.5226	0.6494
Specialized Living Services	0.0663	0.9361
Type of Ownership		
Private, nonprofit organization	0.0702	0.5749
Private, for profit organization	0.2506	0.0252
Government - federal, state, county, or local	0.0000	.

(continued)

Table 6-3. OLS Regression of Direct Care Worker Turnover Rate, 2014 (continued)

Variables	Coefficient	P-Value
Part of Corporate Chain Ownership		
Yes	0.2134	0.0002
No	0.0000	.
Proportion of Direct Care Workers Who are Hispanic/Latino	-0.0002	0.8532
Proportion of Direct Care Workers Who are Nonwhite	-0.0017	0.0277
Proportion of Beneficiaries Who Have Their Care Paid by Medicaid	-0.0016	0.0188
Proportion of Beneficiaries Who Are Over Age 65	-0.0007	0.5032
Number of Beneficiaries	-0.0006	0.5012
Proportion of Direct Care Workers With More Than a High School Education	0.0013	0.4168
Whether the Provider Requires 75 or More Hours of Training		
Yes	0.1283	0.0333
No	0.0000	.
Whether the Provider is Rural		
Metropolitan	-0.3278	0.0012
Micropolitan	-0.1439	0.2159
Non-Metropolitan/Non-Micropolitan	0.0000	.
Proportion of Direct Care Workers Who Make Less Than $12.00 per hour	0.1933	0.0164

Note: Unit of analysis is providers.

Source: RTI International analysis of the 2014 Oregon Wage and Fringe Benefit Survey of Long-Term Care (LTC) Providers.

6.2.1 Long-Term Care Provider Factors

In general, most long-term care provider types did not affect the turnover rate of direct care workers, although the type of ownership, the hours required for direct care worker training, and the pay of direct care workers had significant effects on the turnover rate of direct care workers. Among provider types, only residential care facilities for aged/physical disabilities were significantly more likely to have higher turnover rates (p=0.0144).

Private for-profit providers had significantly higher turnover rates of direct care workers compared to government-owned providers (p=0.0252). Being part of a corporate chain also significantly increased the turnover rates of direct care workers compared to providers that were individual entities (p=0.0002). Unexpectedly, providers that required at least 75 hours of training for direct care workers had higher turnover rates than providers with lower training requirements (p=0.0333). However, providers located in metropolitan areas had

lower turnover rates of their direct care workers when compared to providers located in more rural areas (p=0.0012). Providers that had a higher proportion of low wage direct care workers (less than $12.00 an hour) high higher turnover rates than providers who had a lower proportion of low wage direct care workers.

6.2.2 Direct Care Worker Factors

Among the direct care worker factors accounted for, the race and pay of the direct care workers significantly affected their turnover rates overall. Those providers who had higher proportions of minority direct care workers were significantly more likely to have lower turnover rates than those providers with less minority direct care workers (p=0.0277). The proportion of direct care workers with higher levels of education had no significant effect on their turnover rates.

6.2.3 Service User Factors

Primary payer source for the services received was a significant predictor of turnover. Unexpectedly, providers that had higher proportion of service users who used Medicaid as their primary payer for services had statistically significantly lower turnover rates than those providers with lower proportions of Medicaid service users, although the size of the effect is small (p=0.0188). The proportion of service users who were age 65 or older did not have a significant effect on the turnover rates of direct care workers.

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Data pulled is from Last FFY 10/1/13 – 9/30/14:

Last year our agency records show that there were 366 sanctions for the three levels of licensed long-term care facilities. Some of the sanctions were the result of an abuse complaint, while others arose from licensing surveys. Although not all of the sanctions resulted in a fine, a majority of them were monetary in nature. (Non-monetary sanctions include restriction of admissions, requiring a consultant be on site, etc.) Adult Foster Homes (AFH) had 136 sanctions out of the 1644 licensed as long-term care. (Of the 136 AFH sanctions, 48 were from Multnomah County which regulates and licenses the 409 AFH's separately from the State.) There were 131 sanctions to Residential Care and Assisted Living Facilities (RALF) with the total number of these facilities being 220. Lastly, of the 141 Nursing Homes (NH), the state issued 99 sanctions.

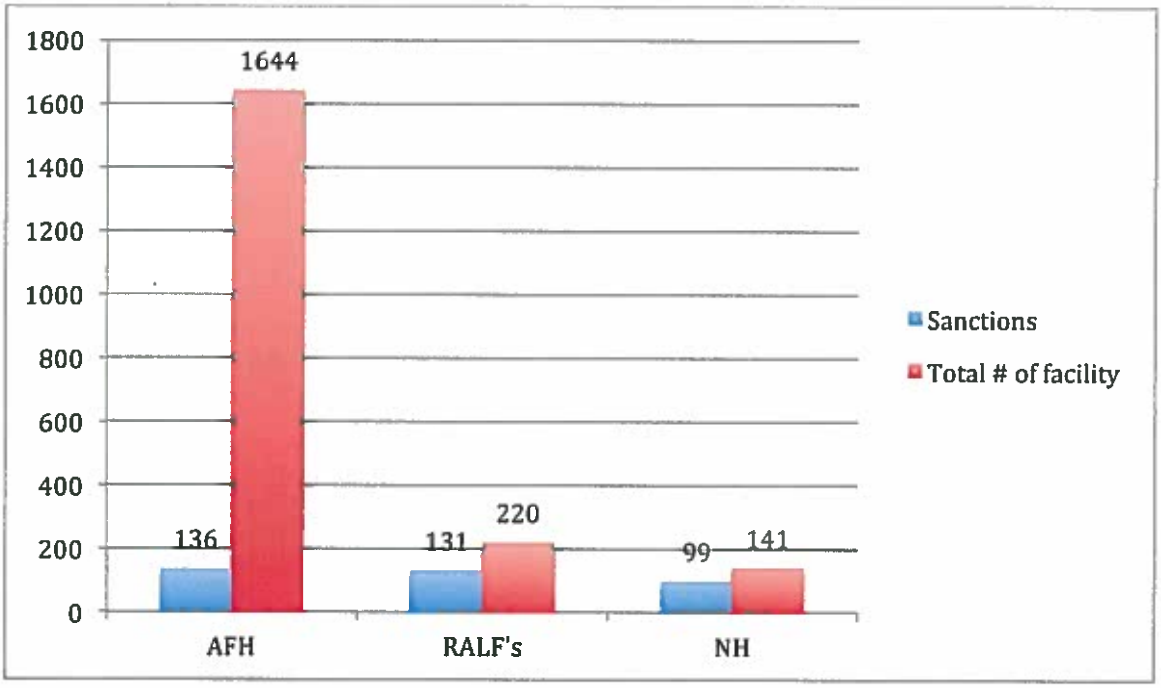

Figure 1 Sanctions vs. Number of Facilities

David – I don't know if you want to put this info in or not.

Per OAAPI report for calendar year 2013:

	NF	ALF	RCF	AFH
Complaints	1105	756	1001	763
Substantiations	319	356	366	303
Licensing	199	195	209	160
Abuse	120 (10.8%)	161 (21.3%)	157 (15.7%)	143 (18.7%)

% is based on all complaints filed.

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Residential Care/Assisted Living Facility
OAR 411-054-0120 Civil Penalties

Level	Severity	Penalty Range	Starting Point
Level 1	No harm or Potential for minor harm	No penalty	N/A
Level 2	Minor harm or Potential for moderate harm	$100 - $300	$200
Level 3	Moderate harm or Potential for serious harm	$200 - $400	$300
Level 4	Serious harm or death	$300 - $500	$400
Enhanced Civil Penalty	Death, serious injury, rape, or sexual abuse according to defined criteria as found in OAR 411-054-0120 (4)(b)	$2,500 - $15,000	$2,500

Harm - a negative impact to resident physical, mental, financial and/or emotional well-being as defined by the following terms:

Potential - the possibility of harm not yet realized.

Minor - harm resulting in: no more than temporary physical, mental or emotional discomfort or pain without loss of function; injury treatable in-house with expected rapid recovery; injury treated with little or no outside professional intervention; or minor violation of residents' rights.

Moderate - harm resulting in: temporary loss of physical, mental or emotional function; illness or pain lasting more than 24 hours even if controlled by medication; injury treatable with possibility of recovery; injury treated by outside professional intervention either in-house, in an emergency or with short-term hospitalization; or violation of residents' rights.

Serious - harm resulting in: long-term or permanent loss of physical, mental or emotional function; extreme or prolonged pain even if controlled by medication; significant loss of dignity; injury requiring aggressive treatment with limited or prolonged recovery or death; injury requiring extensive/ongoing outside professional intervention either in-house, in an emergency department or with long-term hospitalization; injury requiring surgical intervention; or significant violation of residents' rights.

APD Adult Foster Homes

OAR 411-050-0685 Civil Penalties

Civil penalty	Mandatory civil penalty	Violation
$100 per violation, up to $250	No	General rule violation
Up to $500	Yes	Falsifying resident or facility records
$250	Yes	Failure to have qualified caregiver on duty 24 hours per day
$250	Yes	Dismantling or removing the battery from, or failing to install, any required smoke alarm
$250 to $500	Yes	Admitting a resident knowing the resident's care needs exceed the license classification and the admission places the resident or other residents at risk of harm
Up to $1,000 per occurrence	No	Substantiated abuse
Not less than $2,500 per violation	Yes	Substantiated abuse if abuse resulted in the death, serious injury, rape or sexual abuse

ORS 443.775

(10) Except as provided in subsection (11) of this section, any person who violates a provision of ORS 443.705 to 443.825 or the rules adopted there under may be subjected to the imposition of a civil penalty, to be fixed by the licensing agency by rule, not to exceed $100 per violation, to a maximum of $250 or, per occurrence of substantiated abuse, a maximum of $1,000.

(11)(a) If the licensing agency determines that there is reasonable cause to believe that abuse occurred in an adult foster home licensed by the licensing agency and if the abuse resulted in the death, serious injury, rape, sexual

abuse or sexual exploitation of a resident, the licensing agency shall impose a civil penalty on the adult foster home of not less than $2,500 for each violation.

443.790 Authority to impose civil penalty; factors to be considered; rules.

(1) In addition to any other liability or penalty provided by law, the director of the licensing agency may impose a civil penalty on a person for any of the following:

(a) Violation of any of the terms or conditions of a license issued under ORS 443.735.

(b) Violation of any rule or general order of the licensing agency that pertains to a facility.

(c) Violation of any final order of the director that pertains specifically to the facility owned or operated by the person incurring the penalty.

(d) Violation of ORS 443.745 or of rules required to be adopted under ORS 443.775.

(e) Violation of the requirement to have a license under ORS 443.725 (1).

(2) The director shall impose a civil penalty not to exceed $500, unless otherwise required by law, on any adult foster home for falsifying resident or facility records or causing another to do so.

(3) The director shall impose a civil penalty of $250 on a provider who violates ORS 443.725 (3).

(4) The director shall impose a civil penalty of not less than $250 nor more than $500, unless otherwise required by law, on a provider who admits a resident knowing that the resident's care needs exceed the license classification of the provider if the admission places the resident or other residents at grave risk of harm.

Nursing Facilities

ORS	Summary
441.710	DHS may impose CMP for violation terms of licensure/licensing rules (LTC defined in 442.015), DHS may not impose penalty for violations other than those involving direct patient care or feeding, adequate staff/patient ratio, sanitation involving direct patient care or violation of 441.605, 443.880, 443.881 or 410.610 rules unless a violation is found on two consecutive surveys. Correction required within 30 days of first notice or as specified in plan of correction.
441.712	Notice (per 183.745); 10 days to request hearing.
441.715	Objective criteria for CPs; rules - Penalty may be imposed for each day violation occurs, not to exceed $500/day or as required by federal law. Deliberate abuse resulting in death, serious injury, rape or sexual abuse, CP not less than $2,500 for each substantiated occurrence, not to exceed $15,000 per 90 days. Penalties may not exceed $7,500, or as required by federal law, per 90 days.
441.745	All penalties recovered under 441.710-441.740 and 441.995 deposited to Quality Care Fund (443.001)
441.990	Civil and criminal penalties - Violation of 441.015(1) is a Class B violation, each day of continuing violation after a first conviction considered a subsequent violation, willful interference of DHS work is a Class C misdemeanor, removal of notice (441.030) is a Class C misdemeanor, DHS may assess CPs against a facility for violation of 441.015(1); CP under this section may not exceed $5,000. CPs recovered under this section credited to GF.
441.615	Powers and responsibilities of department; rules - administration of 441.600-441.625, 441.710 and 441.715, DHS may inspect facility and records to ensure compliance, adopt rules, file complaints and initiate enforcement proceedings.
441.995(3)	If the department finds the facility is responsible for abuse and if the abuse resulted in a resident's death or serious injury, the department shall impose a civil penalty of not less than $500 nor more than $1,000 for each violation, or as otherwise required by federal law or ORS 441.715 (1)(c), 443.455 or 443.775.
441.055	Facility responsible for selection of medical staff and quality of care rendered in the facility.

EXHIBIT 89-1 Civil Penalty Chart (OAR 411-089-0030)
(Amended 04/01/2014)
I. RANGE OF CIVIL PENALTIES

A. Abuse: ORS 441.715(1)(c) $2,500 - $15,000
B. Abuse: ORS 441.995(3) $500 - $1,000
C. Injury, Serious1 $500 - $1,000
D. Injury, Moderate2 $300 - $500
E. Injury, Minor3 $100 - $300
F. Injury, Potential $100 - $300
G. Other $100 - $500
a. Involuntary seclusion
b. Corporal punishment
c. Verbal abuse
d. Financial abuse (consider amount taken/expended)
e. Emotional abuse
f. Loss of dignity
II. MODIFIERS (The history for the 24 months prior to the incident is used to determine whether penalty is assessed at the upper or lower penalty ranges listed above)
A. Citation of "related problem"4 through survey, complaint investigation, or letter (increases penalty).
B. Civil penalty issues for "related problem" (increases penalty).
C. Facility history of preventing, correcting other violations. If the Department determines the licensee took significant action to correct "related problem," the Department may waive part or all of the modifier (IIA & IIB).
D. Facility history relating to current violation. The Department may increase the penalty if the facility fails to correct the situation or eliminate the threat after being made aware of the situation or incident. Decrease or suspend penalty after evaluating facility response to incident and efforts to eliminate recurrence.
E. Extended duration. If the Department determines the licensee or facility staff had opportunity to correct the deficiency after it first occurred but action was delayed, the Department may either increase the civil penalty by up to 100% or issue the civil penalty on a "per day" basis.
F. Facility Financial Benefit. The Department may increase the base civil penalty or the modifier based upon the Department's estimate of the cost savings to the facility.
G. Complaint is self-reported (reduces penalty).
H. Multiple residents: Potential or actual injury (increases penalty).
1 Serious injury means permanent physical injury that creates a substantial risk of death or that causes serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of any bodily organ.
2 Moderate Injury means an injury, which would ordinarily be temporary loss of functioning in a typical person or illness or pain lasting more than 24 hours, even if controlled by medication.

3 Minor injury means an injury resulting in temporary discomfort or pain, treated in-house, including medication or treatment or bed rest for short duration, ordinarily not more than 24-48 hours.
4 Related problem means the same staff or resident involved or the same rule, same harm, or same underlying cause.

411-089-0030 Civil Penalties

(Amended 04/01/2014)
(1) CONSIDERATIONS. In determining the amount of a civil penalty the Department shall consider:
(a) Any prior violations of statute or rule by the facility or licensee that relates to operation of a nursing facility;
(b) The financial benefits, if any, realized by the facility as a result of the violation, such as costs avoided as a result of not having obtained sufficient staffing, equipment, or supplies;
(c) The gravity of the violation, including the actual and potential threat to health, safety, and well-being of residents, the duration of the threat or number or times the threat occurred, and the number of residents threatened;
(d) The severity of the actual or potential harm caused by the violation, including whether the actual or potential harm included loss of life or serious physical or emotional injury;
(e) The facility's history of correcting violations and preventing recurrence of violations; and
(f) Exhibit 89-1, Civil Penalty Chart, which is incorporated by reference and is a part of this rule.
(2) SINGLE VIOLATION CIVIL PENALTIES. Violations of any requirement within any part of the following statutes, rules, or sections of the following rules are a violation that may result in a civil penalty after a single occurrence.
(a) Violations involving direct resident care, feeding, or sanitation involving direct resident care, including any violation of:
(A) OAR 411-085-0060 (Specialty Nursing Facilities);
(B) OAR 411-085-0200(2) (Facility Employees);
(C) OAR 411-085-0210 to 411-085-0220 (Facility Policies, Quality Assurance);
(D) OAR 411-085-0360 (Abuse);
(E) OAR 411-086-0010 to 411-086-0020 (Administrator, Director of Nursing Services);
(F) OAR 411-086-0040 (except section (3)) (Admission of Residents);
(G) OAR 411-086-0050 to 411-086-0060 (Day Care, Assessment, and Care Plan);
(H) OAR 411-086-0110 to 411-086-0150 (Nursing Services);
(I) OAR 411-086-0200 to 411-086-0260 (Physician, Dental, Rehabilitative, Activity, Social, Dietary, and Pharmaceutical Services);
(J) OAR 411-086-0300 (except section (6)) (Clinical Records);
(K) OAR 411-086-0310 to 411-086-0360 (Employee Orientation and Training, Disaster Preparation, Infection Control, Smoking, Furnishings, and Equipment);

(L) OAR 411-087-0100(1)(a) and (c) (Repair and Cleanliness); or
(M) OAR 411-087-0440 (Alarm and Nurse Call Systems).
(b) Violation involving failure to provide staff-to-resident ratio, including any violation of:
(A) OAR 411-086-0030 (except section (1)) (RN Care Manager); or
(B) OAR 411-086-0100 (Nursing Staffing).
(c) Violation of any rule adopted pursuant to ORS 441.610, including:
(A) OAR 411-085-0300 to 411-085-0350 (Resident Rights);
(B) OAR 411-086-0040(3) (Advance Directives);
(C) OAR 411-086-0300(6) (Record Retention); or
(D) OAR chapter 411, division 088 (Rights Regarding Transfers).
(d) Violation of ORS 441.605 (Resident Rights) or any general or final order of the Department.
(3) CIVIL PENALTIES REQUIRING REPEAT VIOLATIONS. Violation of any Department rule not listed in section (2) of this rule is subject to a civil penalty under the following circumstances:
(a) Such violation is determined to exist on two consecutive surveys, inspections, or visits; and
(b) The Department prescribed a reasonable time for elimination of the violation at the time of, or subsequent to, the first citation.
(4) AMOUNT OF CIVIL PENALTY.
(a) Violation of any requirement or order listed in section (2) of this rule is subject to a civil penalty of not more than $500 for each day the violation occurs, unless otherwise provided by this section;
(b) Violation of any requirement listed in section (3) of this rule is subject to a civil penalty of not more than $500 per violation, unless otherwise provided by this section;
(c) Violation involving resident abuse that resulted in serious injury or death is subject to a civil penalty of not less than $500 nor more than $1,000, or as otherwise required by federal law (ORS 441.995(3) and ORS 441.715(1)(c));
(d) The Department shall impose a civil penalty of not less than $2,500 for each occurrence of substantiated abuse that resulted in the death, serious injury, rape, or sexual abuse of a resident. The civil penalty may not exceed $15,000 in any 90-day period.
(A) To impose this civil penalty, the Department shall establish that:
(i) The abuse arose from deliberate or other than accidental action or inaction;
(ii) The conduct resulting in the abuse was likely to cause death, serious injury, rape, or sexual abuse of a resident; and
(iii) The person substantiated for the abuse had a duty of care toward the resident.
(B) For the purposes of this civil penalty, the following definitions apply:
(i) "Serious injury" means a physical injury that creates a substantial risk of death or that causes serious disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.
(ii) "Rape" means rape in the first, second, or third degree as described in ORS 163.355, 163.365, and 163.375.

(iii) "Sexual abuse" means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, sodomy, sexual coercion, sexually explicit photographing, or sexual harassment. The sexual contact must be in the form of any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.
(iv) "Other than accidental" means failure on the part of the licensee, or licensee's employees, agents, or volunteers for whose conduct licensee is responsible, to comply with applicable Oregon Administrative Rules.
(5) ADMINISTRATOR SANCTIONS - NURSING FACILITY CLOSURES. Any individual who is or was the administrator of a facility and fails or failed to comply with the requirements at OAR 411-085-0025(2)(d)(e)(f)(h), OAR 411-085-0025(3)(a), or OAR 411-088-0070(1)(g), (3)(d), or (4):
(a) Are subject to a civil monetary penalty as follows:
(A) A minimum of $500 for the first offense;
(B) A minimum of $1,500 for the second offense; and
(C) A minimum of $3,000 for the third and subsequent offenses;
(b) May be subject to exclusion from participation in any Federal health care program as defined in section 1128B(f) of the Patient Protection and Affordable Care Act; and
(c) Are subject to any other penalties that may be prescribed by law.
(6) PAYMENT TO BE CONSIDERED ADMISSION OF VIOLATION. Unless the Department agrees otherwise, for purposes of history of the facility, any payment of a civil penalty is treated by the Department as a violation of the statutes or rules alleged in the civil penalty notice for which the civil penalty was paid for.
(7) All penalties recovered are deposited in the Quality Care Fund.
(8) NOTICE. The Department's notice of its intent to impose a civil penalty shall include the statements set out in OAR 411-089-0040(3)(a)-(f) and shall also include a statement that if the licensee fails to request a hearing within 10 days of the date the notice was mailed, the licensee shall have waived the right to a hearing.
(9) HEARING REQUEST.
(a) If the Department issues a notice of intent to impose a civil penalty, the licensee is entitled to a hearing in accordance with ORS chapter 183.
(b) A request for a hearing must be in writing and must be received by the Department within 10 days of the date the notice of intent to impose a civil penalty was mailed to the licensee. The hearing request must include an admission or denial of each factual matter alleged in the notice and must affirmatively allege a short plain statement of each relevant affirmative defense the licensee may have. The Department may extend the time allowed for submission of the admission or denial and affirmative defenses for up to 30 calendar days.
(10) DEFAULT ORDER. If a hearing is not timely requested or if the licensee withdraws a hearing request or fails to appear at a scheduled hearing, the Department may enter a final order by default imposing the civil penalty. In the event of a default, the Department's file on the subject of the civil penalty

automatically becomes a part of the record for purposes of proving the Department's prima facie case.
Stat. Auth.: ORS 441.615, 441.637, 441.710, 441.715, & 441.990 Stats.
Implemented: ORS 410.070, 441.055, 441.615, 441.637, 441.715.

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NURSING FACILITY
FEDERAL/STATE REMEDIES
POLICIES AND PROCEDURES

PURPOSE

Nursing facility survey and certification procedures are regulated by the federal Centers for Medicare/Medicaid Services (CMS). As part of its regulatory function, CMS has identified a number of remedies that can be imposed when a facility is found to not be in compliance with federal regulations.

The remedies are grouped together according to the way in which they are to be applied. The State Operations Manual (SOM) provides guidance for the use of each type of remedy. However, there is little to guide the State Survey Agency (SSA) in determining which remedy, from among a group of potential remedies, to apply in a certain situation.

The purpose of this document is to provide guidelines for imposing, or requesting the imposition of, federal remedies. By providing guidelines for which, if any, remedy to choose in a given situation, it will hopefully result in increased consistency between and within Client Care Monitoring Unit (CCMU) offices in choosing an appropriate remedy. Numeric references are to the pertinent section of the SOM.

ENFORCEMENT REMEDIES BY CATEGORY

Category 1- Mandatory for Levels D and E, Optional for All Other Levels

- Directed Plan of Correction (7500)
- State Monitoring (7504)
- Directed In-Service Training (7502)

Category 2 - Mandatory for Levels F, G, H and I - Optional for Levels J, K and L

- Denial of Payment for New Admissions (7506)
- Denial of Payment for All Residents (7508)
- Civil Money Penalty (7510 - 7534)

Category 3 - Mandatory for Levels J, K and L

- Temporary Manager (7550) (Optional Level F)
- Termination of Provider Agreement (7556)
- Civil Money Penalty (7510 - 7534) (Optional)

Not Associated with a Category

- Transfer of Residents (7552)
- Denial of Participation
- Closure of Facility and Transfer of Residents (7552)
- Other CMS-Approved Alternative State Remedies (7400C3):
  - Restriction of Admissions
  - Trusteeship
  - State Civil Penalty (If CMS Declines to Impose Federal CMP)

Additional Remedies

- Loss of Nurse Aide Training (7536)
- Continuation of Payment During Correction (7600)

CATEGORY 1 REMEDIES

When a recertification survey or complaint survey cites a violation at a Level D or E, the imposition of a Category 1 remedy is required. A Category 1 remedy may also be imposed as an optional remedy for citations at Level F or above.

Category 1 remedies may be imposed directly by the SSA without going through CMS.

Directed Plan of Correction (7500)

A Directed Plan of Correction (DPoC) may be imposed as the required remedy for Levels D and E and an optional remedy for Level F and above when the citation involves concrete, measurable issues. For example, a DPoC should be considered when the facility is cited for violations involving physical plant and environmental deficiencies and violations related to dietary tasks. Fire Marshal may impose a DPoC for Life Safety Code violations.

A DPoC may be imposed without providing the facility an opportunity to correct the violation(s).

Immediate notice must be given to the facility prior to the effective date of the DPoC:

- 2 day notice in IJ situations or
- 15-day notice in non-IJ situations.

The DPoC must be written to address all elements of an approved facility plan of correction (PoC).

The DPoC may be written for a specific citation or for the entire survey.

If the facility fails to comply with the DPoC, or fails to achieve compliance after complying with the DPoC, additional remedies may be imposed.

Liability for non-compliance remains with the facility even if they follow the DPoC.

State Monitoring (7504)

The purpose of imposing State Monitoring (SM) is to oversee the facility's operations during their period of correction as a safeguard against further harm to residents when harm (or potential harm) has occurred.

SM will not be imposed for Level D.

SM will be imposed as a mandatory remedy for Levels F through L after 3 consecutive standard surveys at substandard quality of care (SQC) (7504D)

SM should be strongly considered as an optional remedy for Levels F through L when:

- The facility is cited at SQC;
- A Restriction of Admissions (ROA) has been imposed; or
- The facility is close to decertification and did not pass their 2nd revisit.

SM should be lifted when the facility achieves substantial compliance and, if imposed for repeated SQC, the monitor has determined that the facility is able to sustain compliance.

SM role is to observe the facility's correction process to avoid future harm.

The SM is not a consultant and is not there to assist the facility with achieving compliance.

Monitor should have education and background relating to the issues of concern:

- 1st choice would be a Department/AAA employee;
- 2nd choice would be an outside contractor of the Department.

Directed In-Service Training (7502)

A Directed In-Service Training (DIST) would be imposed, without an opportunity to correct, as the mandatory Category 1 remedy when the following violations are cited at Level D or E:

- Assessment tags, such as use of the Resident Assessment Instrument (RAI);
- Incident/abuse investigation tags; and
- Repeat deficiencies.

A DIST may be imposed for all other types of citations, with or without an opportunity to correct.

A DIST should be imposed as an option remedy at any Level if the SSA believes education is likely to correct the deficiencies and help the facility achieve substantial compliance.

Notice must be given to the facility prior to the effective date of the DIST:

- 2 day notice in IJ; or
- 15-day notice in non-IJ situations.

CCMU will identify specific training topics, identify what staff should attend the training, identify a completion date and require evidence that the training has been conducted as specified. Consider providing assistance with identifying resources such as videos.

The facility bears the cost of the DIST.

CATEGORY 2 REMEDIES

When a recertification survey or complaint survey cites a violation at a Level F, G, H or I, the imposition of a Category 2 remedy is required. A Category 2 remedy may also be imposed as an optional remedy for citations at Levels D, E, J, K and L.

Category 2 remedies must be recommended to CMS, which will review and, if deemed appropriate, impose the remedy. A restriction of admissions is a state remedy and may be imposed by the state office.

Denial of Payment for New Admissions (7506)

A Denial of Payment for New Admissions (DOPNA) will be recommended as a mandatory remedy without the opportunity to correct when the facility has survey findings of substandard quality of care (SQC) or findings at Level H or I which do not constitute SQC.

DOPNA will not be recommended for citations at Levels D and E.

DOPNA may be recommended, with an opportunity to correct, for citations at Level F that do not constitute SQC.

Denial of Payment for All Residents (7508)

The SSA will not recommend the imposition of this remedy for any citation.

Civil Money Penalty (7510 - 7534)

A Civil Money Penalty (CMP) will be recommended as a mandatory remedy for all Level G outcome citations. As a general rule, a CMP will not be recommended for related Level G process citations.

A CMP may be recommended as an optional remedy for:

- repeat citations at Levels D and E;
- citations at SQC when no ROA is being imposed; or
- citations at Levels H-L which do not constitute SQC.

CMP should be recommended for immediate imposition without opportunity to correct.
CMPs may be recommended on either a per-day or per-instance basis.

A **per-day** civil money remedy should be recommended when:

- The facility has made no reasonable attempt to correct prior citation; and
- There is a concrete, measurable solution that will stop the running of the remedy.
- Per-day CMPs are appropriate for citations for pests, structural damage, environmental violations, inappropriate and/or inoperable equipment, inadequate staffing, failure to comply with the terms of a Restriction of Admissions and Life Safety violations.

A per-day CMP will often be effective the date of the survey and accrues for the number of days of noncompliance. A per-day CMP can be increased or decreased based on a subsequent change in facility noncompliance.

The beginning ranges for per-day CMPs are as follows:

Level 4	J $3050	K $4050	L $5050
Level 3	G $ 250	H $ 600	I $1000
Level 2	D $ 100	E $ 150	F $ 200
Level 1	A N/A	B N/A	C N/A

A **per-instance** CMP should be recommended when:

- Citations involve assessment, care planning, nursing, medications, staffing, interventions and other citations involving resident care.
- A per-instance CMP can be recommended on a per person/per instance basis when multiple residents are involved

A per-instance CMP will be effective the last day of the survey.

The beginning ranges for per-instance CMPs are as follows:

Level 4	J $3500	K $4500	L $5500
Level 3	G $1500	H $2000	I $2500
Level 2	D $1000	E $1100	F $1200
Level 1	A N/A	B N/A	C N/A

The following factors are to be considered in setting the amount of either type of CMP:

- Facility's history of non-compliance, including repeat deficiencies;
- Facility's financial condition;
- Seriousness and scope of deficiencies;
- Relationship of one deficiency to other deficiencies;
- Facility's degree of culpability - harm or risk of harm is intentional or the result of neglect, indifference or disregard; and
- Whether other remedies are being recommended or imposed.

CMPs are adjusted upward in $50 increments according to the factors set out above.

A CMP at $5,000 or more will affect the facility's ability to participate in the Nurse Aide Training and Evaluation Program (NATCEP).

Restriction of Admissions

In Level H-L situations, 7550(I) allows for use of an acceptable state alternative remedy in lieu of temporary management (see Category 3 Remedies). Imposition of a Restriction of Admissions (ROA) is authorized under ORS 441.030 (4)(5) and implemented under OAR 411-089-0050. An ROA is imposed by the Department of Human Services, Seniors and People with Disabilities, Office of Licensing and Quality Care without prior recommendation to or approval by CMS.

The purpose of an ROA is to protect current and prospective residents from threats to their health, safety and welfare and help ensure that the attention of facilities with serious deficiencies is directed toward correcting those deficiencies.

When the Department finds an immediate threat to resident health and safety, it may order an immediate restriction of admissions or may immediately restrict the number or type of admissions to the facility. For the purposes of this rule, an immediate threat to resident health and safety exists when:

- The Department finds a pattern of:
  - Failure to assess or take action to prevent or treat decubitus ulcers, weight loss, infection, dehydration or other changes in the physical condition of residents; or
  - Failure to follow physician's orders, including failure to correctly administer medications; or
  - Abuse as defined by ORS 441.630, or preventable injuries; or

- The Department finds that any other condition or combination of conditions exists which, in the opinion of the Department, constitute an immediate threat to resident health and safety, or a potential threat to new residents.

The Department must consider the following factors before deciding to impose an ROA:

- The needs of the residents and prospective residents;
- The severity of the threat to current and prospective residents; and
- The history of the care provided by the licensee.

Any time SQC or IJ is found, CCMU management will:

- Contact Nursing Facility/Corrective Action Unit Manager or Lead Corrective Action Coordinator as soon as possible to advise of finding;
- Be prepared to discuss criteria for an ROA and whether those factors are present in the case at hand; and
- If an ROA is deemed to be appropriate, immediately prepare and submit a statement of the factual findings, the recommendation for an ROA and the rationale for that recommendation.
- CCMU management will not release its survey report citing SQC or IJ until such findings have been staffed with the Nursing Facility/Corrective Action Unit Manager or Lead Corrective Action Coordinator.

Except where the threat to residents is so imminent that the Department determines pre-restriction notice is not practical, the Department will provide the licensee with a pre-restriction notice and opportunity for an informal conference at least 48 hours prior to issuing an Admission Restriction Order. The pre-restriction notice will:

- Describe generally the acts or omissions of the licensee and the circumstances which led to the finding that an immediate threat to resident health and safety exists at the facility;
- Describe generally why the acts or omissions and the circumstances create an immediate threat to resident or prospective resident health and safety; and
- Identify a person at the Department whom the licensee may contact and who is authorized to enter the Admission Restriction Order or to make recommendations regarding issuance of an order; and
- Specify the date and time the Admission Restriction Order will take

effect.

If a pre-restriction notice is given, the Admission Restriction may be issued any time after the informal conference.

If an Admission Restriction Order is issued without prior notice, the licensee may request an immediate informal conference to object to the Department's actions. In either case, the licensee has the right to a contested case hearing if requested within 90 days of the Admission Restriction Order. When a timely request for a hearing is received, the hearing will be held as soon as practical, but not later than thirty days after the request for hearing, unless the Department and licensee agree to a later date.

A timely request for a contested case hearing will not stay the immediate imposition of an ROA.

A licensee who has been ordered to restrict admissions to a facility shall immediately post a Restriction of Admissions Notice on both the inside and outside faces of each door of the facility through which any person may enter or exit the facility.

When the licensee determines the circumstances leading to the ROA no longer exist and that effective systems are in place to help ensure similar deficiencies do not recur, the licensee may request that a reinspection occur within 15 days.

If the reinspection confirms that there is no longer an immediate threat to resident health and safety and finds effective systems are in place to ensure similar deficiencies do not recur, the ROA will be lifted.

If the Department determines an immediate threat to resident health and safety continues to exist after a reinspection, the ROA will not be lifted and the Department is not obligated to reinspect again for at least 45 days.

CATEGORY 3 REMEDIES

When a recertification survey or complaint survey cites a violation at a Level J, K or L, the imposition of a Category 3 remedy is required.

Termination of provider agreement and civil money penalty must be recommended to CMS which will review it and, if deemed appropriate impose the penalty. The state office may impose temporary management and a restriction of admissions.

Temporary Manager (7552)

Under Construction

Termination of Provider Agreement (7556)

Under Construction

Civil Money Penalty (7510 – 7534)

A civil money penalty may be recommended as an optional remedy for citations at SQC or for citations at J, K or L that do not constitute SQC.

See Category 2 Remedy section for discussion of types and amounts of civil penalties.

Restriction of Admissions

In Level H-L situations, 7550(I) allows for use of an acceptable state alternative remedy in lieu of temporary management (see Category 3 Remedies). Imposition of a Restriction of Admissions (ROA) is authorized under ORS 441.030 (4)(5) and implemented under OAR 411-089-0050. An ROA is imposed by the Department of Human Services, Seniors and People with Disabilities, Office of Licensing and Quality Care without prior recommendation to or approval by CMS.

See Category 2 Remedy section for discussion of imposition of ROAs.